STATE OF ALASKA
Department of Administration
Division of Retirement and Benefits

PHARMACY BENEFIT MANAGEMENT (PBM) SERVICES

RFP 180000053

Amendment #3

March 1, 2018

This amendment is being issued to answer questions submitted by potential offerors and to provide additional important information. In addition to adhering to any changes made to the RFP by this amendment, offerors must use Submittal For A – Offeror Information to acknowledge this amendment.

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Questions submitted by potential offerors and answers from the state:
(Note: the question numbering reflects a continuation from RFP Amendment #2)

Question 68: Is there any documentation that can tell us the difference between these two groups?:

Retirees AB
Retirees Non AB

Answer: This was simply an internal plan designation. Retirees were broken into two files because the original retiree file size was too large. Both groups represent the entire EGWP membership.

Question 69: Can we provide a separate set of references for both our Commercial Plans and our EGWP plans, as these might sometimes be separate customers?

Answer: Offerors should submit the number of references requested in the RFP (3 for the firm and at least 1 and up to 3 for the Account Manager listed on Submittal Form A). It is expected the references submitted best represent a offeror's experience and performance. It is not required that the offeror provide both Commercial and EGWP program services for each reference.

Question 70: Regarding Section 8 (Formulary Information) #6 in Submittal Form G – Contractual Requirements, is this requirement intended to apply to both the commercial plan and the EGWP plans? And if it does apply to the EGWP, is it specific to Transition of Coverage, or is there a different purpose/intent?

Answer: Yes, this requirement applies to both the commercial and EGWP plans. For the EGWP plan, it is specific to Transition of Coverage, to prevent member disruption.

Question 71: For the retail pharmacy benefit, please identify the percentage of members with plan designs in each of the following categories:

a) 2 tier generic/brand
b) 3 or more tiers with preferred/non-preferred brands having a copay differential of < $15
c) 3 or more tiers with preferred/non-preferred brands having a copay differential of ≥ $15
d) Coinsurance with flat dollar min/max
e) Coinsurance (percentage)

Answer: Currently 100% defined benefit retirees are in a 2 tier plan design with a fixed copay. With implementation of EGWP we intend to transition to 3 tiers with preferred/non-preferred brands having a copay differential of ≥ $15.

Currently 100% of defined contribution retirees and employees have a 3 tier with coinsurance and flat dollar min/max. Coinsurance and copay differentials are outlined in the AlaskaCare employee health plan booklet available at:
http://doa.alaska.gov/drb/pdf/ghlb/akcare/SelectBenefitsEmployeeBooklet2018.pdf

Coinsurance and copay differentials are outlined in the AlaskaCare Retiree Benefit Plan for DCR Plan Retirees booklet available at:
http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaDcrRetireeHealthPlan-Final-0118.pdf

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Question 72: Please provide detailed prior authorization and step therapy utilization management criteria for the following disease states/classes:

- Antipsychotics
- Anti-diabetics: DPP-4, GLP-1 (Incretin); SGLT-2
- Growth Hormone
- Hepatitis C

- Infertility
- Multiple Sclerosis
- PCSK9
- Rheumatoid Arthritis/Autoimmune

Answer: The state relies on our current vendor (Aetna) to determine prior authorization and utilization management. Aetna provides pharmacy benefit clarifications outlining their criteria online at: https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/pharmacy-clinical-policy-bulletins.html

The state will similarly depend on the offeror to provide their own policies, and prefer these policies be publicly available.

Question 73: If any utilization management strategies are in place today, such as prior authorization, step therapies, and quantity limits, please provide a listing of these programs and a list of drugs applicable to the relevant program.

Answer: The state relies on our current vendor to determine prior authorization, and quantity limits. Aetna provides pharmacy benefit clarifications outlining their criteria online at: https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/pharmacy-clinical-policy-bulletins.html

The state will similarly depend on the offeror to provide their own policies, and prefer these policies be publicly available.

Question 74: Please provide details for any prior authorization or step therapy programs that require failure of a preferred brand before members are eligible to receive non-preferred brands.

