



State of Vermont

AGENCY OF HUMAN SERVICES

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OFFICE OF VERMONT HEALTH ACCESS  
312 Hurricane Lane, Suite 201  
Williston, Vermont 05495  
Telephone: 802-879-5900

**STATE OF VERMONT**  
**REQUEST-FOR-PROPOSALS**

**- FOR -**

**PHARMACY BENEFIT MANAGEMENT  
SERVICES**

*Date of Issuance: March 18, 2005*  
*Proposal Due Date: May 20, 2005*

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## **INTRODUCTION**

The State of Vermont is issuing this Request-For-Proposal (RFP) for PBM Services for beneficiaries enrolled in publicly funded pharmacy benefit programs, including Medicaid and fully state funded programs. The document contains the following sections:

**Background:** This section describes the background information regarding this RFP, including information specific to Vermont's programs and history in using PBM services.

**Section I. - General Procurement Information and Procedures:** This section is used to inform Bidders of the general procurement conditions under which the RFP is issued.

**Section II. - Information Required from Bidders:** This section provides Bidders with instructions regarding the format and nature of the information they must provide in a proposal.

**Section III. – Work Statement:** This section is a detailed description of the services to be provided through the contract based on this RFP. It is the most important portion of the RFP. Bidders shall use this section as a guideline for responding to the information required from Bidders identified in Section III.

**Section IV. - Evaluation Methodology:** This section describes the methodology the State will use to evaluate the proposals submitted in response to this RFP.

**Section V. - Contract Terms and Conditions:** This section describes the contractual terms and conditions that shall be a part of any contract that result from this RFP.

**Acronyms, Terms, and Definitions:** Those used in the RFP are located at the end of this RFP.

**Attachments and Appendices.** This section includes the attachments and appendices for this RFP.

## **BACKGROUND**

### **PBM Services in Vermont**

Vermont's pharmacy initiative emerged from a February 2000 meeting of the Governors of Maine, New Hampshire and Vermont. The focus of the meeting was to discuss a number of health and insurance-related issues. It was clear that all three states were experiencing rapidly rising prescription drug prices, and all three states had a common interest in better management of this area of health care spending.

As a result of the Governors' meeting, representatives from the three states and Vermont's pharmacy consultant met to discuss these issues over several months. It was agreed to pursue acquisition of a Pharmacy Benefit Manager (PBM) on behalf of the three states. The objectives of the initiative were to enhance quality of care, control pharmacy expenditures for individuals who are provided coverage by the states, reduce program administrative costs, and improve access.

A Request-For-Proposals (RFP) was released by the three states in October 2000, with a deadline for bid submission in January of 2001. Eight bids were received, and following bid review and negotiation, a bidder (First Health Services Corporation (FHSC)) was selected. Maine elected to not participate in the contract, but New Hampshire retained FHSC and the Vermont program went live in November 2001.

Since the pharmacy initiative was started, the program has been developed to include a Preferred Drug List managed under the guidance of Vermont's Drug Utilization Review Board; a prior authorization program; expanded and more intensive provider education; drug utilization review techniques to prevent inappropriate drug dispensing and use; and a multi-state supplemental drug rebate effort.

### **Pharmacy Benefit Management**

The State has determined through experience that the Pharmacy Benefit Management (PBM) industry can help control escalating drug expenditures through the use of techniques commonly used by the private sector. The State has also adopted strategies that are unique to state programs, most notably the multi-state supplement rebate negotiation process. This RFP is intended to invite innovative cost reduction proposals for the Medicaid and State covered populations identified in this RFP that continue and build upon programs that have been initiated since 2001.

### **Prescription Cost Trends**

Medicaid is a significant and rapidly growing portion of the State of Vermont's Human Services budget. Within Medicaid, prescription costs continue to grow at rates that are unsustainable over the long term. Medicaid pharmacy spending for SFY '06 is projected to represent approximately 24% of total Medicaid spending. Pharmacy expenditures net of manufacturer rebates have increased from under \$90 million in SFY 2000 to a projected \$151 million in SFY '06. Some of the increase is attributable to the introduction of new kinds of drug therapy that can replace or avoid more costly hospital or medical expense. However, much of this increase is the result of the introduction of new, very costly drugs; an aging population; and aggressive promotion by

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drug manufacturers that results in increasing utilization. Vermont is struggling with the economic burden of continuing to provide appropriate benefits, while staying within budget guidelines.

### **The Uninsured**

The high cost of drugs is especially critical for our residents who do not have prescription insurance (the uninsured). Large employers, HMOs and government programs have crafted strategies to attempt to control their drug costs. These efforts have resulted in lower profits to drug retailers and compelled drug manufacturers to provide rebates and other price concessions. Unfortunately, these savings have only accrued to these large purchasers; there has been a huge and well-documented cost-shift to individuals without prescription drug coverage, who are often least able to bear these costs. One goal of this effort is to continue to improve the State's strategies for lowering drug costs to this vulnerable group.

### **Medicaid**

Prescription cost inflation is a universal problem in America. It is exacerbated for state Medicaid programs for a number of reasons. These include: entitlement issues, mandatory coverage of all prescription drugs for manufacturers participating in government rebates, and limitations on beneficiary cost sharing.

### **Vermont Program Background**

The State of Vermont carried-out a broad-based reform of its Medicaid program in 1995, through implementation of a Section 1115(a) Research and Demonstration waiver, called the Vermont Health Access Plan, or VHAP. Under the waiver, traditional Medicaid beneficiaries are enrolled on a mandatory basis in managed care, and the resulting savings are used to provide coverage to two expansion populations – uninsured adults with incomes up to 150% of the Federal Poverty Level and parents and caretaker relatives up to 185% of FPL who are provided a medical benefit and elderly or disabled Vermonters with incomes up to 175% of FPL who are provided a pharmacy benefit. Although the State contracted with commercial managed care plans for medical benefit coverage in the early years of the demonstration waiver, all beneficiaries who are required to enroll in managed care are now enrolled in a State operated primary care case management program (PCCM) called ***PC Plus***.

The State also supports several other publicly funded pharmacy programs. Currently these are the HIV/AIDS Medication Assistance Program (AMAP), a federally designated State Pharmacy Assistance Program (SPAP) called VScript Expanded, an emergence needs program called General Assistance, and a discount option called the Healthy Vermonters' Program.

The Office of Vermont Health Access, an office within the newly reorganized Agency of Human Services, manages Vermont's pharmacy programs.

In SFY '06, Vermont expects to provide pharmaceuticals to approximately 147,053 beneficiaries that are traditional Medicaid, Medicaid expansion, federal and/or state funded, and uninsured. Details on each of these programs and their pharmacy coverage are described in the following.

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### **A. Covered Populations**

#### **1. Traditional Medicaid**

Traditional Medicaid beneficiaries must meet income, resource, and categorical requirements for eligibility. If found eligible, beneficiaries are provided a comprehensive set of health benefits, including prescription drug coverage. Traditional Medicaid beneficiaries pay a co-payment of \$1.00 for prescriptions or refills up to \$29.99; \$2.00 for prescriptions or refills that cost \$30.00 to \$49.99; and \$3.00 for prescriptions costing more than \$50.

#### **2. Medicaid Expansion Populations under the 1115(a) demonstration waiver**

a) VHAP Uninsured – This group includes uninsured adults with incomes up to 150% of FPL (\$19,245 for a two person household) who have been without insurance for 12 months (waived in certain defined circumstances). Also covered are parents and caretaker relatives with eligible children in households with incomes up to 185% of FPL (\$23,736 for a two person household). These are 2005 FPL amounts. Limits are updated annually. Beneficiaries are provided with a somewhat less comprehensive array of health benefits than traditional Medicaid beneficiaries. Beneficiaries pay monthly program premiums based on income, but do not have other cost sharing for the pharmaceutical benefits.

b) VHAP Pharmacy – This program covers elderly and disabled individuals up to 150% of FPL. Most of these individuals are on Medicare but are not eligible for Medicaid. Pharmaceutical coverage includes all drugs covered under Medicaid. VHAP Pharmacy beneficiaries pay a \$13.00 per month program premium, but have no other cost sharing for their prescriptions.

c) VScript – VScript provides coverage of maintenance medicines for elderly or disabled individuals with incomes between 150% and 175% of FPL. Most of these individuals are on Medicare but are not eligible for Medicaid. Maintenance drugs are identified in a class list and claims that are submitted for a VScript beneficiary are processed against this maintenance list. Beneficiaries generally receive a 30 to 90-day supply. VScript beneficiaries in this income group pay a \$17.00 per month premium, but have no other cost sharing for their prescriptions.

#### **3. The HIV/AIDS Medication Assistance Program (AMAP)**

The HIV/AIDS Medication Assistance Program provides access to certain prescription medications to Vermonters living with HIV disease who meet specific income guidelines. This program is funded through federal/state HIV/AIDS funding. Protease inhibitors and FDA-approved antiretrovirals are included in the AMAP specific formulary. New medications are added to the formulary through an approval process in consultation with the AMAP Advisory Committee, which is made up of consumers and medical professionals.

#### **4. VScript Expanded**

VScript Expanded provides coverage of maintenance medicines for elderly or disabled individuals with incomes between 175% and 225% of FPL. Most of these individuals are on Medicare but are not eligible for Medicaid. This program is not part of the 1115(a) demonstration waiver and is therefore fully state funded. Drug coverage for VScript Expanded is the same maintenance drugs as with VScript if manufacturers have a written agreement with the State to provide rebates equivalent to Medicaid. Otherwise products are not covered. VScript

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Expanded beneficiaries pay a \$35.00 per month premium, but have no other cost sharing for their prescriptions.

### **5. General Assistance**

General Assistance (GA) provides coverage for drugs prescribed to address an emergency need for people without the income or resources to otherwise obtain them. This program is fully state funded. Drug coverage is limited to a specific therapeutic class list against which all claims are processed. Cost sharing may apply on a case-by-case basis as a voluntary contribution.

### **6. Healthy Vermonters Program**

Individuals eligible for the Healthy Vermonters Program include elderly or disabled individuals who have incomes up to 400% of FPL. Other individuals without prescription drug coverage or a limit on coverage with incomes up to 300% of FPL are also eligible to participate. Currently, participants are able to purchase any Medicaid covered drug at the Medicaid rate, but otherwise receive no financial subsidy. Participants in this program do not pay any monthly premium, but pay 100% of the cost of their prescriptions based on the Medicaid fee schedule.

### **B. Program Pricing and Utilization Controls**

Vermont pays the lesser of the average wholesale price (AWP) minus 11.9 % plus the Vermont dispensing fee; the federal upper limit (FUL) plus the Vermont dispensing fee; the Vermont maximum allowable cost (MAC) plus the Vermont dispensing fee; or the billing pharmacy's usual and customary fee including its dispensing fee. The current Vermont dispensing fee is \$4.25.

The FY '06 budget for pharmacy represents (net of rebates) about twenty-four percent (24%) of the Medicaid budget administered by the Office of Vermont Health Access (OVHA). OVHA has instituted a number of changes in its pharmacy programs in the recent past. Most notable has been the creation of a Preferred Drug List, and a requirement that non-preferred drugs receive a Prior Authorization prior to dispensing. Clinical PA's are also in place for selected drugs. The program maintains a MAC and hard edits at the time of claim adjudication for a number of drug utilization review edits; for example, early refill and drug and therapeutic duplicates. The State provides information to participating providers by sending them drug profiles for the patients they are seeing. An innovative supplemental rebate program is managed in concert with multiple states.

Vermont has had a generic substitution requirement in law since the late 70's. A physician can certify in his or her own handwriting that a specific brand is medically necessary for a particular beneficiary. The physician's handwritten phrase "brand necessary" or "brand medically necessary" must appear on the face of the prescription together with a written statement that the generic equivalent has not been effective, or with reasonable certainty is not expected to be effective, in treating the patient's medical condition or causes or is reasonably expected to cause adverse or harmful reactions in the patient. Otherwise, generic substitution is required.

### **C. Projected Enrollment – SFY '06**

Average enrollment in the above-described programs is projected for FY '06 in the following:

Traditional Medicaid - 99,340

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(SSI – 23,728)

(Families – 75,612)

VHAP Uninsured - 21,915

VHAP Pharmacy - 8,818

VScript - 2,847

HIV/AIDS Medication Assistance Program - 83

VScript Expanded - 2,695

General Assistance – Generally concurrently eligible for another program.

Healthy Vermonters – 11,355

Total – 147,053

**D. Medicare Part D Beneficiaries**

The State anticipates that a number of current beneficiaries will be eligible for Medicare Part D when it becomes available effective January 1, 2006. The most current information on the number of Part D beneficiaries is shown in the following table. The data is for July 1, 2004.

**PART D Beneficiaries**

| Category                 | Traditional Medicaid | VHAP Pharmacy | VScript | VScript Expanded | Healthy Vermonters |
|--------------------------|----------------------|---------------|---------|------------------|--------------------|
| Total beneficiaries      | 96,775               | 8,682         | 2,773   | 2,436            | 12,115             |
| Part D eligibles         | 14,778               | 8,620         | 2,684   | 2,340            | 1,654              |
| Percent Part D eligibles | 15.3%                | 99.3%         | 96.8%   | 96.1%            | 13.7%              |

**E. Projected Expenditures – FY '06**

Pharmacy expenditures are increasing 15 - 18% per enrollee per year. The following identifies the projected gross cost for each of the currently covered groups for SFY '06. OBRA '90, Medicaid supplemental, and/or state only rebates apply to all programs except for the HIV/AIDS Medication Assistance Program and General Assistance. Rebates for FY '06 are expected to average approximately 26.9%.

Traditional Medicaid - \$126,301,944

VHAP Uninsured and Caretaker relatives – \$14,928,593

VHAP Pharmacy - \$28,663,297

VScript - \$8,443,554

HIV/AIDS Medication Assistance Program - \$844,031

VScript Expanded - \$8,184,591

General Assistance - \$360,893

**VERMONT OBJECTIVES**

The State's primary objectives in issuing this RFP are to continue to enhance quality of care; improve access to those who need it; control pharmacy expenditures on behalf of the individuals for whom the State provides coverage; and reduce program administrative costs. In addition, the State seeks additional methods to help the Uninsured lower their drug costs. The State also seeks innovative methods to respond to the implementation of the Medicare drug provisions of Part D. Of particular concern is the State's commitment to maintain current levels of drug coverage for soon to be Part D beneficiaries currently receiving benefits through traditional Medicaid, the 1115(a) Medicaid waiver, and state-only funded programs.

