Request for Proposal for Pharmacy Benefit Management Services

Tab A-1: Background and Qualifications

Representations made by the Offeror in this Proposal become contractual obligations that must be met during the contract term.

Instructions: Please complete each cell with the requested information. Items in the response column with the words, "Select one", contain a drop down list of options. Please select a response from those options as applicable.

I. GENERAL OFFEROR INFORMATION

		Response
1.	Offeror's Legal Name	
2.	Address	
3.	City	
4.	State	
5.	Zip	
6.	Web Address	
7.	Operational Date	
8.	Corporate Tax Status	**Select one**
9.	Federal Employer Identification Number	
10.	Ownership/Controlling Interest	
11.	Describe the Offeror's experience in providing pharmacy benefit management services to South Carolina based clients.	
12.	How long has the Offeror administered pharmacy benefits to South Carolina based clients?	
13.	Confirm that the organization is compliant with all applicable HIPAA administrative simplification rules.	**Select one**
14.	Provide a detailed description of any recent (within 5 years) HIPAA breaches.	
15.	a.) Will your organization be involved in any acquisitions or mergers within the next 12 months?	**Select one**
	If yes, please describe.	
	b) Has your organization been involved in any recent acquisitions or mergers?	
	• Within the last year?	**Select one**
	• 1-2 years ago?	**Select one**
	• 2-5 years ago?	**Select one**
	• None in the last five years	**Select one**
	If yes, please describe.	
16.	Confirm that your organization has Errors and Omissions Insurance and Commercial General Liability Insurance.	Please submit a copy of your certificate(s) of insurance indicating coverage limits and label as **"Tab A-1: Certificates of Insurance"**.
	• E & O	**Select one**
	• Commercial General Liability	**Select one**
17.	Please provide a copy of your organization's most recent audited annual and quarterly update financial statements, including income statements and balance sheets.	Please label as **"Tab A-1: Financial Statements"**.
18.	Provide a copy of your most recent *financial* ratings and complete the following table.	Please label as **"Tab A-1: Financial Ratings"**.
	A.M. Best	

	◆ Current Financial Rating	
	◆ Date of Rating	
	◆ Prior Financial Rating	
	◆ Date of rating	
	Standard & Poor's	
	◆ Current Financial Rating	
	◆ Date of Rating	
	◆ Prior Financial Rating	
	◆ Date of rating	
	Fitch	
	◆ Current Financial Rating	
	◆ Date of Rating	
	◆ Prior Financial Rating	
	◆ Date of rating	
19.	a.) Total number of covered enrollees, as of December 31, 2014	
	b.) Percent of enrollees, as of December 31, 2014, who are covered through an employer group.	
20.	Total number of employer clients, as of December 31, 2014	
21.	Total mail order prescription volume, based on days of therapy, for the period January 1, 2014 through December 31, 2014.	
22.	Total number of mail order prescriptions for the period January 1, 2014 through December 31, 2014.	
23.	Total retail prescription volume, based on days of therapy, for the period January 1, 2014 through December 31, 2014.	
24.	Total number of retail prescriptions for the period January 1, 2014 through December 31, 2014.	
25.	Please provide a distribution of employer clients by number of members in the following categories. (Clients do not need to be identified.)	
	Less than 1,000 members	
	1,000 - 4,999 members	
	5,000 - 9,999 members	
	10,000 - 49,999 members	
	50,000 - 99,999 members	
	100,000 - 499,999 members	
	500,000 or more members	
26.	Provide the following enrollment history metrics as of January 1st of each year.	
	2013	
	Number of covered lives:	
	Retail only	
	Mail Order only	
	Integrated (Mail and Retail)	
	Total	0
	Number of employer clients:	
	Retail only	
	Mail Order only	
	Integrated (Mail and Retail)	
	Total	0
	2014	
	Number of covered lives:	

	Retail only	
	Mail Order only	
	Integrated (Mail and Retail)	
	Total	0
	Number of employer clients:	
	Retail only	
	Mail Order only	
	Integrated (Mail and Retail)	
	Total	0
	2015	
	Number of covered lives:	
	Retail only	
	Mail Order only	
	Integrated (Mail and Retail)	
	Total	0
	Number of employer clients:	
	Retail only	
	Mail Order only	
	Integrated (Mail and Retail)	
	Total	0
27.	For the 12 months ending December 31, 2014, provide the following for your book of business under your managed retail and mail pharmacy programs. All cost data should be based on total cost before retiree copays/coinsurance.	
	Average Ingredient Cost	
	Single-source	
	Multi-source Brand	
	Generic	
	% Dispensing Rates	
	Single-source	
	Multi-source Brand	
	Generic	
	Prescription Counts	
	Single-source	
	Multi-source Brand	
	Generic	
28.	The Offeror shall provide any additional information that indicates that it is capable of administering a program for the Plan the size of the State's, including any experience and/or innovations in the administration of similar contracts.	
29.	a.) Is the Offeror and/or any of its Principals presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any state or federal agency? "Principals" means officers; directors; owners, partners; and persons having primary management or supervisory responsibilities within a business entity (*e.g.* general manager; plant manager; head of a subsidiary, division or business segment; and similar positions).	**Select one**
	b.) If yes, please explain.	

30.	a.) Has the Offeror and/or any of its Principals, within a three-year period preceding this offer, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, state or local) contract or subcontract; violation of Federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property?	**Select one**
	b.) If yes, please explain.	
31.	a.) Has the Offeror been the subject of an ERISA investigation?	**Select one**
	b.) If yes, please explain.	
32.	a.) Is the Offeror and/or any of its Principals presently indicted for, or otherwise criminally or civilly charged by a governmental entity with, commission of any of the offenses enumerated in question #30 above?	**Select one**
	b.) If yes, please explain.	
33.	a.) Has the Offeror, within a three-year period preceding this offer, had one or more contracts terminated for default by any public (Federal, state or local) entity?	**Select one**
	b.) If yes, please explain.	
34.	Please provide a list of public sector clients of similar size to PEBA for which the Offeror has performed, at any time during the past three years, services substatially similar to those sought with this solicitation. List commercial clients separately from EGWP with Wrap clients.	Please label as **"Tab A-1: Public Sector Client List"**.
35.	Please provide a list of failed projects, suspensions, debarments, and significant litigation.	Please label as **"Tab A-1: Failed Projects, Suspensions, Disbarments"**.

II. CONTACT INFORMATION

Please identify both the primary contact, who can answer questions related to this RFP, and the account manager, who will have overall responsibility for planning, supervising and performing account services.

Primary Contact	
Name	
Title	
Address	
City	
State	
Zip	
Telephone #	
Fax Phone #	
Cell Phone #	

E-mail Address	

Account Manager	
Name	
Title	
Address	
City	
State	
Zip	
Telephone #	
Fax Phone #	
Cell Phone #	
E-mail Address	

III. MANDATORY MINIMUM QUALIFICATIONS

The minimum qualifications of this RFP are mandatory. For each item, please describe how the Offeror satisfies the requirement.