Answer: The state relies on our current vendor to determine prior authorization, and step therapy criteria. Aetna provides pharmacy benefit clarifications outlining their criteria online at: https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/pharmacy-clinical-policy-bulletins.html

The state will similarly depend on the bidder to provide their own policies, and prefer these policies be publicly available.

Question 75: Please describe any additional formulary, plan design, or UM strategies for preferred products that might not otherwise be identifiable in the information provided.

Answer: Please refer to the responses to Question 46 and Question 47 in Amendment #2 for information regarding the current clinical and compound management programs.

Question 76: Do you allow grandfathering programs to minimize member impact due to negative formulary changes, formulary exclusions, or step therapy implementations? If yes, please describe the duration and extent to which grandfathering applies.

Answer: No, the state requires a broad formulary without drug coverage exclusions.

Question 77: Provide list of formulary excluded products.

Answer: Please refer to the response to Question 56 in Amendment #2.

Question 78: Have any formulary changes been made after the date range of the claims data provided or after the date of the formularies provided? If yes, please detail changes and effective date of those changes.

Answer: Yes, formulary changes were made after the date range of the claims data provided; however, all changes are reflected in the Safety Edits drug list and National Precertification lists provided in the response to Question 46 in Amendment #2.

Question 79: Do any of your formularies include "brand over generic" strategies; i.e., brand drug is preferred/covered on the formulary and the generic equivalent drug is excluded. If yes, please specify.

Answer: Yes, "brand over generic" strategies have been implemented in certain instances, such as the following:

1. In the case of a biosimilar release where the cost of the biosimilar isn't providing an overall lower net cost.

2. In the case of a "market exclusive generic" where the branded product maintains a lower overall net cost. Again, the generic is generally treated as non-preferred vs not covered and each instance is specifically evaluated on a case-by-case basis.

Question 80: Do you cover Diabetic Test Strips as part of the pharmacy benefit? If yes, do you have a preferred product strategy? Please describe.

Answer: Yes, as outlined in the plan documents. We look forward to discussing preferred product strategy during the clarification phase.

Question 81: Regarding Submittal Form G, Section 9 – Appeals, please provide the citation(s) to the applicable state law and specimens of the current appeals forms.

Answer: A decision made by the administrator may be appealed to the Office of Administrative Hearings in the retiree plans in accordance with Alaska Statute 39.35.006. The OAH forms are attached, and the Aetna complaint and appeal form is available online at: http://doa.alaska.gov/drb/pdf/ghlb/akcare/aetna/complaintAndAppeal.pdf

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Question 82: Regarding Submittal Form G, Section 13 – Information Technology, please identify the "state approved electronic format" currently in place today.

Answer: Please refer to the response to Question 63 in Amendment #2.

Question 83: RFP Section 3.19, Nondisclosure and Confidentiality, states, in the third paragraph, that prior authorization of the state is required for any third party disclosure of confidential information. In performing PBM services it is not uncommon for a PBM to receive requests for PHI related to a single plan member. These requests may relate to tax filings/audits, lawsuits, divorce or child custody proceedings, treating physician inquiries or any of many other similar requests. So long as such a request contains the proper authorization, bidder will respond to it. Please confirm that it is not the state's intent that every such request for an individual plan member's PHI or other individually identifiable data must be approved by the state.

Answer: The state's intent is to ensure HIPAA is followed and our member's data is not shared inappropriately. It is not our intent that every request related to a single plan member, such as those you have listed, be approved by the state.

Question 84: Is it the State's expectation that in the event of a termination for default, as contemplated by RFP Section 3.22, unless it is not feasible to cure such default, the PBM will be afforded a reasonable opportunity to cure the default?

Answer: Yes, it is the state's policy to provide contractors the opportunity to correct deficiencies before declaring default.

Question 85: Submittal Form A, Offeror Information, in Certification 3, asks that a bidder confirm that it will not "restrict the rights of the state." As the very nature of a contract is the restriction of the parties' rights in a way determined to be mutually beneficial, can the state please confirm that this certification is intended to mean that the bidder will not restrict the rights of the state in any way that is contrary to the terms of its responses to the RFP, including its agreement to the terms of Standard Agreement Form – Appendix A?