The State expects to meet these objectives in a number of ways. They include but are not limited to the following:

- Maintaining a Preferred Drug List (PDL) to assure clinically appropriate and cost-effective coverage in high use and high cost drug categories;
- Increasing the use of clinically appropriate generic and other lower cost drugs;
- Managing the drug benefits through more intensive clinical management to improve overall quality and outcomes;
- Protecting the health of beneficiaries through use of retrospective and prospective drug utilization review (DUR) to prevent inappropriate drug dispensing and/or use;
- Maintaining positive relationships with the provider community including providing appropriate clinical information to improve prescribing and cost information to assist in product selection;
- Negotiating lower prices through multi-state supplemental rebates; the equivalent of regular Medicaid program rebates for state-only coverage; and financial concessions through a preferred PDP sponsor of Medicare Part D benefits for Vermont program beneficiaries;
- Limiting paid claims to those submitted for eligible clients, by eligible providers, or for covered drug services;
- Preventing payment of fraudulent or duplicate claims;
- Cost-avoiding claims for beneficiaries with third party liability coverage (hereinafter referred to as COB and/or TPL) for pharmacy services;
- Providing maximum efficiency in pharmacy claims processing;
- Managing the program at the lowest administrative cost possible; and
- Expanding Vermont's federally designated State Pharmacy Assistance Program (SPAP), VScript Expanded, to provide wraparound benefits to Vermont program beneficiaries to be enrolled in Medicare Part D.

The State views this RFP as part a "progressive effort." That is, new interventions may be instituted over time during the term of the contract. Accordingly, Bidders are required to quote prices for each module, and describe any volume discounts as the numbers of claims and/or covered lives grow.

The State intends to aggregate as many lives as possible into a relationship with the PBM selected as a result of the RFP. By doing so, the State intends to maximize our ability to manage the benefit, improve the quality of care, control costs, and negotiate rebate dollars. The State will be carefully evaluating the overall quality of both the Bidders and their responses to the RFP.

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Recognizing the complexities of Pharmacy Benefit Management, the State intends to work closely with the successful Bidder to assure the best possible results. Among other things, the State will evaluate flexibility, creativity and capacity. The successful Bidder must be able to demonstrate its ability and willingness to work with prescribers, beneficiaries, drug retailers, and drug manufacturers to find the most effective ways to control drug costs. These efforts will include appropriate therapeutic controls and careful monitoring of performance and pricing.

### **USE OF THE TERM "STATE"**

The term "State" is used throughout this RFP. This term describes the State of Vermont that is issuing this RFP.

**SECTION I**

**GENERAL PROCUREMENT INFORMATION AND PROCEDURES**

This section presents general procurement information pertaining to the State of Vermont.

This Request-For-Proposal (RFP) is designed to elicit bids from qualified Pharmacy Benefit Management contractors, one of whom will be selected to be responsible for managing pharmacy benefits for certain specified populations, as described in this RFP.

The categories of beneficiaries within these programs are provided within the Bidders' library discussed in I-K of this RFP.

Prospective Contractors are expected to carefully examine all documentation, schedules, and requirements stipulated in this RFP and respond to each requirement in their proposals in the format prescribed.

Please note that the Contractor's claims processing system does not specifically require Center for Medicare and Medicaid Services (CMS) certification, although the Contractor must perform comparable edits and provide a paid claim file for incorporation back into the States' Medicaid Management Information System (MMIS). The successful Bidder (Contractor) must provide all staffing, systems, and procedures required to perform the services described herein.

The Contract awarded as a result of this solicitation shall be part fixed price and part unit price (cost per transaction, cost per member per month). The pricing methodology the Bidder shall provide is detailed further in II-H, Price Proposal.

In addition to the provisions of this RFP and the winning proposal, which shall be incorporated by reference in the contract, any additional clauses or provisions required by federal or State law or regulation in effect at the time of execution of the contract will be included.

The State reserves the right to make a contract award without any further discussion with potential Contractors regarding the proposals received. Therefore, proposals should be submitted initially on the most favorable terms available to the State from a price and technical standpoint. The State, however, reserves the right to conduct discussions with all responsible parties who submit proposals that pass the initial screening process described in Section IV of this RFP.

**ISSUING OFFICE**

The State of Vermont has issued this RFP. The following person is the point of contact from the date of release of the RFP, until the selection of the successful Bidder.

**Procurement or Issuing Officer:**

Ann Rugg  
Deputy Director  
Office of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, Vermont 05495

**State of Vermont PBM RFP**

Telephone: 802-879-5911  
E-mail: annr@ahs.state.vt.us

**Alternate Procurement or Issuing Officer:**

Deborah Stempel, Contracts Administrator  
Office of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, Vermont 05495  
Telephone: (802) 879-5926  
E-mail: deborahs@ahs.state.vt.us

**The Director of the Office of Vermont Health Access is as follows:**

Joshua Slen, Director  
Office of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, Vermont 05495  
Telephone: (802) 879-5901

Please note that nothing within this requirement shall be interpreted to prevent the bidder from contacting the state regarding its general procurement process or with complaints. Contact with state personnel is also permitted in the performance of existing contracts or as allowed in response to other, non-related competitive solicitations.

**I-A GENERAL INFORMATION**

The following general information pertains to this procurement:

- 1) Issuing Authority: The State of Vermont is issuing this Request-For-Proposals (RFP).
- 2) Letter of Intent: A Letter of Intent to submit a proposal in response to this RFP **is** required. A letter of intent from the Bidders is necessary as only those prospective Bidders who have submitted a Letter of Intent will receive all subsequent mailings related to the RFP, including answers to written questions submitted to the State and/or RFP amendments. All information disseminated will also be available in the Bidders' Library. Letters of intent will be received until 4:00 p.m. (EST) on **Monday April 4, 2005**. Those Bidders not submitting a Letter of Intent are **not** permitted to bid on this RFP. Letters of Intent must include the name of the company, the name of the primary contact, the primary contact person's title, a telephone number and a fax number where this individual can be reached, and his/her mailing and e-mail addresses. Letters of Intent should also include an indication of whether or not the Bidder plans to attend the Bidders' conference, and the number of individuals the Bidder intends to bring. This is for State planning purposes. Bidders are encouraged to limit attendance to no more than three representatives per Bidder. Letters of intent may be mailed, e-mailed or faxed to:

Ann Rugg  
Deputy Director  
Office of Vermont Health Access

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312 Hurricane Lane, Suite 201  
Williston, Vermont 05495  
Telephone: 802-879-5911  
Fax: 802-879-5962  
E-mail: [annr@ahs.state.vt.us](mailto:annr@ahs.state.vt.us)

- 3) Written Questions and Answers: Bidders may submit, in writing, programmatic and contractual questions raised by this RFP to:

Ann Rugg  
Deputy Director  
Office of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, Vermont 05495  
Telephone: 802-879-5911  
Fax: 802-879-5962  
E-mail: [annr@ahs.state.vt.us](mailto:annr@ahs.state.vt.us)

Written questions received later than 4:00 p.m. EST, **Monday, April 4, 2005**, shall not be answered. The State may consolidate and/or paraphrase questions for clarity. The intention is to mail out answers to written questions by Friday, April 29, 2005. The questions can be submitted via fax or e-mail; however, the State assumes no liability for assuring accurate/complete fax/e-mail transmission/receipt and will not acknowledge receipt except by addressing the question.

- 4) Bidders’ Conference: Bidders will have the opportunity to ask additional questions orally at the Conference and the State will make a reasonable attempt to answer questions. A written summary of the Conference, and answers to questions raised at the Conference will be sent to all potential Bidders who submitted a letter of intent, whether in attendance at the Conference or not. The State intends to mail out answers and the conference summary by Friday, April 29, 2005. Oral answers given at the conference will not be binding on the State. Attendance at the Conference is strongly recommended, but it is not required. The Bidders are responsible for all costs associated with attending the Bidder’s Conference.

The conference will be held:

Date: Wednesday, April 13, 2005  
Time: 10:00 am to 12:00 Noon  
Location: Conference Room, Office of Vermont Health Access, 312 Hurricane Lane, Williston, VT

**I-B PROCUREMENT PROCESS**

The following subsections provide information on the process to be followed for various procurement events:

- 1) Legal Basis: The procurement process for this RFP shall be conducted in accordance with applicable procurement policies and procedures established by the State of Vermont.

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- 2) RFP Issuance and Amendments: State Officials within Vermont reviewed this RFP. The contents represent the best statement of the requirements and needs of the State. Final approval of the contract rests with the State, once all individual state requirements have been met.
- 3) Proposal Submission Requirements: Late submissions shall not be accepted. **Proposals that arrive late will not be accepted and will be returned to the sender unopened.** Delivery of the proposals shall be at the Bidder's expense. The time of receipt at the designated office is the time-date stamp on the proposal wrapper or other documentation of receipt maintained by the State. The State accepts no responsibility for mislabeled mail or misdirected delivery. Any and all damage that may occur due to shipping shall be the Bidder's responsibility. Each Technical/Programmatic Proposal and each Cost Proposal shall be enclosed in a separately sealed envelope or package.

The original and ten (10) paper copies of the Programmatic/Technical Proposal must be submitted under sealed cover and labeled on the outside as follows:

**“VERMONT MEDICAID PBM PROGRAMMATIC/TECHNICAL PROPOSAL”**

The original and ten (10) paper copies of the Cost Proposal must be submitted under separate sealed cover and labeled on the outside as follows:

**“VERMONT MEDICAID PBM COST PROPOSAL”**

One copy of each proposal shall be signed by an official authorized to legally bind the Contractor, and shall be marked:

**“ORIGINAL”**

The Programmatic/Technical Proposal must not contain any mention of the dollar amounts in the Cost Proposal. However, information such as labor hours and categories, materials, subcontracts, and so forth, shall be contained in the Programmatic/Technical Proposal so that the Contractor's understanding of the scope of the work may be evaluated. The Technical Proposal shall disclose the Contractor's technical approach in as much detail as possible, including, but not limited to, the information required by the Programmatic/Technical Proposal instructions.

The face of the package containing the original and copies, whether mailed or hand-delivered, shall bear the following legend:

**“VERMONT MEDICAID PBM PROPOSAL –  
CONFIDENTIAL – OPEN BY ADDRESSEE ONLY.”**

A copy of the entire proposal must also be submitted in an electronic format. One CD should include the entire proposal (including the Technical/Programmatic proposal), but not the Cost Proposal. The Cost Proposal must be submitted on a separate CD. The CDs should use Microsoft Word and Excel as appropriate. The Technical/Programmatic Proposal should be as brief and concise as is possible. The Scope of Work Section should

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be as succinct as possible. It is requested that this be no more than fifty (50) pages, plus any attachments. Responses that are unduly lengthy or verbose will be scored less favorably than will those that are brief and concise. Bidders must use 12-point font, and line spacing must be 1.5. Any financial information provided on spreadsheets must be provided in Excel. Gantt charts must be provided where applicable.

The format and content requirements for the Technical/Programmatic and Cost Proposals must adhere to the instructions contained in this section of the RFP. Failure to respond to a specific requirement may be used as a basis for rejection of the proposal from further consideration, or result in a score of zero or a fail for a particular item. Emphasis should be placed on conformance to the RFP instructions, responsiveness to requirements, and completeness and clarity of content. Elaborate proposals are neither necessary nor desired. If the Contractor's proposal is presented in a fashion that makes evaluation difficult or overly time consuming, it is likely that points will be lost in the evaluation process. Bidders shall not include any personal use items with the bid.

Each proposal part (Technical/Programmatic and Cost) must be bound separately on standard 8 ½" by 11" paper, except that charts, diagrams, and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables must be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text.

All proposals must be delivered no later than 4:00 p.m. EST on **Friday May 20, 2005**, and only to the address below. At 4:30 p.m. the same day, there will be a public bid opening also at the address cited below. The public bid opening will be administered by two employees of the Office of Vermont Health Access. Note that only the names and addresses of Bidders shall be read at the public bid opening.

### **Deliver to:**

**Ann Rugg  
Deputy Director  
Office of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, Vermont 05495**

**Telephone: 802-879-5911  
Fax: 802-879-5962  
E-mail: [annr@ahs.state.vt.us](mailto:annr@ahs.state.vt.us)**

**IMPORTANT NOTE:** Do not send proposals by U.S. mail, as the Williston Post Office will not deliver packages to the OVHA location.

## **I-C PROPOSAL WITHDRAWAL**

Prior to the proposal due date, a submitted proposal may be withdrawn by submitting a written request for its withdrawal signed by the Bidder's authorized agent and sent to Ann Rugg, at the Office of Vermont Health Access, at the address cited in Subsection 3 of I-B.

**I-D ACCEPTANCE OF PROPOSALS**

The State shall accept all proposals submitted according to the requirements and deadlines specified in this RFP. The State reserves the right to reject any or all proposals received. It is understood that all proposals, whether rejected or not, will become the property of the State. After receipt of proposals, the State reserves the right to sign a contract, without negotiation, based on the terms, conditions, and premises of this RFP and the proposal of the selected Bidder(s).

All proposals must be responsive to all requirements in the RFP in order to be considered for a Contract award.

After the opening of proposals, the State may ask any Bidder for written clarification of their proposal. In the event this clarification is requested, submission of the clarification shall be considered an amendment to the proposal.

The State reserves the right to waive minor irregularities in proposals, providing such action is in the best interest of the State. Where the State may waive minor irregularities, such waiver shall in no way modify the RFP requirements or excuse the Bidder from full compliance with RFP specifications and other Contract requirements if the Bidder is awarded the Contract. The State also reserves the right to reject any and all proposals received, or cancel this RFP, according to the best interest of the State.

Proposals must be valid for 180 days following the close date of this RFP. This period may be extended by written mutual agreement between the Bidder and the State. Any proposal submitted shall not be available for disclosure until a contract is executed between the successful bidder and the State.