	Minimum Qualifications	Response
1.	Offeror must have been in the business of providing Pharmacy Benefit Management Services, including administration of a retail pharmacy network, for a minimum of five (5) years. Offerors should provide detailed information to establish that they have been in the business of providing Pharmacy Benefit Management Services, and administering a retail pharmacy network, for a minimum of five (5) years.	
2.	Offeror must be currently providing Pharmacy Benefit Management Services of the type and scope outlined herein (excluding discount card programs) for a minimum of 2,000,000 covered managed lives. Offerors should provide detailed information to establish that they are currently providing Pharmacy Benefit Management Services of the type and scope outlined herein for a minimum of 2,000,000 covered managed lives.	
3.	Offeror must be currently accredited by URAC. Offerors should provide proof of current URAC accreditation.	
4.	Offeror must manage the prescription benefit of at least one (1) state government client or, alternatively, public sector employer, of at least 250,000 lives, with membership including both Medicare and non-Medicare eligible participants; and must manage the prescription benefit of at least three (3) additional employer accounts, each including at least 25,000 lives.	
5.	Offeror must provide proof of an administration of a total drug spend volume (plan payments and patient co-pays and deductibles) of not less than two billion dollars ($2,000,000,000) in calendar year 2014.	
6.	Offeror must have managed the prescription benefit of at least one (1) state government client or, alternatively, public sector employer, of at least 300,000 lives, (coverage more consistent with the numbers of lives the State Health Plan covers) with membership including both Medicare and non-Medicare eligible participants; and must manage the prescription benefit of at least three (3) additional employer accounts, each including at least 100,000 lives.	
7.	Offeror must have filled at least two million (2,000,000) scripts annually in South Carolina any of the last 3 years (2012, 2013, 2014).	

IV. REFERENCES

Please complete the following tables with the requested reference information.

1. Please provide references for two clients with more than 100,000 lives for whom you provide similar prescription drug benefits administration. At least one of the references must be a statewide government sector client.

Information	Reference #1	Reference #2
Company Name		
Contact Person		
Title		
City, State		

Telephone #		
Fax Phone #		
E-mail Address		
# Covered Lives		

2. Please provide references for two clients (public or private sector) with more than 25,000 lives for whom you provide similar prescription drug benefits administration.

Information	Reference #1	Reference #2
Company Name		
Contact Person		
Title		
City, State		
Telephone #		
Fax Phone #		
E-mail Address		
# Covered Lives		

3. Please provide references for two former clients (public or private sector) with more than 25,000 covered lives for whom you provided similar prescription drug benefits administration.

Information	Reference #1	Reference #2
Company Name		
Contact Person		
Title		
City, State		
Telephone #		
Fax Phone #		
E-mail Address		
# Covered Lives		

4. Please provide references for two clients (public or private sector) who began utilizing your prescription drug benefit administration services within the last twelve months.

Information	Reference #1	Reference #2
Company Name		
Contact Person		
Title		
City, State		
Telephone #		
Fax Phone #		
E-mail Address		
# Covered Lives		

5. Please provide references for two clients (public or private sector) for whom you administer an Indirect EGWP + Wrap program for Medicare participants.

Information	Reference #1	Reference #2
Company Name		
Contact Person		
Title		
City, State		
Telephone #		
Fax Phone #		
E-mail Address		
# Covered Lives		

Tab A-2a: Service Description Questionnaire

Representations made by the Offeror in this Proposal become contractual obligations that must be met during the contract term.

Instructions: Please provide a response to each of the following questions. If a drop down list is available, please select a response from that list. If your response for a question exceeds 1,024 characters in length, complete your response in **"Tab A-2b: Questionnaire Answers"** using the directions provided in **Tab A-2b**.

	Question	Response
I. PRICING AND COST CONTAINMENT		
Q-1	Describe, in detail, how you will disclose all revenue sources derived by relationships with pharmaceutical manufacturers, at mail order and at retail.	
Q-2	Provide the following data on your MAC program.	
	a.) Please provide a copy of your proposed MAC list in electronic format using MS Excel with read/write capabilities. Include NDC-11 codes and price per metric quantity.	Please label as **"Tab A-2: MAC List - Commercial Plan"**.
	b.) Number of generic classes on MAC list	
	c.) Number of multi-source brand drugs for which the MAC list provides substitution alternatives (all dosage forms of multi-source drug counted as one)	
	d.) Package size basis for maximum MAC price	
	e.) MAC drugs as a percent of total generic drugs dispensed	
	f.) Average MAC cost as a percent of total generic drug cost	
	g.) Average generic cost as a percent of average multi-source brand drug cost	
	h.) Expected total generic dispensing rate using MAC program	
	i.) Guarantee on total generic dispensing rate using MAC program	
	j.) Expected MAC savings as a percent of plan ingredient cost (total brand and generic cost)	
	k.) Number of MAC drugs added in the past 12 months	
Q-3	Please provide a detailed description of how your organization determines which drugs are preferred versus non-preferred.	Label as **"Tab A-2: Formulary Development Criteria"**.
Q-4	Please provide a detailed utilization management program list, including specific drug names in each program.	Label as **"Tab A-2: Detailed Utilization Management Program List"**.
Q-5	Describe, in detail, your system of coverage review for selected medications, including the use of step therapy algorithms based on national prescribing guidelines.	
Q-6	Describe the activities involving outreach to physicians with regard to prescription drug cost containment.	
Q-7	Describe your background and experience with the following clinical programs:	
	a. concurrent drug utilization review	
	b. retrospective drug utilization review	

Question		Response
	c. prospective drug utilization review	
	d. prior authorization	
	e. step therapy	
Q-8	Please provide the following information for each prospective/retrospective DUR program you offer and include two references.	
	Program #1	
	Number of programs implemented to date	
	PMPM savings associated with the program	
	Risk sharing Arrangements (if any) including outcomes or cost savings	
	PMPM Program Costs (if any)	
	Reference #1 (name/contact/phone)	
	Reference #2 (name/contact/phone)	
	Program #2	
	Number of programs implemented to date	
	PMPM savings associated with the program	
	Risk sharing Arrangements (if any) including outcomes or cost savings	
	PMPM Program Costs (if any)	
	Reference #1 (name/contact/phone)	
	Reference #2 (name/contact/phone)	
	Program #3	
	Number of programs implemented to date	
	PMPM savings associated with the program	
	Risk sharing Arrangements (if any) including outcomes or cost savings	
	PMPM Program Costs (if any)	
	Reference #1 (name/contact/phone)	
	Reference #2 (name/contact/phone)	
	Program #4	
	Number of programs implemented to date	
	PMPM savings associated with the program	
	Risk sharing Arrangements (if any) including outcomes or cost savings	
	PMPM Program Costs (if any)	
	Reference #1 (name/contact/phone)	
	Reference #2 (name/contact/phone)	
II. PHARMACY NETWORK MANAGEMENT		
Q-9	a.) Describe, in detail, how you would extend the opportunity of network participation to all retail pharmacy chains, independent pharmacies and nursing home pharmacies operating in South Carolina as well as to any willing retail pharmacies and pharmacy chain stores located in other states	
	b.) Describe, in detail, the solicitation materials you would use for distribution to all pharmacies in South Carolina.	
	c.) Provide a sample of the solicitation materials you would use for distribution to all pharmacies in South Carolina.	Please label as **"Tab A-2: Sample Pharmacy Solicitation Materials"**.

Question		Response
Q-10	a.) Describe how you will verify that pharmacies entering the network maintain the necessary federal and state licenses and permits required by law.	
	b.) Describe how you will verify that pharmacies entering the network maintain adequate insurance for claims arising out of that pharmacy.	
	c.) Describe how you will verify that pharmacies entering the network will identify and notify the S.C. Public Employee Benefit Authority of any pharmacies which, in the opinion of the Contractor, do not meet minimum professional requirements or business standards for inclusion in the network.	
Q-11	Describe the process used by your organization to verify that network pharmacies charge the applicable coinsurance or copayment to participants at the point of sale.	
Q-12	Describe, in detail, your plan for conducting audits of network pharmacies to ensure compliance with network contract provisions.	
Q-13	List the elements of your various audit programs. Include frequency of the audit for each element and the audit method.	
	Type of Audit	
	Frequency	
	Method	
	Type of Audit	
	Frequency	
	Method	
	Type of Audit	
	Frequency	
	Method	
	Type of Audit	
	Frequency	
	Method	
Q-14	Provide the results of your field audit programs for calendar years 2012, 2013 and 2014.	
	2012	
	Audits completed as a percent of all contracted pharmacies.	
	Pharmacies put on probation as a percent of all contracted pharmacies.	
	Pharmacies terminated as a percent of all contracted pharmacies.	
	Recovery (in dollars) as a percent of total book of business drug spend.	
	2013	
	Audits completed as a percent of all contracted pharmacies.	
	Pharmacies put on probation as a percent of all contracted pharmacies.	
	Pharmacies terminated as a percent of all contracted pharmacies.	
	Recovery (in dollars) as a percent of total book of business drug spend.	
	2014	
	Audits completed as a percent of all contracted pharmacies.	
	Pharmacies put on probation as a percent of all contracted pharmacies.	