Answer: Yes, this certification is intended mean that the offeror will not restrict the rights of the state in any way that is contrary to the terms and conditions of the RFP and Appendix A. For clarity, changes to Appendix A may be requested in accordance with Section 7.02 of the RFP, which is updated below (new language in blue). Please note that the provisions in Appendix A cannot be changed without

the approval from the state's Department of Law, and that "qualifying" your bid by explicitly making your offer contingent upon the state accepting the requested changes, will result in your proposal being found non-responsive.

SEC 7.02 STADARD CONTRACT PROVISIONS

The contractor will be required to sign the state's Standard Agreement Form for Professional Services Contracts (form 02-093/Appendix A). This form is attached with the RFP for your review. The contractor must comply with the contract provisions set out in this attachment. No alteration of these provisions will be permitted without prior written approval from the Department of Law, and the state reserves the right to reject a proposal that is non-compliant or takes exception with the contract terms and conditions stated in the Agreement. Any requests to change language in this document (adjust, modify, add, delete, etc.), must be set out in the offeror's proposal in a separate document. Please include the following information with any change that you are proposing:

1. Identify the provision that the offeror takes exception with.
2. Identify why the provision is unjust, unreasonable, etc.
3. Identify exactly what suggested changes should be made.

Question 86: Submittal Form G, Contractual Requirements, Section 2, Legal Responsibilities, No. 1 refers to a Business Associate Agreement as provided by the state. Will this be subject to reasonable negotiation to reflect the successful bidder's offer and operational capabilities? If not, will the state please provide a copy of its form of Business Associate Agreement for review?

Answer: Yes, this agreement will be discussed during the Clarification Period and be subject to reasonable negotiation, keeping in mind the Department of Law will be the ultimate decider in the final agreement language.

Question 87: Section 2.09 – Please provide an example/scenario of how a member can qualify for having multiple plans within AlaskaCare. How does the coordination of benefits process work with your current provider? Is the state opposed to vendors issuing an additional ID card to COB eligible members to assist with this being done at Point of Sale?

Answer: Please refer to the answer to Question 55 in Amendment #2. The state has no objection to the issuance of an additional ID card to assist with coordination at point of sale.

Question 88: Is the state open to an alternative billing/banking arrangement where the reimbursement of claims shall be paid by the PBM through the issuance of drafts or through electronic funds transfer from the PBM's account prior to reimbursement from State of Alaska?

Answer: The state is open to a billing/banking arrangement where the state would provide the PBM a prefunding to cover a few day lag and the PBM would send us daily claims request based on claims settled basis.

Question 89: Regarding Submittal Form G, Section 1 – Match Current Plan, #3, will Submittal Form K be updated with the drug disruption worksheet?

Answer: Yes, please refer to the "Formulary Disruption" tabs in an updated Submittal Form K.

Question 90: Please provide an outline of the state's current appeals process, as mentioned, for the commercial plan in Submittal Form G – Contractual Requirements, Section 9 – Appeals #1: PBM will follow the state's current appeals process for certification review, claim review and/or billing appropriateness for commercial plan.

Answer: Please refer to the answer to Question 49 in Amendment #2.

Question 91: Are you referring to eligibility file processing or data warehouse files in Submittal Form G – Contractual Requirements, Section 13 - Information Technology, #8: Does your automated data processing capability include the ability to interface with the state's health reporting eligibility system when fully operational?

Answer: Please refer to the answer to Question 64 in Amendment #2.

Question 92: The instructions for Submittal Form E say that we must collect customer satisfaction surveys from "past" clients. Are clients who are currently receiving PBM services acceptable for any of the three required reference submissions for the offeror? Can current clients be submitted as references required for the assigned account manager?

Answer: This was addressed with Amendment #1 to the RFP and the word "past" has been removed from the RFP documents. Offeror clients may be current clients.

Question 93: As you know, we experienced a significant delay in getting the data files required to complete our proposal submission. Would the state consider extending the proposal due date to allow us additional time for analysis?