**I-E ORAL PRESENTATIONS**

At the State's option, oral presentations by selected Bidders may be required. Bidders will be notified if an oral presentation is required. Any cost incidental to an oral presentation shall be borne entirely by the Bidder and the State shall not compensate the Bidder. The Bidders may be requested to provide demonstrations of their proposed systems as part of their presentations.

The Bidders should present complete, comprehensive proposals without relying on oral presentations, because the State reserves the right to award a contract without further discussions.

**I-F SITE VISITS**

At the State's option, a site visit may be requested for the purpose of reviewing the Bidder's organizational structure, subcontracts, policy and procedures, and any other aspect of the proposal that directly affects the provisions of the RFP/Contract and the delivery of health care services. Any Bidder costs incidental to the site visit shall be borne by the Bidder.

A readiness review may also be conducted on-site at the selected Contractor's facilities following execution of the Contract and prior to implementation of the Pharmacy Benefit

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Management services.

**I-G CONTRACT AWARD NOTICE**

The notice of the intended contract award shall be sent to all Bidders who submitted a proposal. A contract award is contingent on approval by the State.

**I-H PROTEST OF INTENDED AWARD**

Should there be any protests of intended contract award, the appropriate State requirements will be employed.

**I-I PROCUREMENT TIMETABLE**

The State expects to adhere to the procurement schedule shown below. It should be noted, however, that dates are subject to change.

| <b>ACTIVITY</b>   | <b>DATE</b>   |
|---|---|
| Release of RFP<br>Bidders' Library Available  | Friday March 18, 2005                               |
| Letter of intent to Bid Due from Bidders<br>(required)<br>Written Question Deadline | Monday April 4, 2005, 4:00 pm                       |
| Bidder Conference   | Wednesday April 13, 2005, 10:00 am<br>to 12:00 noon |
| State Response to Q&A   | Friday April 29, 2005                               |
| Due Date for Submission of Proposals  | Friday May 20, 2005, 4:00 PM                        |
| Expected Date of Selection of Contractor  | Friday July 8, 2005                                 |
| Negotiation and Execution of Contract   | Monday July 11, 2005 – August 12,<br>2005           |
| Conversion Period   | Monday August 15, 2005 –<br>December 22, 2005       |
| Beginning Date for New System   | Sunday January 1, 2006                              |

**I-J RESTRICTIONS ON COMMUNICATIONS WITH STATE PERSONNEL**

From the issue date of this RFP until a Contractor is selected and announced, Bidders are not allowed to communicate with any State staff except during the Bidders' conference. **All communications related to this RFP are restricted to written communications except as set forth below and in the Section labeled 'Issuing Office' above within Section I.** Letters of intent and written questions may be mailed, e-mailed, or faxed by the deadlines included herein to:

Ann Rugg, Deputy Director  
Office of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, Vermont 05495  
Fax: 802-879-5962  
E-mail: [annr@ahs.state.vt.us](mailto:annr@ahs.state.vt.us)

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Violation of this restriction may result in disqualification of the Bidder's proposal. The only *exceptions* to these restrictions are:

- State staff and/or Bidder's staff present at the Bidder's Conference for the purpose of addressing questions,
- Bidders' Library (for purposes of obtaining logistical support only), and
- State personnel involved in oral presentations by Bidders (State option).

As described in this RFP, any clarification regarding the RFP will be issued in writing by the State. No statements, clarifications, or opinions regarding this RFP are valid or binding except those issued in writing by the State. **Under no circumstances will questions be entertained except in writing or at the Bidders' Conference.**

### **I-K LIBRARY LISTING**

The Bidders' Library may be found at [www.ovha.state.vt.us/](http://www.ovha.state.vt.us/), the Vermont Medicaid home page. The following documents are included in the Bidders' Library:

- Required contract Attachment language for the State - Attachments C, E, F
- Vermont Medicaid Provider Manual
- MMIS specifications and record layouts
- Vermont's Preferred Drug List (PDL)
- Vermont's Clinical Criteria related to the PDL
- Vermont's Description of the criteria for exemption from the PDL for drugs used in the treatment of severe and persistent mental illness (SPMI)
- HIV/AIDS Medication Assistance Program (AMAP) formulary
- General Assistance formulary
- Vermont Monthly Eligibles Report
- Required state disclosure statement

### **I-L AWARD**

The State reserves the right to award by module, part or portion of a module, group of modules, or the total proposal, to reject any and all proposals in whole or in part, if the best interest of the State shall be so served. In determination of awards, the qualification of the Bidder, the conformity with the specifications of services to be supplied and the delivery terms shall be considered. The State will select up to four bidders Bidder from this RFP process for the following four components:

1. Specialty pharmacy services.
2. Preferred drug list development and maintenance with rebate negotiation and collection services.
3. All other services described in this RFP.

A bidder may offer on one or more components.

## **SECTION II**

### **INFORMATION REQUIRED FROM BIDDERS**

The Bidder's proposal must be submitted in the format outlined below. There should be no attachments, enclosures, or exhibits other than those considered by the Bidder to be essential to a complete understanding of the proposal submitted. **Each section of the proposal should be clearly identified with appropriate headings:**

#### **II-A TRANSMITTAL LETTER**

A transmittal letter must accompany the proposal, signed in ink by an official authorized to bind the Offeror to the proposal's provisions. The letter must include a statement that the RFP and Bidders' Library contract terms are accepted. Bidders must also include a statement in the letter certifying that the price was arrived at without any conflict of interest.

A "Bidder information sheet" containing the following information must also accompany the transmittal letter:

- Name of company or individual
- Mailing address
- Street address (for FedEx or other mail service)
- Company Federal ID Number (or if an individual, the bidder's social security number)
- Name and title of the person who would sign the contract
- Name and title of the company contact person (if different)
- For each key person: direct telephone number, fax number and e-mail address.

#### **II-B BUSINESS ORGANIZATION**

- State the full name and address of the Bidder organization and, if applicable, the branch office or other subordinate element that will perform, or assist in performing, the work described in the bid.
- Indicate whether the bidder operates as an individual, partnership, or corporation; if as a corporation, include the state in which it is incorporated.
- If appropriate, state whether it is licensed to operate in the State of Vermont.
- List all subcontractors: include firm name and address, contact person, and complete description of work to be subcontracted. Include descriptive information concerning subcontractor's organization, abilities, and commitment to the contract period.
- Please provide annual audited financial reports for the past three (3) years for the Bidder and any subcontractor.
- Identify all owners and subsidiaries that own more than five (5) percent of the organization.
- If the Bidder is an affiliate of another organization, submit the financial information for the parent company and describe the relationship.
- Complete the required State disclosure statement as found in the Bidder's Library.

**II-C LOCATION**

Indicate the site or sites from which the Bidder will perform the relevant tasks embodied in this proposal. It is possible that the Contractor may wish to change the site(s) for some of these tasks during the contract term. Please describe the Bidder time line in this regard if applicable.

Specifically identify where the following activities will take place:

- Systems activity, including all claims processing
- Data analysis
- Rebate negotiation
- Member and provider services
- Project/account management
- Specialty pharmacy services
- Mail order services

**II-D AFFILIATIONS**

Describe all affiliations or ownership relationships with potential suppliers of pharmaceuticals or retail pharmacy services to the State, including:

- Retail pharmacy services
- Mail order pharmacy services
- Drug manufacturing
- Drug distribution

Describe all subcontractor relations that will pertain to work required by this contract. Please indicate whether all appropriate business agreements required by HIPAA are current and available for audit by the State.

Explain how the Bidder can assure the State that these relationships will not create a conflict of interest with the State and that the required State disclosure will be met.

**II-E RELEVANT EXPERIENCE**

The scope of work in this proposal includes services to be provided to distinct groups: Medicaid eligibles, HIV/AIDS patients, state defined beneficiaries, emergency needs populations and those without prescription coverage (the Uninsured). Describe the Bidder's experience with managing care for each group.

**References**

Proposals shall include at least five (5) business references that demonstrate the Bidders' prior experience in areas for which services are being offered. Each reference must include the name, address and phone number of the client, organization, and the responsible project administrator familiar with the firm's performance. Include a description of the services the Bidder is providing to these clients and the number of covered lives. If the Bidder is presently providing

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these or similar services for other states, those references must be included. Additional references will need to be provided if requested by the State.

### **II-F CONTRACTOR ORGANIZATION AND STAFFING**

The Contractor is responsible for providing all resources necessary to develop, implement and operate the system as specified in this RFP. Notwithstanding this general requirement, the State requires that the Contractor commit to certain dedicated staff resources that will act as single points of contact.

### **II-G METHODOLOGY AND APPROACH**

Bidders will be scored, in part, on the methodology and approach proposed in the bid. Be as specific as possible in addressing all of the elements described in each section within Section III, Work Statement, of this RFP. Bidders should include a proposed implementation timeline following execution of a contract with the state within the proposal submitted.

### **II-H PRICE/COST PROPOSAL**

***Please do NOT include cost or cost savings information in the technical proposal, but only in the price/cost proposal.***

#### **Independent Price Determination**

1. By submission of a proposal, the Bidder certifies, and in the case of a joint proposal, each party thereto certifies as to its own organization, that in connection with this proposal:
  - a) The prices in the proposal have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition as to any matter relating to such prices with any other Bidder or with any competitor; and
  - b) Unless otherwise required by law, the prices which have been quoted in the proposal have not been knowingly disclosed by the Bidder and shall not knowingly be disclosed by the Bidder prior to award directly or indirectly to any other Bidder or to any competitor; and
  - c) No attempt has been made or shall be made by the Bidder to induce any other person or firm to submit or not submit a proposal for the purpose of restricting competition.
  
2. Each person signing the proposal certifies that she/he:
  - a) Is the person in the Bidder's organization responsible within that organization for the decision as to the prices being offered in the proposal and has not participated (and shall not participate) in any action contrary to 1. a., b., and c. above; or
  - b) Is not the person in the Bidder's organization responsible within that organization for the decision as to the prices being offered in the proposal but has been authorized to act as agent for the persons responsible for such decision in certifying that such persons have not participated (and shall not participate) in any action contrary to 1. a., b., and c. above.

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3. Should a Bidder be awarded a Contract resulting from this RFP, and be found to have failed to abide by the provisions set forth in this Section, said entry shall be in default of the Contract. Consequences may include cancellation of the Contract.

### **Configuration of the Price/Cost Proposal**

- Since the contract between the Contractor and the State may be progressive, the Bidder shall present its costs for each module, based on metrics defined below for the module in question.
- It is also possible that the State may choose to purchase only selected modules, so the prices quoted for each module should be separate and distinct. The Bidder may, however, provide aggregate discounts should the State elect to purchase multiple and in particular, all of the modules. These discounts should be fully defined in the price proposal submitted.
- Bidders are permitted to provide “tiered” pricing, as incremental lives and claims are added by the State.
- The Bidder must be specific about the cost savings that the State will be able to achieve, including methodologies for tracking and measuring results and methodologies for establishing baselines and proving projected cost savings. **(Please do NOT include cost or cost savings information in the technical proposal, only the price proposal.)**
- The Bidder must be specific about any additional cost savings that the Uninsured will be able to achieve, including methodologies for tracking and measuring results and methodologies for establishing baselines and proving projected cost savings, based on the strategies included in the Bidder’s technical proposal.
- The Bidder may propose a payment structure that provides incentives to reduce the States’ overall cost for pharmacy reimbursements, while preserving or improving health outcomes.
- The Bidder is invited to propose any other cost reduction strategies, including but not limited to, a cost incentive program that tracks its success at reducing costs. Cost reductions generally should be expressed as identified reductions in the growth in PMPM pharmacy costs (include specific percentages). However, savings can also be expressed as a percentage of pharmacy spending in the aggregate, or as a percentage of identified drug classes. All cost reduction strategies should include the methodology for establishing baselines, measuring and tracking results, and proving projected cost savings.
- Prices/rates quoted are the maximum for a period of three (3) years from the date that the Contract becomes effective. The prices and rates quoted shall be effective through the initial three year Contract period.
- Requests for price changes shall be received in writing at least thirty (30) days prior to their effective date, and are subject to approval by the State before becoming effective. Any price change request must document in full the rationale for the change. In the event new prices are not acceptable, the Contract may be canceled.
- It should be noted that price changes in any given fiscal year are contingent upon enactment of legislative appropriations and approval of the State.
- The Contractor is not at risk for changes in drug prices, unless the Contractor includes strategies that offer drug price guarantees for the State.

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### **Instructions**

1. Please provide the costs by filling in the shaded areas of the price proposal below.
2. The Bidder may propose annual inflation rates for years subsequent to the original three year term of the Contract.
3. Since this may be a progressive engagement, the Bidder is encouraged to offer lower prices for each module, predicated on volume or the number of modules selected. Bidders may submit as many price levels as they wish, by adding lines to the table below.
4. The following metrics will be used in the Table:
  - Per Member Per Month (PMPM): Five (2) levels are used in the cost proposal as follows:
    - PMPM – A: Includes all populations covered by the RFP.
    - PMPM – U: Includes only the uninsured (may include the Healthy Vermonters Program beneficiaries and others).
  - Per Transaction (PT): A transaction is either a paid or a denied claim
  - Per Authorization (PA): For Prior Authorizations only – per approved or denied PA, provided by 1) A pharmacist; 2) A technician; 3) An administrative PA; and 4) Via electronic PA determination. Provide separate prices for each level. NOTE: The price for the final resolution of a request will not exceed the price for a single unit of the highest level of intervention needed for final determination of the request.
  - Per Card (PC): For ID cards only
  - Proposed Cost: Equals the proposed cost based on the metrics in the “basis of cost” column.
  - Minimum Cost per Month: Equals the minimum cost to the State for the PBM to provide the type of service indicated.
  - Volume Cost: The State anticipates that Bidders may offer unit price concessions predicated on increased volume.
  - Volume level required to achieve the volume cost: Equals the volume level of the identified metric in order to achieve the volume cost.
  - Savings Potential: An estimate by the Bidder of the savings potential (if applicable) to the State from implementing the type of service indicated, expressed as a reduction in PMPM pharmacy costs or an identified reduction in pharmacy spending.
5. Bidders shall describe potential cost savings for these services. The basis of the savings must be explained at the end of the price proposal section.
6. Bidders shall describe in what ways the proposed strategy might result in reduced or increased costs (to OVHA and/or the program affected).
7. Bidders shall describe if there are negative consequences in some areas of the drug budget resulting from implementation of specific program modules, and to what extent they might be minimized or neutralized by benefits realized in other areas.
8. For specialty pharmacy services, Bidders should attach a list of products that the Bidder would offer to be covered in the specialty pharmacy program and the specific pricing for each product. Pricing should be expressed as a percentage reduction off AWP, for example AWP – 30%. Reductions should be specific to each product and can vary by product.
9. Bidders should identify the number of GCNs covered by their MAC list and the aggregate value of the MAC list expressed as a percentage reduction off AWP, for example AWP – 65%.