Question		Response
	Pharmacies terminated as a percent of all contracted pharmacies.	
	Recovery (in dollars) as a percent of total book of business drug spend.	
Q-15	How are audit recoveries pro-rated back to clients?	
Q-16	a.) Describe, in detail, the contract between the pharmacies and the Offeror, including the terms and conditions the contract will contain.	
	b.) Please provide a sample contract between the pharmacy and the Offeror.	Please label as **"Tab A-2: Sample Contract"**.
Q-17	Will you solicit non-participating pharmacies on behalf of S.C. Public Employee Benefit Authority?	
Q-18	a.) Describe how you would advise S.C. Public Employee Benefit Authority on your progress to obtain network participation of the largest number of pharmacies covering the greatest geographical area of the State.	
	b.) How frequently will you provide the S.C. Public Employee Benefit Authority with an update of your network participation efforts?	**Select one**
III. MAIL ORDER PHARMACY MANAGEMENT		
Q-19	Where is the primary mail order facility location you propose for the S.C. Public Employee Benefit Authority?	
Q-20	What are the days and hours of operation for this facility?	
Q-21	a.) Is this facility owned and operated by your organization?	**Select one**
	b.) If so, are purchase discounts passed along to the purchaser or kept as margin by the PBM?	
Q-22	a.) Total number of mail order service centers as of December 31, 2014.	
	b.) Percent of capacity at which the mail order service centers are functioning.	
Q-23	a.) What was the average daily number of prescriptions filled during the period January 1, 2014 through December 31, 2014?	
	b.) Does this represent an increase or decrease in volume from the previous year?	**Select one**
	c.) If this represents an increase or decrease from the previous year, by how much did the average daily number of prescriptions change as a percent?	
Q-24	What is the estimated daily capacity of the proposed facility as of December 31, 2014?	
Q-25	Provide the average number of clinicians/pharmacists for the following:	
	Pharm D.	
	Full-time	
	Part-time	
	Registered Pharmacist	
	Full-time	
	Part-time	
	Pharmacy Technicians	

Question		Response
	Full-time	
	Part-time	
	Other clinical staff	
	Full-time	
	Part-time	
Q-26	a.) Describe your process for ordering refills by mail.	
	b.) Provide a sample refill order form	Label as **"Tab A-2: Sample Refill Order Form"**.
Q-27	a.) Describe your process for ordering refills by phone.	
	b.) What percentage of fills are ordered by phone?	
	c.) How far in advance can participants order a refill?	
Q-28	a.) Describe what quality controls are in place to ensure accurate dispensing of prescriptions.	
	b.) How many levels of review take place and who conducts the reviews?	
Q-29	Describe on-line integration, if any, with retail pharmacies to ensure non-duplication and to identify potential adverse interactions.	
Q-30	a.)What are your contingency plans and procedures for providing backup service in the event of strike, natural disaster, or backlog?	
	b.) What are your contingency plans and procedures for providing backup service in the event of a total system failure?	
Q-31	a.) How often do you switch generic manufacturers for particular products?	
	b.) How are participants notified of the switch?	
Q-32	Provide your claim processing standards versus actual results for 2013 and 2014 for the following:	
	Turnaround time for routine prescriptions	
	Claim processing standard	
	2013 Actual	
	2014 Actual	
	Turnaround time for prescriptions requiring intervention	
	Claim processing standard	
	2013 Actual	
	2014 Actual	
	Prescription accuracy	
	Claim processing standard	
	2013 Actual	
	2014 Actual	
Q-33	Please list the top ten manufacturers of generic medications for your book of business by volume for calendar year 2014.	
	1. Manufacturer Name	
	2014 volume (in units)	
	2. Manufacturer Name	
	2014 volume (in units)	
	3. Manufacturer Name	
	2014 volume (in units)	
	4. Manufacturer Name	
	2014 volume (in units)	
	5. Manufacturer Name	
	2014 volume (in units)	
	6. Manufacturer Name	
	2014 volume (in units)	
	7. Manufacturer Name	
	2014 volume (in units)	

Question		Response
	8. Manufacturer Name	
	2014 volume (in units)	
	9. Manufacturer Name	
	2014 volume (in units)	
	10. Manufacturer Name	
	2014 volume (in units)	
Q-34	a.) Are on-site audits performed at your mail service pharmacies?	
	b.) Describe the frequency and types of audits performed.	
	c.) Is the Mail Service Pharmacy that will support the S.C. Public Employee Benefit Authority mail order program subjected to the same audit programs as your Retail Network?	
Q-35	Please describe the process for notifying customers of:	
	a.) Expiration date of their prescription	
	b.) Their next refill date and the number of refills	
	c.) Prescriptions not on formulary	
	d.) Generic substitution availability	
Q-36	a.) Describe your system of providing patient advisory information with prescriptions filled, including next refill date and the number of refills.	
	b.) What percentage of prescriptions receives a patient information supplement?	
	c.) Provide sample materials of your patient advisory information.	Please label as **"Tab A-2: Patient Advisory Information"**.
Q-37	a.) How is the member billed (i.e. before or after the prescription is filled)?	
	b.) How does the member know which copay applies?	
Q-38	Does the Offeror e-mail:	
	a.) Refill reminders	**Select one**
	b.) Savings intervention opportunity messages	**Select one**
	c.) COB messages	**Select one**
IV. SPECIALTY PHARMACY (Biotech and Injectables)		
Q-39	a.) Does your organization offer an integrated specialty program?	**Select one**
	b.) If yes, describe the operations of the program and include elements describing your case and care management abilities.	
Q-40	a.) Does your organization own a specialty pharmacy?	**Select one**
	b.) If yes, are purchase discounts passed along to the plan or kept as margin by the PBM?	
Q-41	Please provide a copy of your proposed Specialty drug list in electronic format using MS Excel with read/write capabilities. Include NDC-11 codes and price per metric quantity.	Please label as **"Tab A-2: Specialty Drug List - Commercial Plan"**.
Q-42	a.) Is there separate pricing for injectable and biotech products?	**Select one**
	b.) If yes, please provide a separate fee schedule.	
Q-43	a.) How long has your organization had this program in place?	
	b.) How many patients do you currently provide services to?	
Q-44	Please provide a client reference for this program.	