Answer: Yes, the deadline for receipt of proposals is extended until **2:00 p.m.,** Alaska Time, on **March 15, 2018.** The RFP schedule provide in Section 1.03 of the RFP is also revised as follows:

ACTIVITY	TIME	DATE
Issue Date / Draft RFP Released		1/22/18
Educational Meeting	10:00 am	1/29/18
Draft RFP Period Ends		2/1//18
Pre-Proposal Conference and Second Educational Meeting	2:00 pm	2/6/18
Deadline to Submit Questions	4:30 pm	2/27/18
Deadline for Receipt of Proposals / Proposal Due Date	2:00 pm	3/15/18

Initial Evaluations and Proposal Analysis		3/16/18
Present Financial Analysis (Segal) to Procurement		4/17/18
Present Proposal Analysis (Segal) to State		4/17/18
Shortlisting (optional)		4/18/18
Interviews	TBD	5/1/18
Clarification Period Begins		5/4/18
Notice of Intent to Award		6/15/18
Contract Issued		6/25/18
Start Date		6/26/18

Please note that in order to ensure the project schedule remains on track, this amendment serves to effect the 2/27/18 deadline to submit questions. Also note that the dates provided for events after the deadline for receipt of proposals are approximate and may be adjusted accordingly.

Question 94: Submittal Form K is a locked document and does not allow us to make any changes to it for value adds/options that we are considering for our proposal. Will the state accept additional pricing documents submitted in addition to Submittal Form K?

Answer: Offerors must use Submittal Form D to submit value-adds/options. Please note that per RFP Section 4.06, costs for value-adds must not be identified Submittal Form D and Submittal From D must be kept anonymous. Costs for value-adds will be discussed during the Clarification Period.

Question 95: Does a TPA License or Pharmacy License satisfy the requirement to have a "Business License"? Per 7.01 of the RFP "You are not required to hold a valid Alaska business license at the time proposals are opened if you possess one of the following licenses and are offering services or supplies under that specific line of business:

- fisheries business licenses issued by Alaska Department of Revenue or Alaska Department of Fish and Game,
- liquor licenses issued by Alaska Department of Revenue for alcohol sales only,
- insurance licenses issued by Alaska Department of Commerce, Community and Economic Development, Division of Insurance, or
- Mining licenses issued by Alaska Department of Revenue.

Answer: No, a TPA License or Pharmacy License is not an Alaska Business License, which must be obtained from the Department of Commerce, Community, and Economic Development.

Question 96: Submittal Form B – Please clarify if the four page limit applies in aggregate or per part (e.g. four pages total for Parts 1 – 3 or four pages each for Part 1, Part 2, and Part 3). If per Part – is there a four page limit for Part 1 – Network Plan (Commercial) and an additional four page limit for Part 1 – Network Plan (EGWP)?

Answer: The four-page limit applies in part, so four pages for Service Approach – Network Plan (Commercial), four pages for Service Approach – Network Plan (EGWP), four pages for Service Approach – Customer & Member Support, and four pages for Service Approach, Medicare Part D Enhanced EGWP.

Question 97: Submittal Form E – Performance Qualifications – the revised form sent with Amendment #1 still contains language indicating the state is looking for information from previous clients. See second sentence "The firm/individual listed below has identified you as a previous client." Is it the state's intent to obtain information from bidder's current OR previous clients? If the intent is for current or previous would the state consider revising the form as the current version is confusing if we are sending to current clients. We would also like to request a timely response since we need to allow time for clients to respond and return the form for inclusion in the final RFP response.

Answer: Thank you for catching this. Submittal Form E has been updated. Clients may be current clients. If your references have already returned the form, submitting that form is acceptable since it contains all the same fields.

Question 98: Submittal Form G, Section 9, Questions 6 and 7 – Please clarify if the state's plan is subject to ERISA. These questions imply it is however in the first educational meeting it was verbally stated it is not.

Answer: No, the plan is not subject to ERISA.

Question 99: Submittal Form G, Section 16, Questions 21 and 23 – These questions discuss the provision of performance guarantees to the state, however there is not a formal performance guarantee request within the submittal forms. Is it the state's intent that respondents provide their proposed guarantees as an additional attachment to the response?

Answer: Do not provide specific performance guarantees at this time. The state is seeking a commitment to provide and comply with the items referenced in these questions. It is anticipated specific performance guarantees and associated assessments/penalties will be discussed during the Clarification Period.