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**Note: Refer to instructions for descriptions of matrices used in cost proposal.**

| <b>PRICE PROPOSAL</b>  |   |                      |                               |                    |   |                           |
|--|---|----------------------|-------------------------------|--------------------|---|---------------------------|
| <i>Type of Service</i>   | <i>Basis of Cost</i>                      | <i>Proposed Cost</i> | <i>Minimum Cost per Month</i> | <i>Volume Cost</i> | <i>Volume level Required to achieve the volume cost</i> | <i>Savings Potential*</i> |
| Claims processing (on-line and batch; with all pricing including MAC; including COB) | Per month cost                            |                      |                               |                    |   |                           |
| Claims processing – Keying paper claims  | Per month cost                            |                      |                               |                    |   |                           |
| Specialty pharmacy   | AWP minus “%”, by drug (see instructions) |                      |                               |                    |   |                           |
| Auditing   | Per on-site audit                         |                      |                               |                    |   |                           |
| Drug coverage management (Preferred Drug List), including P & T Committee support    | Per month cost                            |                      |                               |                    |   |                           |
| Analysis and reporting – standard and decision support ad hoc capabilities           | Per month cost                            |                      |                               |                    |   |                           |
| Medicaid (OBRA ‘90) and VScript state-only, OBRA ’90 equivalent rebate               | Per month cost – R1                       |                      |                               |                    |   |                           |

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| <b>PRICE PROPOSAL</b>   |                                     |                      |                               |                    |   |                           |
|---|-------------------------------------|----------------------|-------------------------------|--------------------|---|---------------------------|
| <i>Type of Service</i>  | <i>Basis of Cost</i>                | <i>Proposed Cost</i> | <i>Minimum Cost per Month</i> | <i>Volume Cost</i> | <i>Volume level Required to achieve the volume cost</i> | <i>Savings Potential*</i> |
| management including disputes and collection  |                                     |                      |                               |                    |   |                           |
| Supplemental rebate negotiation, rebate managements and disputes, and collection                    | Per month cost – R2                 |                      |                               |                    |   |                           |
| SPAP rebate negotiation, rebate managements and disputes, and collection                            | Per month cost - SPAP               |                      |                               |                    |   |                           |
| Drug Utilization Review, including DUR Board support for all beneficiaries except AMAP, GA, and HVP | Per month cost                      |                      |                               |                    |   |                           |
| Utilization management for all beneficiaries except AMAP, GA, and HVP                               | Per month cost                      |                      |                               |                    |   |                           |
| Disease management for all beneficiaries except AMAP, GA, and HVP                                   | Per month cost                      |                      |                               |                    |   |                           |
| Prior authorization   | PA – four levels (see instructions) |                      |                               |                    |   |                           |

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| <b>PRICE PROPOSAL</b>   |                      |                      |                               |                    |   |                           |
|---|----------------------|----------------------|-------------------------------|--------------------|---|---------------------------|
| <i>Type of Service</i>  | <i>Basis of Cost</i> | <i>Proposed Cost</i> | <i>Minimum Cost per Month</i> | <i>Volume Cost</i> | <i>Volume level Required to achieve the volume cost</i> | <i>Savings Potential*</i> |
| Telephone support - Pharmacy providers and prescribers                              | PMPM – A             |                      |                               |                    |   |                           |
| ID cards  | PC                   |                      |                               |                    |   |                           |
| Epocrates® contract   | Cost per month       |                      |                               |                    |   |                           |
| Required staffing (list by each required staff – separate salary and benefit costs) | Annual cost          |                      |                               |                    |   |                           |
| Other   |                      |                      |                               |                    |   |                           |
| Other   |                      |                      |                               |                    |   |                           |
| *Bidders shall attach separate narrative to describe savings potential.             |                      |                      |                               |                    |   |                           |

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**Uninsured Network Claim Costs**

**Instructions:**

Complete the tables below for an uninsured option. The tables will be used to evaluate the Bidder's network costs and strategies to reduce costs for the uninsured.

**Table A** should be completed for the following program design:

- a) Current uninsured program remains in place
- b) Claims processing and telephone services are fees paid by State
- c) Bidder's network is utilized
- d) Bidder's formulary and rebate contracts are applied to program

**Table A**

| <b>Per Claim Network Costs -- Non-Funded (Uninsured) Claims</b>  |  |                   |
|--|--|-------------------|
| <b>Type of Provider</b>  | <b>Retail<br/>(Community)<br/>Pharmacy</b> | <b>Mail Order</b> |
| Discount from AWP for brand claims   |  |                   |
| Brand dispensing fee   |  |                   |
| Generic cost basis (if MAC pricing is used, the State will calculate generic costs based on the MAC costs submitted by the Bidder) |  |                   |
| Pricing rule for non-MAC generics  |  |                   |
| Generic dispensing fee   |  |                   |
| Proposed formulary rebate percentage to be retained by the Bidder, if any  |  |                   |

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**Table B** should be completed for the following program design:

- a) Program will be offered to all uninsured
- b) Bidder’s network is utilized
- c) Bidder’s formulary and rebate contracts are applied to program
- d) This is a self-funded program without any cost paid by the State
- e) An application fees may be charged

**Table B**

| <b>Per Claim Network Costs -- Non-Funded (Uninsured) Claims</b>  |                                    |                            |
|--|------------------------------------|----------------------------|
| <b>Type of Provider</b>  | <b>Retail (Community) Pharmacy</b> | <b>Mail Order Pharmacy</b> |
| Discount from AWP for brand claims   |                                    |                            |
| Brand dispensing fee   |                                    |                            |
| Generic cost basis (if MAC pricing is used, the State will calculate generic costs based on the MAC costs submitted by the Bidder) |                                    |                            |
| Pricing rule for non-MAC generics  |                                    |                            |
| Generic dispensing fee   |                                    |                            |
| Proposed formulary rebate percentage to be retained by the Bidder, if any  |                                    |                            |
| Application fee (if applicable)  |                                    |                            |

**SECTION III**  
**WORK STATEMENT**

**III-A BIDDER RESPONSE TO RFP – GENERAL REQUIREMENTS**

Through this RFP, the State is asking Bidders to describe Bidder capabilities in regard to the requirements set out in each section of the Work Statement. If there are specific features of the module that the State wishes Bidders to note or respond to, they are described in the section titled “**RFP Response**”. This section may also reflect the State’s understanding of the functions or goals of the module. The requirements are articulated in the section labeled “**Requirements**”.

As applicable, the Bidder should describe their ability to meet the requirements, any unique or innovative method the Bidder proposes in meeting the requirement, applicable experience the Bidder has in performing the function in other settings, and any other information relevant to the module being described. If the Bidder is not able to meet the requirement, it should describe in detail the limitations of their system or capacity. If the Bidder’s proposes to exceed these requirements, this should likewise be described in detail in the Bidder’s proposal.

The Bidder should describe its ability to meet any applicable implementation schedule, the lead time to implement a module, and describe the organizational structure and responsibilities for implementation, including key personnel, experience of these personnel with similar implementation projects, organizational authority of these personnel, and other relevant information that will allow the State to judge the capacity of the Bidder to execute successfully the module under discussion.

**III-B CLAIMS PROCESSING AND SYSTEMS**

**1. Discussion and Overview**

Presently the State has systems in place through its existing PBM contract to provide for claims processing and the other relevant systems’ tasks for claims processing. Claims adjudication is the responsibility of the Contractor. However, provider payments are made by the State's current MMIS Contractor. Under this scenario, the Contractor transmits the adjudicated claims electronically to the MMIS Contractor, and the MMIS Contractor performs all of the tasks associated with payments to providers and reporting to the State.

The State may elect to continue to use the current MMIS Contractor to make payments for adjudicated claims to providers.

In adjudicating claims the Contractor would perform a number of prescribed functions, including applying DUR edits, Prior Authorizations, and COB functions. Those responses would be transmitted back to the pharmacy. Once the claim is adjudicated by the Contractor, a file will be transmitted to the MMIS provider for payment to providers on a weekly basis. Details of this processing will be concluded with the Contractor during the implementation phase.

**Healthy Vermonters Program:** The Contractor will be responsible for all claims processing for drug claims for any Healthy Vermonters Program beneficiaries included in the contract even though currently there is no provider payment involved. This population has a non-funded pharmacy benefit similar to a discount card. Beneficiaries pay the entire cost of the prescription

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in the Medicaid pharmacy network at the time they obtain it. Payment from the HVP beneficiary to the pharmacy is at Medicaid rates.

### **2. Systems Implementation**

The Contractor shall have an implementation schedule that conforms to the schedule set out in this RFP that enables the system to go live effective January 1, 2006, unless otherwise approved by the State. The Contractor shall provide the State with a requirements analysis and will design, code, and test all systems requirements and benefit plan designs based on State specifications.

The State shall conduct user acceptance testing. The Contractor is responsible for providing user training. The Contractor shall provide conversion of data and file loads. As required, the State shall conduct an operational readiness review and post implementation review. The Contractor shall provide implementation support sufficient to complete implementation within a 150 day time frame. During the implementation period, the Contractor's staff shall be responsible for prescriber and network provider training and consumer education as directed by the State.

Prior to commencement by the Contractor of operational services, the State shall review and approve in writing all edits, criteria, and procedures used by the Contractor in any drug utilization review services provided by the Contractor.

#### **RFP Response:**

The Bidder should:

- describe its ability to meet the implementation schedule;
- describe its testing and quality assurance program for program implementation and future changes to the State's benefit programs;
- describe other implementations, whether or not the schedule was met, and significant issues that needed to be addressed subsequent to the system going live;
- provide a table by month that identifies the frequency and amount of unscheduled system downtime experienced by its accounts within calendar 2004;
- include the anticipated schedule for regular system maintenance for the system that will be used to process claims under the contract;
- describe its claims capture abilities;
- describe the ability to use claims history in the processing of claims; and
- describe the its disaster recovery systems.

#### **Requirements:**

The Contractor shall integrate drug coverage design with the eligibility system by utilizing eligibility, drug, and benefit systems to adjudicate claims for appropriate coverage. Batch, POS, and paper claims are adjudicated through the same adjudication model.

The Contractor shall provide the ability to perform a drug search by eligible beneficiary with the following capabilities:

Drug coverage; e.g., covered, for that beneficiary, on that day, etc.;

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Drug limitations; e.g., requires PA, has quantity limits, has beneficiary limits (e.g., calendar year, benefit period, lifetime, etc.), etc.;  
PA status; e.g., PA required, PA exists and expiration date, etc.; and  
Cost sharing.

The Contractor shall maintain a claims processing system with the following capacities or specifications:

1. POS, on-line, real-time 24 hours per day/7 days per week capabilities for the adjudication and reversal of pharmacy claims.
2. Support for paper or batch (electronic tape/disk) claims processing.
3. A claims capture system in the event of scheduled or unscheduled downtime.
4. A fully documented disaster recovery program.
5. Compliance with all applicable published HIPAA requirements within the time frames established in the HIPAA rules.
6. Compliance with NCPDP standards.
7. The inclusion of “Lock-In” functions to lock a beneficiary into at least two pharmacies and/or three prescribers, including the ability to perform multiple lock-in functions. The Bidder’s system shall allow the State to lock a beneficiary into a specific pharmacy or pharmacies, prescriber(s), or combinations of both.
8. Assurances that a transaction is subject to all syntax editing (e.g., number-only fields are all numeric) and that the transaction is subject to all relational editing (e.g., member number is on file).
9. Eligibility verification prior to pricing claims. The Contractor shall interface with the State's eligibility system (ACCESS) for ongoing eligibility file downloads necessary to support all claims functions.
10. In cases of retroactive eligibility where a beneficiary’s benefit increases/decreases liability, the Contractor shall instruct the provider to reverse the original claim, reimburse the beneficiary for any overpayment, and submit a new claim.
11. The ability to track variable benefit limits; e.g., monthly, quarterly, annually, lifetime.
12. Editing for prescriber and pharmacy eligibility prior to pricing claims. The Contractor shall interface with the State's MMIS Contract for at least weekly provider file updates. The Contractor shall accept daily third party liability files on beneficiary coverage and weekly third party liability carrier files.
13. The ability to accept compound prescriptions claims that allow providers to use the NDCs for each ingredient (NCPDP compliant) and bill for labor.