Question		Response
	Organization	
	Contact Name	
	Title	
	Telephone	
Q-45	Describe the process to address exclusivity or limited distribution scenario.	
Q-46	Do you provide any of the following programs?	
	a.) a package recovery program	**Select one**
	b.) a vial/assay management program	**Select one**
	c.) a ready to inject program	**Select one**
Q-47	Do you report on compliance and adherence to therapy as part of your standard reporting package?	
Q-48	Please describe what you anticipate, both for unit and aggregate costs, to be the top ten most costly specialty drugs in the next three years for your customers.	
Q-49	What is your net annual enterprise forecasted specialty drug claim trend factor for each of the following calendar years?	
	a.) CY 2016	
	b.) CY 2017	
	c.) CY 2018	
Q-50	Please describe your company's strategy to effectively manage cost of specialty drugs while ensuring access for those needing those services, either solely on the prescription plan and/or in collaboration with the medical plan vendor.	
Q-51	Please describe your company's strategy to effectively manage costs associated with Hepatitis C.	
V. CUSTOMER SERVICE, COMMUNICATIONS AND TRAINING		
Q-52	Please provide sample communications materials, including request letters for clinical programs, switching programs and sample EOBs.	Label as **"Tab A-2: Sample Communications Materials"**.
Q-53	a.) Does the Offeror own and operate the customer service department that will be used to support the S.C. Public Employee Benefit Authority?	**Select one**
	b.) If no, please explain.	
	c.) Describe the customer service unit (organization, staffing and services) that would handle the S.C. Public Employee Benefit Authority account.	
Q-54	a.) Will the S.C. Public Employee Benefit Authority customer service representative team be dedicated to S.C. Public Employee Benefit Authority?	**Select one**
	b.) If yes, define what is meant by dedicated.	
Q-55	Briefly describe the training that each associate receives to prepare to manage the S.C. Public Employee Benefit Authority benefit? Include length of time it takes to go from training to CSR.	
Q-56	a.) Are there any scheduled changes to any of the CSR support platforms?	**Select one**

Question		Response
	b.) If so, include description of old and new platform along with a timeline of when the changes will be implemented.	
Q-57	How would the customer service unit be staffed?	
Q-58	What are customer service hours of operation?	
Q-59	What happens to after-hours calls?	
Q-60	How do you track and monitor phone service on an account-specific basis?	
Q-61	Provide your phone service standard versus actual results for calendar years 2013 and 2014.	
	Average speed to answer	
	Phone service standard	
	2013 Actual	
	2014 Actual	
	Call abandonment rate	
	Phone service standard	
	2013 Actual	
	2014 Actual	
	Percent of calls solved without requiring a call back	
	Phone service standard	
	2013 Actual	
	2014 Actual	
	Percent of calls resolved on the first contact	
	Phone service standard	
	2013 Actual	
	2014 Actual	
Q-62	Does your CSR system support TTY, TDY technologies?	**Select one**
Q-63	a.) Can your member services unit support non-English speaking members?	**Select one**
	b.) If yes, please specify languages.	
Q-64	a.) Do you expect to make major changes to the service organization (e.g. moving to a different location, merging units, etc)?	**Select one**
	b.) If yes, please describe the changes.	
Q-65	Please describe the process by which you notify plan participants of formulary changes.	
Q-66	a.) Provide a copy of the latest customer satisfaction survey your organization has conducted.	
	b.) How was the survey instrument developed?	
	c.) Do you use an independent outside vendor to conduct the survey? If so, who?	
	d.) Are survey results released to the public?	
	e.) How are respondents to the survey selected?	
	f.) What was the date of the last survey?	
	g.) What percentage of respondents were either very satisfied or satisfied with the services of your organization?	
Q-67	Are there tools available to participants who don't register on your site?	

Question		Response
Q-68	a.) Can you do prospective modeling for patients and demonstrate their personal savings associated with changing medications from their current prescriptions?	**Select one**
	b.) Does this function use existing claim history, S.C. Public Employee Benefit Authority specific plan design and pricing as a starting point?	
	c.) If you have this capability, what have you seen for utilization patterns and changes from brand to generic medications?	
Q-69	a.) What percentage of your employer sponsored organization's employees register on your site (e.g., basis = they sign up and get a password)?	
	b.) What target should S.C. Public Employee Benefit Authority set for their population given nearly 50% web access and strong promotion?	
Q-70	a.) Describe your personalization and push messaging capabilities.	
	b.) How do these capabilities impact cost or quality for your clients?	
VI. CLAIMS PROCESSING and PAYMENT		
Q-71	Describe, in detail, your approach to providing pharmacy claims processing and adjudication.	
Q-72	Describe the adjudication platforms (hardware, software and communications) that would be used to perform retail and mail order prescription claim processing	
Q-73	a.) Does the Offeror own the adjudication platforms (hardware, software, and communications) used to perform the retail and mail order prescription claims processing?	**Select one**
	b.) If no, please explain.	
Q-74	a.) Does the Offeror own the code that is used to build all system platforms that govern the claim adjudication functions? (These platforms include, but are not limited to, retail and mail order adjudication, eligibility systems, plan design systems and reporting systems.)	**Select one**
	b.) If no, please explain.	
Q-75	a.) Describe your capability of separately processing prescription drug claims for members enrolled in a Health Savings Account qualified plan and transmitting information to the Plan's medical claims administrator (currently, Blue Cross Blue Shield of South Carolina).	
	b.) Describe the frequency at which you are able to transmit prescription drug claims data to the Plan's medical claims administrator (*e.g.* real time, hourly, daily, weekly, etc.)	

Question		Response
Q-76	a.) Describe your capability of separately processing prescription drug claims for members and transmitting information to the Plan's medical claims administrator (currently, Blue Cross Blue Shield of South Carolina) in order to comply with federal requirements, including combined out of pocket limits.	
	b.) Describe the frequency at which you are able to transmit prescription drug claims data to the Plan's medical claims administrator (*e.g.* real time, hourly, daily, weekly, etc.)	
Q-77	a.) Describe the online data link between each participating pharmacy and the Offeror.	
	b.) Provide a list of items the online data link will allow the pharmacist to review prior to completion of a transaction.	
Q-78	Identify which of the following edits are performed at the point of service:	
	a.) Ineligible participant	**Select one**
	b.) Ineligible drug	**Select one**
	c.) Incorrect AWP	**Select one**
	d.) UCR input	**Select one**
	e.) Duplicate Rx	**Select one**
	f.) Refill too soon	**Select one**
	g.) Incorrect dosage	**Select one**
	h.) Rx splitting	**Select one**
	i.) Drug interactions	**Select one**
	j.) Over utilization	**Select one**
	k.) Under utilization	**Select one**
	l.) COB	**Select one**
	m.) Benefit maximums for certain drug types	**Select one**
	n.) Drug is inappropriate for the patient due either to age or sex	**Select one**
	o.) Other (specify)	**Select one**
Q-79	Please describe your appeals process including your brand/generic appeals process.	
Q-80	Please identify how you would propose to monitor and increase member's prescription compliance.	
Q-81	How would you propose to optimize the mix between retail and mail order prescriptions?	
Q-82	Please describe programs you have implemented to expedite conversion to newly released generic medications. Please provide examples.	
Q-83	a.) Do you have a managed injectable program? If so, please describe.	
	b.) Are you partnered with anyone?	
	c.) Does your proposed price include the cost of this program?	
Q-84	How are out-of-network claims processed?	
Q-85	Describe how you would notify S.C. Public Employee Benefit Authority if covered person fraud, provider fraud or improper provider billing practices were discovered.	
Q-86	a.) Describe, in detail, how you will enforce coordination of benefits at the point of sale.	