Question 100: Submittal Form H – The requested access standards are more restrictive than current CMS network adequacy standards (urban 1 in 3, suburban 1 in 5 and rural 1 in 15). Please explain the rationale for the more restrictive standards appreciating that most of the state of Alaska is classified as rural.

Answer: Submittal Form G, Section 18, Question 1 asks bidders to confirm the proposed EGWP program is compliant with all CMS requirements. The state is interested in understanding if any offerors exceed the CMS access standards and, if so, to what degree and in what locations.

Question 101: Submittal Form K, Section 8.1 Administrative Fees: Commercial and Administrative Fees: EGWP – How does a vendor indicate whether they are proposing Traditional with 100% Pass Through or Transparent with 100% Pass Through? Also, please provide clarification or further definition as to what is meant by Transparent with 100% Pass Through.

Answer: Offerors may use the Details section at the bottom of these tables to indicate pricing structure. The state requires the PBM to pass-through to the state 100% of all rebates. Regarding discounts, administrative fees and dispensing fees, the state is open to consider proposals with traditional or transparent pricing. "Transparent with 100% Pass Through" refers to pricing that is 100% transparent for the discounts and dispensing fees, with the state receiving 100% of rebates. In this pricing structure, the PBM's sole source of revenue on this contract will be administrative and program fees invoiced directly to the state and paid directly by the state to the PBM.

Question 102: Regarding the state's response to Question 23 in Amendment 2, we would like the state to reconsider allowing us to provide separate names for the four key personnel in our proposal submission. While we understand there will be a limitation as it relates to the interviews, we feel this is critical to the submission so we are representing the team members who would be assigned to the state's account for both plans (commercial and EGWP). Any team members that support our Medicare business with CMS are specialized, have specific training for CMS rules and compliance and do not manage or service any commercial business.

Answer: To clarify, outside of the limitation as it relates to interviews, if the offeror has different team members for commercial and EGWP, those members and their roles may discussed in Submittal Form B (remember no identifying information).

Question 103: From the RFP document: Section 3.03 Item 27: Medicare Part D and Retiree Drug Subsidy administrative services – include access to an online system providing covered participants and dependents with a designated contact for issue resolution and reconciliation. Please clarify if this requirement refers to providing access for the State of Alaska to an online system versus member access to an online system for this.

Answer: This requirement is for providing access to a website for members that has a designated contact for issue resolution and reconciliation.

Question 104: Regarding Submittal Form G, Section 14, Question 8: Please clarify whether "automatically coordinate" can require the pharmacy to submit the Part B claims to Part B followed by the retiree plan's PBM to avoid the retiree from having to submit secondary Part B claims manually.

Answer: The state is interested in the offeror's capability to direct claims for drugs covered under Part B to CMS for Part B reimbursement, while minimizing member impact.

Question 105: Submittal Form H – GeoAccess Analysis, is it permissible to provide the requested summaries in excel if the columns mirror the tables in the Submittal Form? Providing in an excel format would facilitate the analysis process.

Answer: Yes, Excel submissions are acceptable. At minimum, the submission should be in a modifiable format.

Question 106: Regarding Submittal Form B – Service Approach Part 3 – Medicare Part D Enhanced EGWP and slide #30 from the PBM Educational Meeting, please clarify what the state's intent is related to Part B drugs. We ask because we want to make sure our response addresses the specific issue or need. For example, is the state asking the Part B vs. Part D determinations be made at the point of service, or indicating a desire for Part B drugs to be covered as part of a "wrap" formulary instead of billed to a Part B carrier?

Answer: The state is interested in the offeror's capability to direct claims for drugs covered under Part B to CMS for Part B reimbursement, while minimizing member impact.

Question 107: Submittal Form G – Contractual Requirements – Section 1 – Number 3 – The RFP requests that we use a spreadsheet found in Submittal Form K to provide a listing of all products that will be negatively impacted, positively impacted, or remain unchanged in regard to formulary status. We are unable to find a tab in Submittal Form K that requests this information. Can the state please provide?

Answer: Please refer to the "Formulary Disruption" tabs in an updated Submittal Form K.

End of Amendment #3