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14. Support for a Preferred Drug List.
15. Support of prior authorization (PA) requirements.
16. Ability to accept PAs entered directly to the system manually, by batch, and electronically.
17. Ability to grandfather; that is, create a PA based on known conditions.
18. Allowance for claims processing exceptions to specific benefit designs by a certain panel of providers or by location.
19. Ability to accept three years of claims history at implementation and retain at least three years in operations.
20. Systems capacity to adjudicate claims using claims history to verify formulary status, diagnosis, and approval or denial of claims.
21. Support for pricing methodologies based on:
  - a. Variable pricing and benefit design as set by the State for specified populations; e.g., Medicaid including the Vermont Health Access Program and Vermont publicly-supported health care programs, elderly or disabled populations, Healthy Vermonters Program individuals, or other populations supported by the system;
  - b. Federal Upper Limit (FUL), State MAC, or Contractor's MAC;
  - c. Lesser of logic: U&C, gross amount, State pricing, FDB pricing; FUL pricing; MAC pricing;
  - d. Brand vs. Generic (typically indicators from vendors like First Data Bank are used to determine brand vs. generic; however, the proposed system shall allow for the State's determination of a drug's brand/generic status when applicable);
  - e. Standard vs. non-standard package size;
  - f. Unique service pricing; e.g, compounded prescriptions and infusion claims;
  - g. Dispensing fee with the capacity to pay variable fees (e.g., Clozaril, unit dose medications);
  - h. Other insurance price reductions;
  - i. Beneficiary payments including full or partial reimbursement and cost-sharing; i.e., co-payments, deductibles, and coinsurance; and

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22. The ability to apply COB edits for other insurance coverage in terms of benefits and cost sharing to the extent possible according to NCPDP standards.
23. The ability to apply COB edits for Medicare Part D coverage both in terms of benefits and cost sharing to the extent possible according to NCPDP standards. This includes the formularies for each Medicare Part D Pharmacy Drug Provider (PDP) in the State's region; other coverage information billed using the Medicare Part D; and cost sharing details including deductibles, coinsurance, and the application of the coverage gap ("donut hole")
24. The ability to allow for provider-submitted TPL overrides when other benefits have been exhausted or partially exhausted. The carrier/plan name, client identifier, and member information shall be communicated to the provider using messaging information in the NCPDP response record. Multiple carrier/plan data shall be provided to the pharmacist as part of the cost avoidance override process.
25. The ability to accept NCPDP values for COB/Other Payer Detail Reject Codes.
26. The ability to allow for voluntary beneficiary payments.
27. The capacity to message pharmacy providers on claims matters at POS.
28. The capacity to send messages to pharmacy providers when a new PA is required within 30 days or less of the date of service.
29. An interface with the State's MMIS for transfer of information according to the following:
  - a. The Contractor shall send paid and denied claims transaction information per the State's direction to the State's fiscal agent to allow for claims payment on a weekly basis, database population functions, and Federal and State reporting purposes.
  - b. Contractor shall receive medical claims data per agreed upon schedule to carry out DUR and Utilization and Disease State Management functions.

## **III-C SPECIALITY PHARMACY**

### **1. Discussion and Overview**

The State continues to seek innovative approaches to managing the care of beneficiaries. The implementation of the Preferred Drug List and Prior Approval of medications was the State's initial step in improving the quality and cost effectiveness of its programs. As these programs continue to mature, the State has identified additional areas where innovative programs will assist in ensuring quality of care for its beneficiaries.

The State is seeing an increasing number of beneficiaries that require relatively complex and challenging drug therapies to manage their chronic diseases/conditions. This relatively small portion of beneficiaries continues to expend an increasing percentage of the pharmacy budget.

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Many specialty therapies are biotechnology products that require special handling and patient monitoring. Examples of these chronic diseases/conditions include but are not limited to Crohn's Disease, Hemophilia, Multiple Sclerosis, Hepatitis, Growth Hormone Deficiency, Rheumatoid Arthritis, Cancer, Transplants, and RSV. The State understands that the need for these agents will continue to grow as the pharmaceutical industry predicts that the market for biotechnology products will double in the next few years due to the acceleration of the development of these therapies.

### **2. RFP Response**

The Bidder's response must provide a complete and detailed description of its programs and the process for implementation. The bidder should describe the programs offered to support the management of these chronic patients, including the following:

1. List of available products and programs for these and other diseases/conditions:
  - a. Crohn's
  - b. Hemophilia
  - c. Multiple Sclerosis
  - d. Hepatitis
  - e. Growth Hormone Deficiency
  - f. Rheumatoid Arthritis
  - g. Cancer
  - h. Transplants
  - i. RSV
2. Product distribution network that will be used by the Bidder.
3. Care management programs for identified disease states/conditions.
4. Educational programs for patients and providers.
5. The Bidder's experience in managing specialty programs and cost savings attributed to the implementation of their programs.
6. Programs and methodology to identify patients qualifying for each program module.
7. A description of the clinical management staff and expertise of the bidder.
8. Programs and systems to integrate pharmacy and medical claims data.
9. Standard report package that will be generated by the Bidder for each specialty pharmacy programs.
10. Any patient satisfaction survey that has been used by the Bidder.

### **3. Requirements**

The State seeks a program that will improve the quality of patient care and therapeutic compliance in the most cost effective manner. The Contractor will work with the State to implement a comprehensive care management program for this segment of its population. The Contractor will identify individuals who would qualify for the programs using medical and pharmacy claims data. Once identified, these patients will be enrolled in the Contractor's program. The Contractor's program must work with community prescribers to ensure a transition to the program that is not disruptive to the beneficiary's care.

## **III-D AUDITING**

### **1. Discussion and Overview**

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The State believes that an audit program can produce meaningful savings. The Contractor will be required to describe a complete, comprehensive audit program that will include both desk and on-site audits where compliance deficiencies would be reported to the State's Program Integrity Unit for appropriate follow up. This process will be negotiated with the successful Bidder.

The Contractor will be required to manage required audit and compliance programs for its network for the uninsured, if applicable. This includes appropriate sanctions and recoveries.

### **2. RFP Response**

The bidder should describe its audit program including a description of the methodology for determining when an audit will provide cost effective results, if the frequency of audits has an effect, and the relative return of each type of audit. The bidder should describe how the following impacts on the cost effectiveness decision:

1. Percentage of pharmacies.
2. Type of audit.
3. Parameters that trigger a desk audit.
4. Items subject to review including:
  - Compliance with the usual and customary price provision;
  - Average prescription billed;
  - Average amount paid;
  - Average quantity per prescription;
  - Accuracy of days supply information;
  - Frequency of fill;
  - Low generic utilization and dispensing;
  - Amount of controlled substance drugs per prescription;
  - Accuracy of physician identification;
  - Frequency of denial; and
  - Other (please identify).
5. Criteria discovered in a desk audit will result in an on-site audit.
6. Impact of:
  - Suspected "short-counts" (i.e., fraudulent under-dispensing);
  - Partially filled prescriptions;
  - Under-stocked drugs;
  - Scripts that are not picked up are reversed in a timely fashion; and
  - Other (please identify).

When audits are determined appropriate:

1. Describe how providers are selected for audit.
2. Describe the characteristics of those who perform desk audits indicating any credentials required.
3. Describe the characteristics of those who perform on-site audits indicating any credentials required.
4. For on-site audits:
  - Identify records reviewed;
  - Describe the methodology for record duplication and handling; and

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- Indicate other concerns.
- 5. Describe how settlements are calculated.
- 6. Describe approaches with respect to onsite and desk audit recoveries and their return to the State programs.

### **1. Requirements**

The Contractor will be prepared to provide a comprehensive audit program plan in order to detect questionable pricing/discounting, duplication of claims, or other types of potential fraud, abuse and misuse of the prescription drug benefits. All prescription claims may be reviewed and analyzed during the detection phase. The Contractor's approach to pharmacy audits might include all or portions of the following: collaborating with State Program Integrity staff to identify data reporting/capturing that may be responsible for erroneous fraud, waste and abuse detection; identifying and analyzing statistically valid samples of claims; performing desk audits and, where necessary, reviewing original documents on-site; interviewing providers, beneficiaries, and related persons; reviewing cases with medical consultants; referring all cases to the State Program Integrity Unit; keeping qualitative and quantitative statistics on substantiated cases and compiling reports; initiating all necessary recovery reports; and maintaining documentation of findings and recoveries as applicable.

The Contractor shall develop audit criteria for desk and on-site audits that will be reviewed and approved by the State prior to use. Such criteria may include providers that deviate from other providers by a set percentage or more from average claim statistics such as number of claims per beneficiary, total payment per beneficiary, and number of brand certifications; evidence of abuse of usual and customary charges for processed claims; number of claims in excess of high dollar thresholds or number of "high-cost" compound claims; excluded drug category prescriptions dispensed; and any other such criteria proposed by the Contractor and approved by the State. The Contractor shall work with State clinical and Program Integrity staff to determine the criteria for special audit selection procedures and directives. The number of audits to be performed will be determined by the State. The Contractor shall work closely with the State to identify outlier criteria in order to determine the amount of on-site reviews. As directed by the State, the Contractor shall conduct audits of the outliers identified through desk audits, using criteria developed with the State. On-site audit personnel shall also be approved by the State.

If required, full on-site pharmacy abuse compliance audits, in which all claims are selected for review and checked against the hard copy of the prescription on-site, will include:

1. Verification of patient name and eligibility
2. Drug information per authorized prescription
3. Dispense as written code
4. Quantity authorized to dispense and refill limitations
5. Brand/Generic substitution
6. Day supply
7. Co-payment collection
8. DEA compliance
9. Dispensing accuracy
10. Signature log
11. Unfilled prescription policy and procedures

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12. Telephone order authorization
13. Reversal of unclaimed prescriptions
14. Adequate inventory and purchases to support the volume of drugs billed

Upon completion of an audit, a final report shall be generated and mailed within 30 days to the affected pharmacy or third party administrator when released by the State. The Contractor shall keep reports about each audit and about any about specific audit concerns. The Contractor shall provide quarterly reports to State to summarize and detail audits performed.

Audits shall be shared with the State's Medicaid Provider Fraud Unit under a protocol established by the State.

### **III-E ANALYSIS AND REPORTING**

#### **1. Discussion and Overview**

The State has determined that analysis and reporting is critical to effective management of drug benefits. As programs grow in complexity and cost, more sophisticated reporting and analysis will assist the State in focusing its efforts to manage the growth in expenditures, educate providers, and make required program changes. The reporting process must be flexible and timely. The creation of federally required MMIS reports including MARS and SURS shall not be required of the PBM Contractor. The creation of federally required reports related specifically to the pharmacy benefit including the annual CMS DUR report are the responsibility of the Contractor.

Neither the State nor the Contractor will have ownership in any of the software developed or owned by the other party and used in connection with services rendered under the contract. The State will agree that it acquires no right, title, interest, or license to the Contractor's system by virtue of the contract. In the event the State is granted possession of, or access to, any of the Contractor's proprietary software products, the State will execute in advance a Software License Agreement as agreed to with the Contractor.

#### **2. RFP Response**

Listed below are specific reporting requirements. Bidders should indicate their capability for providing these reports. In addition, bidders should describe their overall analysis and reporting philosophies including their quality assurance process for data and reporting accuracy. Bidders should also include samples and recommendations for proper reporting. Reporting flexibility is being assigned a very high priority. Bidders should describe their capabilities and ideas in this regard. The State is interested in reviewing standard management and utilization reports that the Contractor's system generates as a means to supplement its own reporting. The State also is interested in reports that will compare utilization and other trends between and among its various State programs and other states' Medicaid and state programs, including SPAPs. The State is interested in the mechanism used to deliver and catalogue the bidder's standard reports. If the bidder has an electronic library, please provide a description of the library and how it is accessed including the security levels of the system.

The State also needs to have access to an ad hoc reporting tool that allows for an analysis of both clinical components and the costs and utilization of the pharmacy benefit. The State anticipates

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that up to ten (10) users will need access to the ad hoc reporting tool(s). The State views initial and ongoing training in the use of the tool(s) an essential component of the ad hoc system.

### **3. Requirements**

The Contractor will be expected to provide an electronic copy of all paid pharmacy claims to the State on a scheduled basis as determined by the State. These claims will be separated by type, i.e. Medicaid, Medicaid 1115(a) expansions (VHAP, VHAP-Pharmacy, and VScript), VScript Expanded, any Part D supplement coverage plan, AMAP, GA, Healthy Vermonters, and any program developed for the uninsured.

The Contractor will provide reports and reporting capability subject to approval by the State. Reports may be standardized for routine production or for periodic production using templates with changeable data elements or customized using the ad-hoc report manager. The format will be subject to State approval.

Standardized report capability will be provided for the following periods: month, quarter, and year to date by Calendar Year, State Fiscal Year, and Federal Fiscal Year. Reports involving beneficiaries will include number of beneficiaries (eligibles), number of recipients (users), number of prescriptions and cost per prescription, cost per beneficiary/recipient, as well as total cost for all specified periods. All standardized reports shall be clearly titled and dated, and include appropriate data element keys and row and column totals and percents, where appropriate. The Contractor shall provide documentation for all standardized reports providing data field descriptions and sources.

The Contractor shall provide personal computer software for ad-hoc reporting to the State for 10 users. The Contractor shall provide an ad-hoc information system for utilization management screenings. The Contractor will provide documentation/user manuals for the software and the Contractor's application of it.

The Contractor will provide training for standardized and ad-hoc reporting tools at the State with designated staff, which shall include refresher training up to one time per year, and training for all new hires who will be using the ad-hoc reporting tools. The initial training will be at a State designated facility. Thereafter training should be in the State or via the Internet. Exceptions to this will be solely at the approval of the State. The Contractor will provide a designated individual who, on an ongoing basis, will be responsible for addressing questions from State users regarding use of the ad-hoc reporting system.

Standardized reports or reporting capability shall include but not be limited to the following:

#### Utilization Reports:

1. Claims summary report
2. Claims detail report
3. Denied claims analysis
4. PMPM report
5. Cost and utilization reports
6. Drug utilization analysis
7. Therapeutic class analysis

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8. Patient claim history report
9. New drug listing report
10. Drug Utilization Review Reports

### Financial Reports:

1. MAC savings report
2. Drug Trend Report
  - a. Baseline
  - b. Projections
3. Generic analysis reporting
4. Beneficiary summary
5. Monthly summary
6. Twelve-month summary
7. Cost sharing analysis
8. DAW1 and DAW 8 analysis
9. Balancing reports

### Provider Reports:

1. Top "X" beneficiary user ranking report
2. Top "X" prescribers
3. Top "X" pharmacy providers
4. Physician report cards
5. Pharmacy report cards
6. LTC report cards

### Auditing Reports:

1. Monthly listing of claims with excess dollars
2. Over and under utilization reviews
3. Quarterly desk audit summary
4. On-site audit review summary
5. Lock-in reports

### Preferred Drug List Reports:

1. Market shift reports
2. Drug Trend report
3. Top 20 Prior Authorized Drugs
4. Physician compliance reports

### Claims processing reports:

1. Daily POS transaction detail, by script
2. Daily POS transaction time (in 1 second intervals)
3. Daily POS transaction by pharmacy and by prescriber
4. POS capture detail (when, for how long, and why)

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5. Eligibility reports
6. Patient claim history report
7. Prescribing provider ranking by region as defined by the State
8. Dispensing provider ranking by region as defined by the State
9. Prescribing provider ranking by peer group
10. Dispensing provider ranking by peer group
11. Drug ranking
12. Drug search
13. Distribution report

Coordination of benefit (COB) reports:

1. Other insurance frequency by state/county
2. Other insurance frequency by dispensing provider
3. COB override frequency reports by NCPDP value by state
4. COB override frequency reports by NCPDP value by dispensing provider
5. Fraud and abuse detection reports

As requested by the State, the Contractor will prepare for use by the State:

1. The compilation that constitutes the preferred drug list or list of drugs subject to prior authorization or any other utilization review procedures;
2. Any utilization review procedures, including any prior authorization procedures; and
3. The procedures by which drugs are identified as preferred on the preferred drug list, and the procedures by which drugs will be selected for prior authorization or any other utilization review procedure.