Question		Response
	b.) Describe how you will cooperate with S.C. Public Employee Benefit Authority to obtain information on other health insurance for covered persons.	
	c.) Describe how you will report plan savings as a result of coordination of benefits.	
Q-87	Describe how you will cooperate with the operation of the S.C. Public Employee Benefit Authority appeals process for disputed claims.	
Q-88	Briefly describe your organization's capabilities in monitoring the costs and utilization of compound drugs.	
Q-89	With respect to plan design options, briefly describe each of your organization's solutions to controlling the costs and utilization of compound drugs.	
VII. REPORTING		
Q-90	List the reports and provide examples of the standard reporting package you will be delivering to the S.C. Public Employee Benefit Authority.	Please label as **"Tab A-2: Sample Standard Reporting Package"**.
Q-91	Describe your online access query system for analysis of individual and/or group prescription drug claims data related to individual claimants, prescription drug information, network pharmacy information and prescriber information. Offerors should describe all of the data available for analysis on this system. (NOTE: The highest scored Offeror's online access query system may be subject to demonstration prior to contract award.)	
Q-92	Describe the information that will be contained on the detailed claims transaction file provided to the S.C. Public Employee Benefit Authority.	
Q-93	Describe the typical turnaround time for custom report requests.	
Q-94	Describe typically requested ad hoc reports, including turnaround time and additional fees, if any.	
Q-95	a.) Will you provide normative data against which the S.C. Public Employee Benefit Authority can benchmark its plan?	**Select one**
	b.) What is the source of the data and what specific benchmark information will you provide?	
Q-96	What is your preferred method of data transfer (CD, tape, EDI, FTP)?	
Q-97	a.) Does your organization regularly omit the Social Security number from identification cards, benefit statements and benefit drafts?	**Select one**
	b.) If yes, specify which documents do not include Social Security numbers.	
	c.) If not, state why not and whether you have future plans to delete the Social Security number.	
VIII. RETIREE DRUG SUBSIDY (RDS)		

Question		Response
Q-98	Describe, in detail, your approach to providing RDS services to S.C. Public Employee Benefit Authority.	
Q-99	Describe your background and experience in providing RDS services.	
IX. FINANCIAL		
Q-100	Describe, in detail, your process of releasing pharmacy payments, including the timeline between requesting claims reimbursement from the S.C. Public Employee Benefit Authority and releasing payment to pharmacies.	
X. INDIRECT EGWP + WRAP OPTIONS		
The S.C. Public Employee Benefit Authority requires the Contractor to provide and maintain a CMS approved prescription drug plan in the form of an Indirect EGWP + Wrap for Medicare eligible participants. Please provide the information requested below and note that all pricing information must be provided in Tab A-9: Financial Proposal.		
Q-101	a.) Are you able to duplicate the current pharmacy benefits for Medicare primary participants covered by the SHP?	**Select one**
	b.) If you are not able to duplicate the current pharmacy benefits, please describe the differences between the current pharmacy benefits for Medicare primary participants covered by the SHP and the plan you are able to provide.	
Q-102	Please describe the participant out-of-pocket expense under an Indirect EGWP + Wrap plan for 90-day prescriptions filled at a retail pharmacy that is willing to accept mail order pricing.	
Q-103	Please provide a copy of your proposed MAC list for the Indirect EGWP in electronic format using MS Excel with read/write capabilities. Include NDC-11 codes and price per metric quantity.	Please label as **"Tab A-2: MAC List - Indirect EGWP"**.
Q-104	Please provide a copy of your proposed Specialty drug list for the Indirect EGWP in electronic format using MS Excel with read/write capabilities. Include NDC-11 codes and price per metric quantity.	Please label as **"Tab A-2: Specialty Drug List - Indirect EGWP"**.
Q-105	Will you provide all CMS required filings related to formulary, medication therapy management and other clinical programs on a timely basis?	**Select one**
Q-106	Please describe your medication therapy management program, including the process for enrollment, targeting, intervention and outcomes reporting.	
Q-107	Will you provide all CMS required filings related to certification of compliance to waste, fraud and abuse requirements?	**Select one**
Q-108	a.) Does your member appeals process meet all CMS Medicare Part D requirements?	**Select one**
	b.) Describe your member appeals process.	

Question		Response
Q-109	a.) What is the location (city/state) of the customer service call center the Offeror will be utilizing for the Indirect EGWP? (Please note that this location cannot be offshore.)	
	b.) Is this the same facility that will be used for non-Medicare participants?	**Select one**
Q-110	Please provide a sample member communications package for the Indirect EGWP + Wrap.	Please label as **"Tab A-2: Indirect EGWP Sample Communications"**.
Q-111	Describe the transition process you will use for members who are currently using non-formulary prescription drugs, drugs requiring pre-authorization, step therapy and quantity level limits.	
Q-112	Describe the enrollment process, including when changes will be effective.	
Q-113	Describe the disenrollment process, including when changes will be effective.	
Q-114	What are your standards regarding turnaround time for issuing identification cards and accuracy?	
Q-115	Confirm that you will provide separate reporting and billing for the Indirect EGWP + Wrap enrollees.	**Select one**
Q-116	a.) Please describe your preferred accounting methodology for tracking direct subsidy monies received as result of the S.C. Public Employee Benefit Authority utilization to assure 100% pass through of costs and revenue.	
	b.) Please describe your preferred accounting methodology for tracking catastrophic reinsurance received as a result of the S.C. Public Employee Benefit Authority utilization to assure 100% pass through of costs and revenue.	
	c.) Please describe your preferred accounting methodology for tracking discounts received from pharmaceutical manufacturers for brand drugs in the Standard Part D benefit donut hole to assure 100% pass through of costs and revenue.	
Q-117	Confirm that you will mirror the current clinical rules as closely as possible consistent with CMS regulations.	**Select one**
Q-118	Confirm that you process low-income premium subsidy refunds to members and the S.C. Public Employee Benefit Authority and low-income cost sharing refund requests to members.	**Select one**
Q-119	Please provide a distribution of employer clients by number of members in the following categories for who you provide EGWP + Wrap administration services. (Clients do not need to be identified.)	
	Less than 1,000 members	
	1,000 - 4,999 members	
	5,000 - 9,999 members	
	10,000 - 49,999 members	
	50,000 - 99,999 members	

Question		Response
	100,000 - 499,999 members	
	500,000 or more members	
XI. ELIGIBILITY OF PARTICIPANTS AND COMPUTER SUPPORT		
Q-120	Please describe your eligibility system that will be used to keep track of the S.C. Public Employee Benefit Authority's eligibility files, including:	
	◆ System "trade name"	
	◆ System organization	
	◆ Date eligibility system was put in place	
	◆ Number of system upgrades since inception	
Q-121	a.) Is eligibility processing real-time with the claim system?	**Select one**
	b.) If no, what is the delay time?	**Select one**
Q-122	The S.C. Public Employee Benefit Authority would like direct access to the Offeror's eligibility systems for review and input purposes. Please describe your ability to provide The S.C. Public Employee Benefit Authority with direct access to the eligibility system only.	
Q-123	Offerors should state that it understands and agrees that it shall provide a secure online connection for purposes of permitting selected S.C. Public Employee Benefit Authority personnel access to make online inquiries of the Offeror's database and the ability to make limited routine changes to the Offeror's records regarding covered person eligibility.	
Q-124	a.) Offerors should state that it understands and agrees that it will be responsible for all costs associated with the installation, line test, and maintenance of the data line equipment.	
	b.) Offerors should provide the name, background and qualifications of the individual who will be the contact for S.C. Public Employee Benefit Authority's use in resolving any computer related problems.	
Q-125	Describe, in detail, all the information you will provide in your online inquiry and entry program.	
Q-126	Describe, in detail, the training you will provide to the S.C. Public Employee Benefit Authority staff on all of your customer service systems at the S.C. Public Employee Benefit Authority 's office in Columbia, South Carolina.	
Q-127	Describe, in detail, how you will maintain database backups in a manner that will eliminate disruption of service or loss of data due to system or program failures.	
Q-128	a.) Describe your disaster preparedness and recovery plans.	
	b.) Offerors should state the maximum period of interruption in the case of an emergency.	

Question		Response
Q-129	Offerors shall fully describe the methods and means to be deployed in order to satisfy the requirement described in Part III, Section I, #11 of the RFP.	Please label as **"Tab A-2: Data Security"**.
Q-130	Offerors shall fully complete the Service Provider Security Assessment Questionnaire included in Attachment Three (3) of Section IX of the RFP.	Please label as **"Tab A-2: Service Provider Security Questionnaire"**.
Q-131	Are you able to receive eligibility data via the Internet?	**Select one**
Q-132	Please state if you provide a test environment (file).	
Q-133	Briefly describe how your organization will process the HIPAA 834 file layout internally (convert to proprietary file specification, dump to paper, etc.)	
Q-134	Briefly describe your process for correcting data in the event of a data tape which contains "bad data".	
Q-135	What practices and policies have you implemented to ensure the confidentiality of all confidential information, including protected health information as defined by the HIPAA privacy rule, retiree/participant information, or other sensitive information of S.C. Public Employee Benefit Authority and its retirees and/or participants?	
XII. IMPLEMENTATION PROGRAM (Not an evaluated item)		
Q-136	Please discuss your procedures and processes for handling the following during the transition period:	
	◆ Transition of care	
	◆ Employee communications regarding change in administrators	
Q-137	**Implementation Plan**	
	◆ Name of the person with overall responsibility for planning, supervising and implementing the program for the S.C. Public Employee Benefit Authority.	
	◆ Title	
	◆ What other duties, if any, will this person have during implementation? Please include the number and size of other accounts for which this person will be responsible during the same time period.	
	◆ What percentage of this person's time will be devoted to the S.C. Public Employee Benefit Authority during the implementation process?	
	◆ Please provide an organizational chart identifying the names, area of expertise, functions, and reporting relationships of key people directly responsible for implementing the S.C. Public Employee Benefit Authority's account. In addition, resumes of these individuals should be included.	Please label as **"Tab A-2: Implementation Team Organizational Chart"**.

Question		Response
	◆ Provide a detailed implementation plan that clearly demonstrates the Offeror's ability to meet the S.C. Public Employee Benefit Authority's requirements to have a fully functioning program in place and operable on January 1, 2016. This implementation plan should include a list of specific implementation tasks/transition protocols and a time-table for initiation and completion of such tasks, beginning with the contract award and continuing through the effective date of operation (January 1, 2016). The implementation plan should be specific about requirements for information transfer as well as any services or assistance required from the State during implementation. The implementation plan should also include a communications plan, which describes the timeline and process for launching new program materials including greeting letter, ID cards, new programs, etc.	Please label as **"Tab A-2: Implementation Plan"**.
Q-138	Describe the process you propose to provide a January 1, 2016 transition that is as seamless as possible for all participants.	
XIII. ACCOUNT MANAGEMENT AND PERSONNEL		
Q-139	Describe the organization and structure of the account service team that will support the S.C. Public Employee Benefit Authority. Include the rationale for this structure and the ways in which it is particularly responsive to the S.C. Public Employee Benefit Authority's needs and goals.	
Q-140	◆ Name of the person with overall responsibility for planning, supervising and performing account services for the S.C. Public Employee Benefit Authority.	
	◆ Title	
	◆ Where will the account manger be located?	
	◆ What other duties, if any, does this person have? Please include the number and size of other accounts for which this person is responsible.	
	◆ What percentage of this person's time will be devoted to the S.C. Public Employee Benefit Authority?	

	Question	Response
	◆ Please provide an organizational chart identifying the names, functions and reporting relationships of key people directly responsible for account support services to the S.C. Public Employee Benefit Authority. It should also document how many account executives and group services representatives will work full-time on the S.C. Public Employee Benefit Authority's account and how many will work part-time on the S.C. Public Employee Benefit Authority's account.	Please label as "**Tab A-2: Account Management Team Organizational Chart**".
	◆ Describe account management support, including the mechanisms and processes in place to allow the S.C. Public Employee Benefit Authority personnel to communicate with account service representatives, hours of operation; types of inquiries that can be handled by account service representatives; and a brief explanation of information available on-line. The S.C. Public Employee Benefit Authority requires identification of an account services manager to respond to inquiries and problems, and a description of how the Offeror's customer service and other support staff will respond to subscriber or client inquiries and problems.	Please label as **"Tab A-2: Account Management Support"**.
Q-141	Please provide a bio of each team member, including length of time with your organization and job held while with your organization.	Please label as **"Tab A-2: Account Team Biographies"**.
Q-142	Will this team be responsible for implementing the S.C. Public Employee Benefit Authority account?	

Request for Proposal for Pharmacy Benefit Management Services

Tab A-2b: Additional Answers to Questionnaire

Representations made by the Offeror in this Proposal become contractual obligations that must be met during the contract term.

Instructions: Use this space to continue responses for **"Tab A-2a: Service Description Questionnaire"** when answers exceed 1,024 characters in length. Responses must be numbered to correspond to the question number and section number (**Tab A-2a**) to which it pertains.

Section #	Question #	Additional Response

Section #	Question #	Additional Response

Tab A-3: Subcontractor Questionnaire

Representations made by the Offeror in this Proposal become contractual obligations that must be met during the contract term.

Instructions: Please complete one section of "Tab A-3: Subcontractor Questionnaire" for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is certified by the State of South Carolina's Office of Small and Minority Business Assistance (OSMBA).

	Question	Response
Subcontractor 1		
SQ-1	Provide the name of the subcontractor.	
SQ-2	Is the subcontractor a South Carolina Certified Minority Business? If so, please submit a completed the Minority Participation questionnaire located in the RFP with your proposal.	
SQ-3	Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the performance of the Contract?	
SQ-5	Please confirm that the Contract has been resolved and is ready for execution upon award.	Select one
SQ-6	a.) Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results.	
	b.) List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed.	
SQ-7	Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years.	
SQ-8	Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership.	
SQ-9	Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship.	
SQ-10	What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review.	
Subcontractor 2		
SQ-1	Provide the name of the subcontractor.	
SQ-2	Is the subcontractor a South Carolina Certified Minority Business? If so, please submit a completed the Minority Participation questionnaire located in the RFP with your proposal.	
SQ-3	Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the performance of the Contract?	
SQ-5	Please confirm that the Contract has been resolved and is ready for execution upon award.	Select one
SQ-6	a.) Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results.	
	b.) List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed.	

	Question	Response
SQ-7	Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years.	
SQ-8	Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership.	
SQ-9	Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship.	
SQ-10	What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review.	
Subcontractor 3		
SQ-1	Provide the name of the subcontractor.	
SQ-2	Is the subcontractor a South Carolina Certified Minority Business? If so, please submit a completed the Minority Participation questionnaire located in the RFP with your proposal.	
SQ-3	Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the performance of the Contract?	
SQ-5	Please confirm that the Contract has been resolved and is ready for execution upon award.	**Select one**
SQ-6	a.) Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results.	
	b.) List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed.	
SQ-7	Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years.	
SQ-8	Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership.	
SQ-9	Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship.	
SQ-10	What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review.	
Subcontractor 4		
SQ-1	Provide the name of the subcontractor.	
SQ-2	Is the subcontractor a South Carolina Certified Minority Business? If so, please submit a completed the Minority Participation questionnaire located in the RFP with your proposal.	