The Contractor shall provide data, materials, documents or analyses sufficient to assist the State in reporting quarterly to the Legislative Health Access Oversight Committee concerning the following:

1. The efforts undertaken to educate health care providers about the preferred drug list and the program's utilization review procedures;
2. The number of prior authorization requests made, the number of requests denied, the number of denial appeals, and the result of such appeals; and
3. The number of utilization review events (other than prior authorization requests), the number of such cases in which coverage of a drug is denied, the number of denial appeals, and the results of such appeals.

Finally, the Contractor shall assist the State in preparing an annual report on or before January 1 of each year for the duration of the contract, concerning implementation of the contract. The report shall include:

1. A description of the activities of the Contractor;

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2. An analysis of the success of the Contractor in achieving each of the State's public policy goals, together with the Contractor's report of its activities and achievements;
3. An assessment of Medicaid including the Vermont Health Access Program and Vermont publicly-support health care programs administrative costs relating to prescription drug benefits, including any recommendations for increasing the administrative efficiency of such programs;
4. A fiscal report on the state fiscal costs and savings to the State of the contract, including an accounting of any payments, fees, offsets, savings and other financial transactions or accountings; and
5. Any recommendations for enhancing the benefits of the contract, and an identification of, and any recommendations for minimizing any problems with the contract.

The Contractor shall compile and produce a performance report on its contract administration on an annual basis. This should report annual performance including reports on the Performance Standards found in Section V-K. It should also include operational reporting on an annual basis and since the inception of this contract. Operational reporting should include, but not limited be to, claims processing statistics, specialty pharmacy use, audits performed and savings generated, PDL compliance, generic use, prescriber performance, and any other performance indicators that would be useful in reporting on the Contractor's and the Vermont Health Access Pharmacy Benefit Management Program's performance.

### **III-F DRUG COVERAGE MANAGEMENT**

#### **1. Discussion and Overview**

The State will retain the right to formulate its own drug coverage list(s). The Contractor shall be expected to apply the State's list(s) in Claims Processing.

In Vermont, for HIV and AIDS-related medications used by individuals with HIV or AIDS, a preferred drug list and any utilization review procedures may not be more restrictive than the drug list and the application of the list used for the State's HIV/AIDS Medication Assistance Program. The list and procedures for these medications is formulated by the Vermont Department of Health. Thus, HIV and AIDS-related medications are not subject to the Contractor's Drug Coverage Management responsibilities.

The General Assistance program is limited to specific therapeutic classes. Thus, it is not subject to the Contractor's Drug Coverage Management responsibilities.

The Medicaid Preferred Drug List (PDL) is formulated under the direction of the Vermont DUR Board acting as Vermont's Pharmacy and Therapeutics (P&T) Committee and applicable State law. Applications for drug coverage, approval for coverage, policy formulation, and the drug coverage parameters will continue to be part of the State's oversight, although the Contractor shall be requested to provide expert consultation and input at these activities.

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The Contractor is expected to administer the drug coverage design developed with the guidance of the State's DUR Board. The drug coverage rules include prior authorization drugs and appropriate generic substitution, maximum allowable cost enforcement, and other utilization review edits such as early refills.

The Contractor is expected to approve or deny benefits to covered individuals based on reliance upon the eligibility lists provided by the State. In the event of any retroactive termination of members, the State will assume liability for all claims approved for such members prior to loading of the eligibility data deleting such members.

## **2. RFP Response**

The Bidder's response must specify how it proposes to perform this function most effectively.

## **3. Requirements**

### **Drug Coverage Process**

The requirements for the Contractor's management of the drug coverage process include the following.

1. The Contractor shall implement the drug coverage parameters established with the DUR Board, which includes State health care professionals who advise the State on the development of the PDL with input from the Contractor.
2. The Contractor shall have the ability to apply the current reimbursement methodology for the State's programs. The Contractor shall have the ability to apply any exemptions from the PDL that the State identifies; for example, Vermont currently exempts drugs used in the treatment of severe and persistent mental illness (SPMI). The Medicaid PDL indicates drug product limitations in billing Medicaid. It applies to drugs billed by retail pharmacies and long-term care pharmacies. (See Bidders' Library for current PDL, clinical criteria and SPMI exemption details).
3. The Contractor shall assign a clinical manager (RPh or PharmD) who shall be responsible for daily oversight of drug coverage parameters and all clinical programs and interfaces with the DUR Board.
4. The Contractor shall assign plan management staff who shall be responsible for coverage file updates at the direction of the clinical manager.
5. The Contractor's clinical manager shall collaborate with the Contractor's clinical resources in the analysis of data and materials on drug use and in the development of recommendations for changes in approach in program administration.
6. The Contractor's clinical manager must attend each DUR Board meeting and present the Committee with a written report containing the following information when requested by the State:
  - Based on previous quarter's pharmacy claims, recommendations for additions or changes in drug coverage and prior authorization, dispensing limitations, generic substitution protocols, and other relevant or innovative suggestions.
  - Supportive clinical research, documentation, financial impact analysis, and recommendations for newly approved therapies and indications to the DUR Board for consideration.

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7. The Contractor shall provide a written and electronic report weekly to identify changes made to the drug file.
8. The Contractor shall provide the State with the ability to review changes in national drug codes' or GCNSeq's supporting data on a weekly basis.
  - Review changes to GC3 (Specific Therapeutic Drug Class, GCNS) or DF (Drug Form), which is an exception report now generated by FDB to assure valid drug coverages.
  - Review reports of new generic sequence numbers added to FDB file, which is generated weekly and taken to the DUR Committee to consider for inclusion into the Medicaid PDL.
9. The Contractor shall update its drug prices and other supporting drug data on a weekly basis using a recognized entity, such as First DataBank (FDB). The State currently uses First DataBank but will consider other options. The Bidder should present justifications for such options; for example, better pricing information. Current coverages are keyed by FDB's generic code sequence (GCNSeq) and the national drug code (NDC). The Bidder shall specify in its bid response its approach to updating pricing data and other supporting drug data.
10. The Federal Upper Limit (FUL) will be updated weekly using First Data Bank (FDB).
11. The Contractor shall recommend State Maximum Allowable Cost (MAC) limits. Limits, when approved by the State will be updated monthly or more often when indicated.
12. The Contractor shall have the ability to accept electronic files from other insurers. These files would identify the insurer's formulary and coverage conditions and would be used in COB activities in claims processing.
13. The bidder will describe its quality assurance program in respect to auditing of the claims processing system for benefit design, PDL adjudication, and COB activities. The bidder will supply any client reports designed demonstrating specific program and overall quality assurance of the claims processing department.
14. The drug coverage design shall integrate with the Contractor's eligibility system and POS/batch/paper adjudication edits. For example, each pay code or program code in the eligibility system must be maintained so that unique drug coverages can be assigned.

### **Medicaid Preferred Drug List (PDL)**

The State maintains a preferred drug list PDL for select classes. All drugs in classes not specifically identified are considered preferred. The PDL applies to Medicaid, Medicaid 1115(a) expansion programs, and VScript Expanded. It does not apply to AMAP, GA, or HVP.

The Contractor shall propose additions or changes to the preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions including generic alternatives. The Contractor through its Pharmacy and Therapeutics (P & T) Committee shall determine through evaluation of available clinical data, which drugs within the same therapeutic class are equivalent in terms of clinical efficacy and safety, and make recommendations to the State DUR Board for review and approval. The preferred list is designed to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies. The Contractor shall support the State in ensuring that all affected interests, including consumers, health care providers, pharmacists, and others with pharmaceutical expertise have an opportunity to comment on changes in the preferred drug list prior to adoption and implementation.

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The Contractor shall make recommendations for the management of drugs newly introduced into the market. The Contractor shall recommend procedures that the State can establish for the timely review of prescription drugs newly approved by the federal Food and Drug Administration, including procedures for the review of newly approved prescription drugs in emergency circumstances.

The Contractor shall assign a clinical manager (RPh or PharmD) for daily oversight of State's clinical program. The clinical manager should collaborate with the Contractor's clinical resources in the analysis of data and materials on drug use and in the development of recommendations for changes in approach in program administration. The clinical manager recommends the preferred drug list drugs to the State for consideration; present the preferred drug list to the DUR Board and other groups as requested; recommends drugs for prior authorization; attend meetings of the DUR Board; is available to the State for consultation and oversight activities related to the management of the State's PDL; and gathers and reviews information as requested by the State in order to facilitate and support preferred drug list management.

At each meeting of the DUR Board, the clinical manager shall be expected to provide written information as requested by the State or Board. The clinical manager shall provide recommendations for additions or changes in the programs and provide educational materials including supportive clinical research, protocols, and financial analysis for newly approved therapies and indications.

The preferred drug list should be readily available to prescribers and providers through mailings, manuals, and in a manner that could be accessed via a website, including the State's website. Minimally, the drug list shall be available as follows: on paper, electronically for website posting, and via Epocrates®.

The Contractor shall provide the State with a copy of the preferred drug list suitable for use by beneficiaries, including a description of the process by which exceptions to the preferred list may be made.

The Contractor shall provide electronic point-of-sale preferred drug list messages to all participating pharmacies so that the pharmacists know prior to dispensing when a prescribed drug is not on the preferred list. If appropriate, the pharmacist can talk to the patient or call the doctor's office to see if a preferred brand or generic substitution can be made.

The Contractor shall authorize pharmacy benefit coverage when a patient's health care provider prescribes a prescription drug which is not one of the list's preferred choices, under the same terms as coverage for preferred choice drugs, if:

1. The preferred choice has not been effective, or with reasonable certainty is not expected to be effective, in treating the patient's condition or
2. The preferred choice causes or is reasonably expected to cause adverse or harmful reactions in the patient.

The Contractor is expected to provide the State with subscriptions to: Price Alert, Medispan, Consulting Pharmacist, and Drug Topics Redbook.

### **III-G NETWORK, FORMULARY AND REBATES FOR THE UNINSURED**

#### **1. Discussion and Overview**

Network management requirements will differ for the two types of programs to be administered. The Contractor will **not** be responsible for contracting or credentialing the network to be used for Medicaid, Medicaid 1115(a) expansion programs, AMAP, VScript Expanded, GA, and the Healthy Vermonters Program. However, the Contractor will be responsible for managing the network(s) for the Healthy Vermonters Program **if** the Bidder proposes to provide reduced costs for enrollees based on programs currently available by the Contractor for uninsured populations.

The State is assured rebates from drug manufacturers through the process defined in the OBRA '90 legislation. Unfortunately, these rebates are not assured for other groups, such as Healthy Vermonters Program enrollees or any additional programs that the State may wish to offer the uninsured within the State. The State is soliciting, through this RFP, advice as to how to reduce costs for the Uninsured

#### **2. RFP Response**

For manufacturers' rebates for non-Medicaid claims, include the following:

1. Number of network pharmacies within your network; percentage of Vermont pharmacies within network.
2. Methods for recruiting new pharmacies to supplement existing network in areas where coverage may not be optimal.
3. Marketing and outreach programs to consumers.
4. Application, eligibility determination and eligibility file transfer process.
5. Card production process.
6. Description of any Website application and educational component for this program.
7. Describe customer services ability to answer pricing questions by consumers.
8. Describe the Bidder's standard rebate arrangements.
9. Estimate the rebate recovery per brand name Rx.
10. Identify the amount or percentage of the rebate per brand name claim that the Bidder will guarantee.
11. Describe the time line for reporting and receiving of rebates.
12. Provide samples of Bidder rebate performance reports.
13. Describe ideas for maximizing rebate potential. The State recognizes that rebates are not the only metric; for example, high generic usage drives down brand rebates; duplication of single source products within therapeutic categories may result in substantial competition; etc.
14. Describe how rebate arrangements might be developed for the Healthy Vermonter population as it currently exists or as it might develop.
- 15.

Working relations with pharmacy providers are a key part of this section of the RFP. Please describe the Bidder's relationship with these providers in the context of long term partnering relationships, and Bidder's strategies and accomplishments in securing discounts for uninsured individuals.

### **3. Requirements:**

The State will be responsible for enrolling pharmacy providers for its publicly-supported health care programs. The Contractor may be responsible for enrolling pharmacy providers for uninsured enrollees if a special network is used. The Contractor will be responsible for negotiating provider discounts and rebates for uninsured beneficiaries within the context of a strategy agreed to between the State and the Contractor.

## **III-H MEDICAID (OBRA '90), SUPPLEMENTAL, AND STATE ONLY REBATES**

### **A. OBRA Rebates and State Only Rebates**

#### **1. Discussion and Overview**

Working relations with Pharmaceutical Manufacturers are a key component of the selection process. This relationship is essential for the long term success of rebate as a cost control initiatives, negotiation of favorable state only rebate agreements, and implementation of aspects of a State Pharmacy Assistance Program (SPAP) to coincide with the implementation of Medicare Part D.

The State has been actively involved with the Drug Rebate Program since the passage of OBRA '90. There are working systems in place that follows CMS' requirements. Manufacturers enter into drug rebate agreements with CMS. These manufacturers are designated as approved manufacturers for Medicaid. Each quarter manufacturers are required to submit pricing data to CMS. CMS then calculates the unit rebate amount from this data. Thirty (30) days after the beginning of the quarter, CMS provides the states with the unit rebate amounts for the prior quarter. The states then use this data to bill approved manufacturers on a quarterly invoice by multiplying the unit rebate amounts times the amount of units (tablets, capsules, milliliters, etc.) paid during the quarter. Also, the State submits to CMS an electronic copy of its manufacturer billings. If manufacturers have disputes regarding the units paid by a State, the State resolves the manufacturer disputes.

OBRA rebates are currently performed by the State's MMIS Contractor. The State will consider having Medicaid Drug Rebates processed by the Contractor. The Contractor shall not retain any portion of the rebate.