	Question	Response
SQ-3	Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the performance of the Contract?	
SQ-5	Please confirm that the Contract has been resolved and is ready for execution upon award.	Select one
SQ-6	a.) Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results.	
	b.) List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed.	
SQ-7	Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years.	
SQ-8	Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership.	
SQ-9	Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship.	
SQ-10	What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review.	
Subcontractor 5		
SQ-1	Provide the name of the subcontractor.	
SQ-2	Is the subcontractor a South Carolina Certified Minority Business? If so, please submit a completed the Minority Participation questionnaire located in the RFP with your proposal.	
SQ-3	Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the performance of the Contract?	
SQ-5	Please confirm that the Contract has been resolved and is ready for execution upon award.	Select one
SQ-6	a.) Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results.	
	b.) List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed.	
SQ-7	Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years.	
SQ-8	Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership.	
SQ-9	Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship.	

	Question	Response
SQ-10	What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review.	
Subcontractor 6		
SQ-1	Provide the name of the subcontractor.	
SQ-2	Is the subcontractor a South Carolina Certified Minority Business? If so, please submit a completed the Minority Participation questionnaire located in the RFP with your proposal.	
SQ-3	Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the performance of the Contract?	
SQ-5	Please confirm that the Contract has been resolved and is ready for execution upon award.	**Select one**
SQ-6	a.) Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results.	
	b.) List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed.	
SQ-7	Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years.	
SQ-8	Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership.	
SQ-9	Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship.	
SQ-10	What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review.	
Subcontractor 7		
SQ-1	Provide the name of the subcontractor.	
SQ-2	Is the subcontractor a South Carolina Certified Minority Business? If so, please submit a completed the Minority Participation questionnaire located in the RFP with your proposal.	
SQ-3	Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the performance of the Contract?	
SQ-5	Please confirm that the Contract has been resolved and is ready for execution upon award.	**Select one**
SQ-6	a.) Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results.	
	b.) List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed.	
SQ-7	Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years.	

	Question	Response
SQ-8	Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership.	
SQ-9	Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship.	
SQ-10	What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review.	
Subcontractor 8		
SQ-1	Provide the name of the subcontractor.	
SQ-2	Is the subcontractor a South Carolina Certified Minority Business? If so, please submit a completed the Minority Participation questionnaire located in the RFP with your proposal.	
SQ-3	Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of South Carolina.	
SQ-4	Specifically what role will the subcontractor have in the performance of the Contract?	
SQ-5	Please confirm that the Contract has been resolved and is ready for execution upon award.	**Select one**
SQ-6	a.) Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results.	
	b.) List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed.	
SQ-7	Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years.	
SQ-8	Explain the subcontractor's organization's ownership structure, listing all separate legal entities in chart format. Describe all major shareholders/owners (10% or greater ownership) and list their percent of total ownership.	
SQ-9	Does the subcontractor have contractual relationships with third party administrators/organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship.	
SQ-10	What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review.	

Tab A-4: Access to Network Pharmacies - Chain Pharmacies

Instructions: The S.C. Public Employee Benefit Authority is interested in the availability of key chain pharmacies to its participant population using a broad, national network. Using the table below, provide the the requested data for each chain pharmacy included in Your proposed network of pharmacies for the commercial and/or the Medicare Part D plan.

Pharmacy Name	Chain Identification	Address Line 1 of Corporate Headquarters	Address Line 2 of Corporate Headquarters	City of Corporate Headquarters	State of Corporate Headquarters	ZIP Code of Corporate Headquarters	Number of Pharmacy Locations in SC	Number of Pharmacy Locations Nationwide	Commercial Retail Network Effective Date	Commercial Retail Network Ending Date	Commercial Retail 90 Network Effective Date	Commercial Retail 90 Network Ending Date	EGWP Retail Network Effective Date	EGWP Retail Network Ending Date	EGWP Retail 90 Network Effective Date	EGWP Retail 90 Network Ending Date

Request for Proposal for Pharmacy Benefit Management Services
Tab A-5: Access to Network Pharmacies - Independent Pharmacies

Instructions: The S.C. Public Employee Benefit Authority is interested in the availability of key pharmacies to its participant population using a broad, national network. Using the table below, provide the the requested data for each independent pharmacy included in Your proposed network of pharmacies for the commercial and/or the Medicare Part D plan.

Pharmacy NABP	Pharmacy Name	Pharmacy FEIN	Pharmacy NPI	Address Line 1	Address Line 2	City	County	State	ZIP Code	Phone Number	Compounding Pharmacy Indicator	Commercial Retail Network Effective Date	Commercial Retail Network Ending Date	Commercial Retail 90 Network Effective Date	Commercial Retail 90 Network Ending Date	EGWP Retail Network Effective Date	EGWP Retail Network Ending Date	EGWP Retail 90 Network Effective Date	EGWP Retail 90 Network Ending Date

Request for Proposal for Pharmacy Benefit Management Services

Tab A-6: Pharmacy Disruption based on Volume

Instructions: From **Confidential Data Exhibit 1**, copy and paste the Pharmacy NABP Number, Pharmacy Name, Total Number of Prescriptions, Total Number of Distinct Utilizers, Average Days Supply per Script, Total Quantity, Total Amount Paid and Average Amount Paid per Script into the table below. Then, complete each row by selecting either a "Yes" or "No" from the drop down list in column I and column J to indicate whether or not the named provider is an in-network provider. All other responses will be treated as a "No" response.

Pharmacy NABP numbers are confidential information and should be treated accordingly. Please destroy all TIN numbers within 5 business days of award of contract as described in Attachment 1: Non-Disclosure Agreement.

								Member of Network (Yes or No)	
Pharmacy ID	Pharmacy Name	Total Number of Days of Therapy	Total Number of Distinct Utilizers	Average Days Supply per Script	Rx Count	Total Amount Paid	Average Amount Paid per Script	Standard Plan	Indirect EGWP with Wrap Plan
								Select one	Select one
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								Member of Network (Yes or No)	
Pharmacy ID	Pharmacy Name	Total Number of Days of Therapy	Total Number of Distinct Utilizers	Average Days Supply per Script	Rx Count	Total Amount Paid	Average Amount Paid per Script	Standard Plan	Indirect EGWP with Wrap Plan
								Select one	Select one
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Tab A-7: Pharmacy Disruption based on Total Amount Paid

Instructions: From **Confidential Data Exhibit 2**, copy and paste the Pharmacy NABP Number, Pharmacy Name, Total Number of Prescriptions, Total Number of Distinct Utilizers, Average Days Supply per Script, Total Quantity, Total Amount Paid and Average Amount Paid per Script into the table below. Then, complete each row by selecting either a "Yes" or "No" from the drop down list in column I and column J to indicate whether or not the named provider is an in-network provider. All other responses will be treated as a "No" response.

Pharmacy NABP numbers are confidential information and should be treated accordingly. Please destroy all TIN numbers within 5 business days of award of contract as described in Attachment 1: Non-Disclosure Agreement.

								Member of Network (Yes or No)	
Pharmacy ID	Pharmacy Name	Total Number of Days of Therapy	Total Number of Distinct Utilizers	Average Days Supply per Script	Rx Count	Total Amount Paid	Average Amount Paid per Script	Standard Plan	Indirect EGWP with Wrap Plan
								Select one	Select one
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								Member of Network (Yes or No)	
Pharmacy ID	Pharmacy Name	Total Number of Days of Therapy	Total Number of Distinct Utilizers	Average Days Supply per Script	Rx Count	Total Amount Paid	Average Amount Paid per Script	Standard Plan	Indirect EGWP with Wrap Plan
								Select one	Select one
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Request for Proposal for Pharmacy Benefit Management Services

Tab A-8: Formulary Analysis

I. Preferred Drug List

Please provide your Preferred Drug List (PDL), including NDC-11 Code, drug name and price per metric quantity, in electronic format using **MS Excel with read/write capabilities**. Submit the MS Excel file labeled as **"Tab A-8: Preferred Drug List"**.

II. Preferred Drug List - Indirect EGWP

Please provide your Preferred Drug List (PDL) that will be used in conjunction with the Indirect EGWP plan. The PDL should include NDC-11 Code, drug name and price per metric quantity, in electronic format using **MS Excel with read/write capabilities**. Submit the MS Excel file labeled as **"Tab A-8: Preferred Drug List - Indirect EGWP"**.

III. Formulary Analysis

From **Confidential Data Exhibit 3**, copy and paste the NDC11 Code, Drug Name, Total Days of Therapy and Rx Count into the table below. The data contains a list of the top 250 drugs utilized by Plan participants during calendar year 2014. In column F, select the formulary tier applicable for each drug assuming the standard plan, or current program. In column G, select the formulary tier applicable for each drug under the Indirect EGWP with Wrap plan.

				Formulary Tier	
NDC-11	**Drug Name**	**Total Days of Therapy**	**Rx Count**	**Standard Plan**	**Indirect EGWP + Wrap Plan**
				Select one	Select one
				Select one	Select one
				Select one	Select one
				Select one	Select one
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				Formulary Tier	
NDC-11	**Drug Name**	**Total Days of Therapy**	**Rx Count**	**Standard Plan**	**Indirect EGWP + Wrap Plan**
				Select one	Select one
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				Formulary Tier	
NDC-11	Drug Name	Total Days of Therapy	Rx Count	Standard Plan	Indirect EGWP + Wrap Plan
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				Formulary Tier	
NDC-11	Drug Name	Total Days of Therapy	Rx Count	Standard Plan	Indirect EGWP + Wrap Plan
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Tab A-9: Performance Guarantees

Representations made by the Offeror in this Proposal become contractual obligations that must be met during the contract term.

Instructions: As part of the effort toward continuous improvement in the services provided to participants, the S.C. Public Employee Benefit Authority would like to implement performance standards with contractors. These standards and accompanying guarantees may be negotiated. Offeror's shall propose guarantees using the following S.C. Public Employee Benefit Authority specific definitions and measurements outline. The Offeror shall provide their organization's Proposed Amount at Risk for PG-2 through PG-17.

Offerors will report results on all performance measurements quarterly per the requirements set forth below. Performance results will also be audited annually by the S.C. Public Employee Benefit Authority's contract auditor.

	Performance Indicator	Reporting Measurement (subject to audit by the S.C. Public Employee Benefit Authority and/or contract auditors)	Standard/Goal	Proposed Amount at Risk
PG-1	Final Implementation Plan	The Final Implementation Plan, as described in Q-137 of Tab-A-2 Questionnaire will be submitted to the S.C. Public Employee Benefit Authority.	On or before May 15, 2015.	$5,000 per day for each day or partial day during which the Contractor is not in compliance with the FIP.
PG-2	Average Speed to Answer	a.) The dedicated toll-fee customer service phone line will answer calls within the time specified. Measurement will be from the initial ring.	Within an average of 30 seconds or less	
		b.) The dedicated toll-free customer service phone line shall provide an opt out option to speak with a live customer service representative at any time during the call. For those Participants who require assistance, a live customer service representative will answer calls within the time specified. Measurement shall be from the point at which the caller requests live assistance via the IVR.	Within an average of 30 seconds or less	
PG-3	Call Abandonment Rate	The call abandonment rate of the dedicated toll-fee customer service phone line will not exceed the specified rate.	3% or less	
PG-4	Paper Claims	**a.) For the commercial pharmacy plan,** the Contractor will respond (mail a check or reject notice) to reimbursement paper claims within the guidelines specified.	~~97% or greater within 5 business days~~ **100% within 14 business days**	
		b.) For the EGWP with Wrap plan, the Contractor will respond (mail a check or reject notice) to reimbursement paper claims within the guidelines specified.	**100% within 15 business days**	
PG-5	Participant Overall Satisfaction Rate	a) The Contractor will conduct telephonic surveys to gauge participant satisfaction on a monthly basis. (See Part III, Section C, #15 of the RFP). The overall satisfaction rate will meet or exceed the specified goal.	95% or greater	$5,000 per month for each month that the Contractor fails to meet a 95% overall satisfaction rates.
		b) The Contractor will mail participant satisfaction surveys on a annual basis. (See Part III, Section C, #16 of the RFP). The overall satisfaction rate will meet or exceed the specified goal.	95% or greater	
PG-6	Automated Claim System Availability Rate	The automated claims system will be available 24 hours a day, 7 days per week.	99.5% or greater	
PG-7	Dispensing Accuracy Rate	Mail Order prescriptions will be dispensed accurately at the specified rate.	99.9% or greater	
PG-8	Financial Accuracy Rate	The financial accuracy rate for all prescriptions dispensed at both retail and mail order pharmacies will be greater than or equal to the specified rate.	99.9% or greater	
PG-9	Mail Order Dispensing Turnaround Time	a.) The Contractor shall dispense all non-protocol prescriptions under the mail service program within the time specified.	average of 2 business days following receipt	
		b.) The Contractor shall dispense all protocol within the time specified.	average of 4 business days following receipt	

	Performance Indicator	Reporting Measurement (subject to audit by the S.C. Public Employee Benefit Authority and/or contract auditors)	Standard/Goal	Proposed Amount at Risk
PG-10	Eligibility Transactions	a.) Processable maintenance eligibility transactions will be processed within the time specified.	within 2 business days	
		b.) For emergencies (retiree is at the retail pharmacy and system shows they are not eligible), eligibility transactions will be processed within the time specified.	same business day if requested during normal business hours; otherwise, within 24 hours	
PG-11	ID Card for the Indirect EGWP + Wrap participants	All maintenance ID cards will be mailed within the time specified following receipt of a processable eligibility tape.	99.0% within 4 business days	
PG-12	Standard Reporting Package	a.) Standard monthly management/utilization reports will be delivered to the S.C. Public Employee Benefit Authority by close of business within the time specified.	within 30 business days following the month's end	
		b.) Standard quarterly management/utilization reports will be delivered to the S.C. Public Employee Benefit Authority by close of business within the time specified.	within 45 business days following the quarter's end	
		c.) Standard semi-annual management/utilization reports will be delivered to the S.C. Public Employee Benefit Authority by close of business within the time specified.	within 45 business days following the second quarter's end	
		d.) Standard annual management/utilization reports will be delivered to the S.C. Public Employee Benefit Authority by close of business within the time specified.	within 45 business days following the Plan Year's end	
PG-13	Access Rate	The Contractor shall establish and maintain a network of participating pharmacies to provide service under the retail pharmacy plan.	98% of primary eligible participants will have at least one participating pharmacy within 5 miles of their home ZIP code where any retail pharmacy exists within 5 miles of their home ZIP Code.	
PG-14	Decline in Participating Pharmacies	**Unless Contractor and S.C. Public Employee Benefit Authority mutually agree to limit the retail network in order to meet cost or quality objectives during the contract period,** the network of participating pharmacies should not decrease in size by more than the specified percentage on an annual basis.	5.0% or less	
PG-15	Final Reconciliation	The Contractor will calculate and submit final cost reports to client for client's review under Step 6 of Final Reconciliation of the current Retiree Drug Subsidy claim.	On or before the tenth workday following the date client completes Step 5 of Final Reconciliation	
PG-16	Notices of Creditable and Non-Creditable Coverage	Annually, the Contractor will use eligibility files furnished by client to mail personal notices to Medicare Plan participants notifying them of creditable or non-creditable prescription drug coverage.	100% of mailings will be made on or before October 31st of each year.	
PG-17	Monthly Cost Reports	The Contractor will submit monthly cost reports for client's review and submission of RDS payment request.	~~On or before the fifth workday following the date of client's request for the cost report.~~ **On or before the 21st calendar day of the month following the reporting month.**	