The State has one program, VScript Expanded, which receives state only rebates. State law requires that the only drugs covered in this program are from manufacturers that have entered into a rebate agreement with the State. The agreement requires the manufacturer to provide Medicaid equivalent rebates. Invoicing is done in conjunction with OBRA '90 invoicing. The Contractor may be responsible for soliciting new contracts, responding to questions concerning the rebate requirements, and maintaining an up-to-date list of participating manufacturers. Contracts are not time limited. Likewise, if the State should opt to negotiate for rebates for a SPAP subsequent to the implementation of Medicare Part D, the Contractor may be responsible for the contracts and the collection of rebates.

#### **2. RFP Response**

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Bidders should describe the Bidder's relationship with pharmaceutical manufacturers, in the context of long term, partnering relationships. The Bidder should describe experience and expertise with this process, and/or the Bidder's ability to manage the rebates effectively for the State based on the requirements set out below. The Bidder should describe experience with respect to rebate collection processes performed for other states and provide performance information with respect to these states. Also include the following:

1. List the manufacturers with whom the Bidder has rebate arrangements for the Bidder's self-funded clients.
2. State the bidder's collection percentage.
3. Describe the flow of compensation between the Bidder and the drug companies. Include both direct rebates and other sources of compensation the Bidder receives from the drug manufacturers.
4. Identify recommendations for controlling costs at the manufacturer level. Answer this in the context of:
  - a. Medicaid exclusively
  - b. The Uninsured exclusively
  - c. A collective effort, involving both of the above or any additional group with which the Bidder has experience.

### **3. Requirements**

- The Contractor shall develop and/or maintain working relations with pharmaceutical manufacturers. The contractor shall make any recommendations for controlling costs at the manufacturer level.
- The Contractor shall implement all accounting functions that are part of the drug rebate program, including but not limited to preparing and submitting manufacturer invoices quarterly. Invoices include the following data: NDC, drug name, CMS unit, unit rebate amount, total units reimbursed, total amount claimed, number of prescriptions, total reimbursed amount, correction record flag, TPL prescriptions, and TPL payment amount. Invoicing is based on the date of payment. Invoices shall be issued within sixty (60) days after each rebate period for Medicaid beneficiaries.
- The pharmacies must be allowed to submit claims for obsolete NDC's for two (2) years post obsolete date to allow for its shelf life. Post two (2) years from the obsolete date pharmacies should receive an on-line message indicating denial is due to "NDC obsolete".
- If a claim is reversed post invoicing a manufacturer for the rebate, the State staff must be able to see all transactions: the initial payment, the reversal, and the possible subsequent re-bill.
- The Contractor shall maintain quarterly unit rebate amount data supplied by CMS from 1991 forward.
- The Contractor shall maintain an accounting procedure for prior period adjustments for manufacturers.

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- The Contractor shall be capable of calculating interest due on overdue payments per CMS guidelines.
- The Contractor shall implement all dispute resolution functions that are part of the drug rebate program, including but not limited to researching and resolving discrepancies between State and manufacturer records.
- The Contractor shall perform quarterly posting of the reconciliation of the invoice from manufacturers and transmit reports to the State of payment receipts.
- The Contractor shall perform posting of the prior quarter adjustment statement.
- The Contractor shall provide all appropriate quarterly and annual reporting to CMS, in both electronic and paper form.
- The Contractor shall be able to respond to any changes in CMS requirements.

### **B. Supplemental Rebates**

#### **1. Discussion and Overview**

Working relations with Pharmaceutical Manufacturers are a key component of the selection process. This relationship is essential for the long term success of the State's cost control initiatives particularly the multi-state rebate initiative and the negotiation and maintenance of favorable supplemental rebate agreements.

The State Supplemental Rebate Process was established with the assistance of the State's current PBM Contractor, FHSC. It was undertaken as a multi-state effort, initially in conjunction with the State of Michigan. This initiative was approved by CMS in April of 2004. At the time of approval, the states of New Hampshire, Nevada, and Alaska had joined Vermont and Michigan. Minnesota, Hawaii and Montana have since obtained federal approval to join the pool. Kentucky and Tennessee have requested authorization. The State's current PBM Contractor negotiates rebates on behalf of the participating states. The pool increases the leverage of participating states by increasing the number of lives covered by the process.

While rebate programs and preferred drug lists (PDLs) are commonly used in private sector or commercial drug programs and Medicaid managed care plans, they have only recently been implemented in Medicaid fee-for-service programs. Michigan and Vermont were the first state Medicaid programs to jointly implement a preferred drug list and supplemental rebate program to help contain the costs of pharmaceutical drugs in a clinically appropriate way.

The State's PDL is a list of preferred prescriptions developed with the State's DUR Board acting as its P&T Committee. The PDL presents options for prescribers' consideration for use in meeting the drug therapy needs of their patients. Medications are preferred if they meet clinical and therapeutic criteria established by the DUR Board or if the manufacturer offered supplemental rebates making their product cost-effective. Medications that are not preferred can be prescribed and reimbursed based on a clinical review of appropriateness for a particular patient situation. These prior authorization review protocols are developed with the guidance of the DUR Board. The preferred drug management systems implemented in Vermont have

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been effective tools in helping manage pharmacy costs and maintaining access to pharmacy benefits for vulnerable, low-income populations.

Under the pooling program, the purchasing power of multiple states is combined for the purposes of negotiating supplemental rebates with pharmaceutical manufacturers in connection with the Preferred Drug List management systems. Supplemental rebates are in addition to the baseline “standard CMS rebates” that all pharmaceutical manufacturers must pay states to participate in the Medicaid program under the provisions of OBRA '90. Under this pooling approach, flexibility and choice remains with the individual state and its DUR Board/P&T Committee to determine which classes to include on the PDL and which drugs to select as preferred. Under the Vermont model, 100% of all rebate revenues are returned to the State. They are not shared with the PBM.

## **2. RFP Response**

The Bidder should describe their experience and expertise with this type of process, and/or the Bidder's ability to manage the supplemental rebate process effectively for the State based on the requirements set out below. The Bidders should describe the entities that are part of any pooling program they manage or of which they are a part. Bidders should describe in detail the framework, conditions and processes used in negotiating rebates and in evaluating the rebate value in relation to the State's drug product utilization mix.

If the Bidder proposes to use a proprietary Drug Rebate and Dispute Resolution system to support the supplemental rebate process, this system should be described in detail, including a description of the advantages it will provide the State.

## **3. Requirements**

- The Contractor will provide a standard, (CMS-approved) Supplemental Rebate Agreement for use in Vermont. State staff must review the proposed agreement to incorporate any legal requirements that are specific to the State. Only the approved agreement will be used with the manufacturers during the negotiation process. Any negotiated changes must be acceptable to CMS and the State. The Contractor is responsible for obtaining CMS approval.
- The Contractor shall develop and/or maintain working relations with pharmaceutical manufacturers. The contractor shall make any recommendations for controlling costs at the manufacturer level.
- The Contractor will identify, schedule, and coordinate all meetings with the designated manufacturers on behalf of the State.
- The contractor shall evaluate rebate proposals to determine what proposals are most appropriate clinically and financially for the State and provide the State with options.
- The State will have final approval on the preferred drug list for its beneficiaries.
- Manufacturers and the State will be provided with a projection of rebate dollars due for the next quarter.

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- The Contractor shall implement all accounting functions that are part of the drug rebate program, including but not limited to preparing and submitting manufacturer invoices quarterly. Invoices include the following data: NDC, drug name, CMS unit, unit rebate amount, total units reimbursed, total amount claimed, number of prescriptions, total reimbursed amount, correction record flag, TPL prescriptions, and TPL payment amount. Invoicing is based on the date of payment. Invoices shall be issued within sixty (60) days after each rebate period for Medicaid beneficiaries.
- The pharmacies must be allowed to submit claims for obsolete NDC's for two (2) years post obsolete date to allow for its shelf life. Post two (2) years from the obsolete date pharmacies should receive an on-line message indicating denial is due to "NDC obsolete".
- If a claim is reversed post invoicing a manufacturer for the rebate, the State staff must be able to see all transactions: the initial payment, the reversal, and the possible subsequent re-bill.
- The Contractor shall maintain quarterly unit rebate amount data supplied by CMS from the inception of the program.
- The Contractor shall maintain an accounting procedure for prior period adjustments for manufacturers.
- The Contractor shall be capable of calculating interest due on overdue payments per any agreements in the contracts.
- The Contractor shall implement all dispute resolution functions that are part of the drug rebate program, including but not limited to researching and resolving discrepancies between State and manufacturer records.
- The Contractor shall perform quarterly posting of the reconciliation of the invoice from manufacturers and transmit reports to the State of payment receipts.
- The Contractor shall perform posting of the prior quarter adjustment statement.
- The Contractor shall provide all appropriate quarterly and annual reporting to CMS, in both electronic and paper form.
- The Contractor shall be able to respond to any changes in State or CMS requirements.

### **III-I DRUG UTILIZATION REVIEW AND FEDERAL DUR REQUIREMENTS**

#### **1. Discussion and Overview**

The State has responsibility for meeting federal DUR requirements, including analysis of claims, identification of prescribing patterns inconsistent with best clinical practices, and education of providers. Federal requirements included annual reporting on DUR activities, which in Vermont are performed under the direction of the State Drug Utilization Review Board (DUR Board). The Contractor is expected to perform these functions.

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Drug Utilization Review includes ProDUR, Concurrent DUR, RetroDUR, potential fraud and/or abuse assessment, and educational programs. The Contractor shall consider these programs as a clinical continuum of utilization management of prescribing habits, provider dispensing practices, and beneficiary abuses or misuses of the system. The Contractor must use advanced ProDUR techniques and RetroDUR, which profiles patients, pharmacies, and disease states, to direct educational and intervention initiatives. The goal of these activities is to ensure that prescriptions are appropriate, medically necessary and that they do not result in adverse drug events. The DUR program functions as an adjunct and support to the prescriber and the pharmacist's education and professional judgment and does not replace the human cognitive review process.

The State recognizes that effective Drug Utilization Review (DUR) is critical to effective drug benefit management. Bidders will be evaluated on their present and future capabilities in this regard. Proposals should include the availability of any databases needed for implementation of specific DUR edits. Bidders should describe how these capabilities could be implemented for each of the groups that are the subject of this RFP. Bidders should also include recommendations for the most effective DUR programs.

Drug Utilization Review (DUR) includes these major elements. Bidders should describe these elements within the proposal submitted:

- Prospective drug utilization review
- Concurrent drug utilization review
- Retrospective drug utilization review
- Fraud and abuse programs
- Education programs

The purpose of the DUR program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate, medically necessary, and that they are not likely to result in adverse medical results, in accordance with OBRA '90. The program must be designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. The program needs to evaluate drug use patterns among physicians, pharmacists and beneficiaries, and those associated with specific drugs or groups of drugs. DUR compares data on drug use against predetermined standards, consistent with peer-reviewed literature and the recommendations of the State DUR Board. The assessment must include, but need not be limited to:

- Monitoring for therapeutic appropriateness
- Over-utilization and under-utilization
- Therapeutic duplication
- Drug-disease contraindications
- Age/gender contraindications
- Drug-drug interactions
- Drug allergy interactions
- Incorrect drug dosage or duration of drug treatment
- Clinical abuse/misuse
- Appropriate use of generic products

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Prospective DUR provides for a review of drug therapy before each prescription is filled or delivered to a beneficiary. The review must include screening for the items listed above. The Contractor must develop a program that encourages pharmacists to comply with applicable pharmacy, State, and Federal requirements, laws, and regulations, which require pharmacists to offer to discuss anything about the prescription that the pharmacist feels is important, based on the Prospective DUR. The Contractor will also be expected to encourage pharmacists to make a reasonable effort to obtain, record, and maintain specific beneficiary profile information.

In compliance with OBRA '90, pharmacists are required to counsel beneficiaries on the significant findings of the Prospective DUR. The Contractor should encourage pharmacists to comply with this law. The States are responsible for establishing the standards for this counseling, and the Contractor should provide expert advice to the DUR Board in this regard.

The Retrospective DUR should assess data on drug use against explicit predetermined standards and introduce appropriate remedial strategies to improve the quality of care and reduce medical care costs.

Finally, the Contractor will need to develop active and ongoing educational outreach programs to educate practitioners on common drug therapy problems, in order to improve prescribing or dispensing practices.

The DUR Board is responsible for approving all Prospective and Retrospective DUR programs prior to their distribution or implementation.

## **2. RFP Response**

The requirements for the Contractor's DUR and education programs shall minimally include the requirements listed under the following subheadings: General, Prospective DUR, Concurrent DUR, Fraud and Abuse Programs, and Educational Programs. Bidders should address the requirements in their proposals and are encouraged to expand on any or all of them:

### **General**

1. The dedicated clinical manager (RPh or PharmD) that the Contractor must provide to the State will be responsible for daily oversight of the pharmacy programs and provide clinical analysis and guidance to the DUR Board.
2. The Contractor/clinical manager must coordinate with the DUR Board, which includes health care professionals who are responsible for approving all DUR programs.
3. Within one hundred twenty (120) days following contract implementation and annually thereafter, the Contractor's clinical manager shall present an annual DUR plan to the DUR Board for consideration, including a profile of all proposed DUR programs and dates for execution, as well as expert advice regarding standards for pharmacist counseling of beneficiaries.
4. On an annual basis, the Contractor shall prepare a report to the State that includes a description of the DUR activities (part of annual clinical plan), scope and nature of the Prospective and Retrospective drug use review programs, a summary of the interventions used, and an assessment of the impact of these educational interventions

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- on the quality of care, and an estimate of the cost savings generated as a result. This report will be used to evaluate the effectiveness of the DUR program.
5. A clinical manager will be required to attend each DUR Board meeting and present the committee with reports, as requested by the State or Board, addressing issues identified by the State or Board. Examples can include the following types of information:
    - Based on previous quarter's pharmacy claims, current ten (10) top therapeutic classes and top five (5) high growth therapeutic classes, their current DUR protocol, and recommendations for additions or changes in the DUR program.
    - Educational materials including supportive clinical research, protocols and financial analysis for newly approved therapies and indications to the DUR Board for consideration. If approved, this information would be included as part of the Prospective and Retrospective DUR program to targeted physicians.
  6. As requested by the State, provide face-to-face clinical detailing, with detailed criteria provided by the State.
  7. The Contractor's DUR programs must comply with all OBRA '90 and PL 104-191 requirements.

### **Prospective DUR**

1. The Contractor must provide a Prospective Drug Utilization Review process that is linked to the electronic claims management network, so as to furnish medical and drug history information for each beneficiary. This process is subject to the review and recommendation of the DUR Board. This process must have the flexibility to adjust to changes in criteria or procedures as recommended by the DUR Board.
2. The Contractor will be required, if requested by the State, to provide educational materials targeted to pharmacists informing pharmacists about their legal obligation to provide counseling to beneficiaries regarding meaningful Prospective DUR findings.

### **Concurrent DUR**

For Concurrent DUR to be effective, the system must have the following capabilities at a minimum:

1. A table with days supply limits by drug
2. Quantity limits by drug
3. A dual-tracking system for early refills that tracks both current and cumulative usage
4. Age and gender edits

Bidders should describe the Bidder capabilities in this regard, including a description of how the Bidder maintains these edits.

### **Retrospective DUR**

1. The Contractor will be required to analyze pharmacy and non-pharmacy claims on an ongoing basis and present recommendations quarterly for additions or changes to the Retrospective DUR programs and interventions. The State shall be responsible for

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- providing non-pharmacy claims data from its MMIS application. The proposed DUR programs shall address both high risk and high cost/utilization drug therapies and tie where applicable to the top drugs/disease states that are being used by the beneficiaries.
2. The program must, on a monthly and quarterly basis, assess data on drug use against explicit predetermined standards including but not limited to monitoring for therapeutic appropriateness, over-utilization and under utilization, incorrect drug dosage, or duration of drug treatment and clinical abuse/misuse and, as necessary, introduce remedial strategies to improve the quality of care and to conserve program funds or personal expenditures.
  3. The Retrospective DUR program must also provide ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of Retrospective DUR activities.
  4. The Retrospective DUR program must include written, oral, or electronic reminders containing beneficiary-specific or drug-specific (or both) information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of beneficiary-related information.
  5. The Bidder's process must include intensified review or monitoring of selected prescribers or dispensers, proposing detailed program interventions to the DUR Board for consideration.
  6. The Bidder's process must include periodic evaluation of interventions to determine if the interventions improved the quality of drug therapy. The Contractor is to evaluate the success of interventions and make modifications as necessary.

### **Fraud and Abuse Programs**

1. The Bidder must have methods and models used to screen and identify potential fraud and abuse by prescribers, pharmacists, pharmacies, and beneficiaries.
2. The Bidder approach must be able to distinguish between blatant fraud, creative fraud and unintentional processing errors.
3. The Bidder's approach should include manual and system supported tools to track and monitor cases where the potential exists.
4. The Contractor must have processes to report cases of suspected fraud as designated by the State.

### **Educational Programs**

1. At least on a quarterly basis, the Contractor will provide educational materials including supportive clinical research, protocols, and financial analyses for newly approved therapies and indications to the DUR Board for consideration. Upon approval, this information shall be included as part of the Retrospective DUR Program to targeted physicians and other prescribers.
2. The DUR Program must integrate with edits (whether POS, batch, or paper claims processing), and provide communications and education to pharmacies that are not appropriately complying with these edits, including encouraging pharmacists to counsel beneficiaries on DUR findings.
3. The Bidder is expected to demonstrate experience in effective physician and pharmacy targeting that is focused on the high value prescribers who contribute the largest impact on improved quality of care and/or drug cost reduction.

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4. The Bidder is expected to demonstrate experience in implementing interventions to optimize prescriber behavior.
5. The Bidder must demonstrate success in attaining prescriber agreement to use a clinically appropriate alternative product or generic, if relevant, in the same therapeutic class.
6. The Bidder must demonstrate effective use of face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for educational intervention, including discussion of optimal prescribing, dispensing, or pharmacy care practices and follow-up face-to-face discussions.
7. The Bidder must have clinically appropriate staff to meet with targeted physicians. The face-to-face meetings may include retrospective, beneficiary specific DUR issues. The staff may also meet with physician groups, providing prospective and retrospective DUR education that is not beneficiary specific.

### **Additional Recommendations**

Bidders should describe any additional suggestions or recommendations for DUR.

### **3. Requirements**

In performing the DUR function, the Contractor shall comply with all federal regulations regarding DUR including OBRA '90 and PL 104 – 191 requirements. The Contractor shall perform prospective and concurrent DUR online, real-time, 24 hours per day/7 days per week, and perform retrospective DUR through analysis of claims history. The Contractor shall have a POS system-based process for exceptions that can be made by the local pharmacist for any DUR hard edits. Standards for exceptions will be approved by the State based on the recommendations of the Contractor. The DUR system shall be operated in such a manner that there is not any unnecessary delay in access to appropriate medications by beneficiaries.

The dedicated clinical manager (RPh or PharmD) that the Contractor must provide to the State shall coordinate with the State DUR Board. The Contractor shall present analysis, education materials and a list of targeted prescribers with specific profiles to the DUR Board for approval. The Contractor shall also:

1. Develop and present an annual DUR plan
2. Prepare an annual DUR report for both the State and CMS
3. Coordinate the agenda for each DUR Board meeting with State staff
4. Attend each DUR Board meeting, report on activities and the results of interventions since the last meeting, and prepare and distribute analyses and recommendations for consideration by the Board.

The Contractor shall apply automated tools in support of fraud and abuse activities. The Contractor's program representative shall be responsible for collaborating with the clinical manager to review fraud and abuse reports, submit a quarterly activity report to the State, and work with the pharmacies on recoupment activities.

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As requested by the State, the Contractor shall offer to retail pharmacists educational materials informing them, not only about their legal obligations to provide counseling to beneficiaries, but information on different levels of potential DUR therapeutic interventions.

In addition to the requirements listed here, the State is considering a clinical detailing program for which it would negotiate a separate fee. The Bidder should indicate its fee under Other at II-H. The description of the program the state envisions follows:

- The Contractor shall implement a program of clinical detailing. The Contractor shall develop policies and procedures for the clinical detailing program for review and approval by the State. This program may use clinical pharmacist educators recruited from the local area or the Contractor may propose other methods. It shall include a process for orientation and training as applicable. The Contractor shall introduce the program to the provider community prior to start-up in order to gain acceptance and cooperation, and modify the process based on feedback from the provider community. To the extent feasible, any clinical detailing program may be integrated with similar programs operated by other payers and clinical detailing efforts will be coordinated and/or integrated with similar efforts underway in the State. As part of this effort the Contractor shall develop educational materials for prescribers.
- The Contractor shall identify target drug therapies and/or targeted prescribers. The Contractor shall use targeted drug/prescribers profiles to perform face-to-face interventions. Clinical detailing will focus on the preferred drug list, less costly drug therapy options, and methods to improve prescribing patterns for identified prescribers, including over treatment/under treatment, treatment failure, drug to drug interactions, iatrogenic effects/adverse reactions, therapeutic duplication, drugs with diagnosis/drugs without diagnosis, drugs without procedure, or other issues identified in the prescriber profile.

## **III-J UTILIZATION MANAGEMENT (UM)**

### **1. Discussion and Overview**

Clinical programs should be integrated to best preserve both clinical and fiscal resources. The State's utilization management plan includes ProDUR, RetroDUR, educational programs, and disease state management. These processes focus on controlling/reducing unnecessary or inappropriate pharmacy utilization, while integrating disease management and retrospective DUR to identify beneficiaries, pharmacy providers and prescribers who are candidates for intervention. However, the State's utilization management plan involves the use of predictive models to identify those beneficiaries “at risk,” pharmacies who are candidates for further investigation, and prescribers practicing outside standards of care. A key aspect of the use of predictive models involves the use of historical data to identify trends of interest and to identify variables that can be used as early, reliable predictors of subsequent outcomes. Predictive model case management will identify parameters that can be used to target individuals who are at increased risk for a given outcome. Outcomes of interest vary and may include any specific clinical result, hospitalization, over utilization, or excessive expenditures.

Utilization Management must focus on beneficiary, physician, and pharmacist utilization patterns and must be integrated with both the Retrospective DUR and network management

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programs. The utilization management protocols will be proposed by the Contractor to the DUR Boards and presented to the State for approval. While the primary focus of utilization management is controlling/reducing pharmacy utilization, utilization management programs may also integrate with disease management and Retrospective DUR, identifying beneficiaries who are non-compliant or inconsistently using their therapies.

Utilization management consists of reviewing, on a regular basis, the utilization patterns of beneficiaries. Examples would include beneficiaries receiving a large number of prescriptions each month, high cost prescriptions, controlled substances, or seeing multiple physicians and/or receiving prescriptions from multiple pharmacists (referred to as poly-physician, poly-pharmacy). Once beneficiaries are systematically identified, they shall be assessed by a clinician to determine the appropriate intervention, which may include referring the beneficiary to a case management program, physician notification, beneficiary lock-in, or other interventions.

Physician utilization management is integrated with Retrospective DUR and assists in targeting the appropriate method of communication and intervention with the physician.

Pharmacy utilization management consists of systematic reviews of pharmacy prescribing patterns, focusing on unusual activity such as disproportionate drug dispensing patterns and generic substitution opportunities. Pharmacy utilization management shall integrate with pharmacy network management, identifying potential candidates for further investigation or on-site audits.

The State is responsible for approving all utilization management targeting protocols and making beneficiary lock-in decisions.

## **2. RFP Response**

Bidders shall describe how the Bidder's UM processes can be utilized to improve care and compliance for all beneficiaries that may be covered through this RFP. Utilization management includes written, oral, or electronic reminders containing specific information and suggested changes in prescribing or dispensing practices, communicated in a manner designed to ensure the privacy of beneficiary-related information. Bidders should include recommendations and samples of recipient and prescriber educational materials. Bidders should address the following requirements, at a minimum, within proposals submitted.

1. The Bidder should address their capacity to analyze pharmacy claims on a monthly basis and capacity to present recommendations for additions or changes to the utilization management program and interventions. The proposed utilization management program should include review of both high risk and high cost/utilization therapies for integration with prior authorization, POS edits, and DUR programs.
2. The Bidder should address their capacity, on a quarterly basis, to provide a written report profiling the top one hundred (100) utilizing beneficiaries, pharmacies and physicians for each of the proposed groups. The report would highlight the percentage of cost (to total) attributed to the top utilizers, the actions taken (including DUR and detailing programs) and future action to be taken.

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3. The Bidder should demonstrate experience in effective and efficient utilization management programs that integrate with drug coverage protocols, DUR and pharmacy network management.
4. The Bidder should address their information system capacity to support programs for utilization management screening, which includes flexible evaluation criteria and timely data integration.
5. The Bidder should address their capacity, where appropriate, to use face-to-face discussions between health care professionals who are experts in rational drug therapy and selected prescribers and pharmacists who have been targeted for utilization management.

### **Additional Recommendations**

Bidders should describe any additional suggestions or recommendations for UM.

### **3. Requirements**

The dedicated clinical manager (RPh or PharmD) that the Contractor must provide shall be responsible for daily oversight and clinical review of beneficiaries, physicians, and pharmacies that have been identified through the utilization management program. The Contractor/clinical manager shall coordinate with the State who shall be responsible for approving all utilization management programs.

Within one hundred twenty (120) days of Contract implementation and annually thereafter, the Contractor's clinical manager shall present an annual utilization management plan to the State for consideration. The Contractor shall present the plan for review and adoption by the State. In developing this plan, the Contractor shall analyze claims and present recommendations for utilization management programs to be undertaken by both the Contractor and the State's clinical staff. The Contractor shall provide the capacity to provide utilization management reminders containing specific information and suggested changes in prescribing and dispensing practices.

The Contractor shall analyze utilization patterns on a quarterly basis for beneficiaries/pharmacies/prescribers along the following characteristics, or other characteristics recommended by the Contractor and agreed to by the State:

1. Large number of prescriptions per month;
2. High cost of prescriptions;
3. Prescriptions from multiple pharmacies or prescribers;
4. Disproportionate dispensing patterns;
5. Low generic substitution;
6. High dispense as written rate; and
7. High number of DUR overrides.

## **III-K DISEASE MANAGEMENT**

### **1. Discussion and Overview**

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Disease management is a name applied to use of pre-established protocols or best practices, as identified by qualified medical personnel, to review care and services received by beneficiaries with a specified condition or condition(s) to validate that care offered is optimal and conforms to best practice treatment guidelines. This review may apply to either acute illness (e.g., pneumonia in adults) or to chronic medical conditions such as asthma, hypertension, and schizophrenia.

A disease management system/process must be developed in consultation with the State, must have physician oversight, and will focus on beneficiary, physician, and pharmacist education. Therefore, the Contractor will coordinate meetings with these organizations and other organizations and State agencies specified by the State. The Contractor will facilitate literature review, select a topic or topics for implementation, analyze the capacity of data to support such a topic, and prepare strategies for translating disease management protocols and observed findings to educational opportunities for eligible beneficiaries of applicable pharmacy programs with the selected condition, and the pharmacy and physician providers caring for them. Of necessity, this function will rely on identification of physician services and other data containing diagnoses, if available, in addition to pharmacy and other paid claims information detailing treatments.

Following consensus with the State and the other organizations to be consulted, the Contractor will identify the selected disease(s), the beneficiaries to be reviewed, the findings of the review, the analyses of strategies to improve the findings, and re-measurement of the findings after interventions with the beneficiary, physician, and pharmacist communities.

## **2. RFP Response**

The Bidder, in its response, is to provide recommendations as to what the State should do with regards to direction and operations of disease management programs, including the type and frequency of activities to be performed, and extent of education and intervention efforts. The Bidder should list the types of diseases that shall be covered in its program, and prioritize them. At a minimum, Bidders should address the following requirements:

1. Disease management activities to identify and manage troublesome therapies.
2. Examples of disease management activities including any materials and documentation that are part of its program.
3. The philosophy and strategy behind its clinical management services and initiatives, including:
  - How the program emphasizes beneficiary-centered care.
  - Summary of the key features that distinguish its clinical management capabilities.
4. Clinical management activities, including but not limited to: outreach and education, physician profiling, Retrospective and Prospective Drug Utilization Review, prior authorization, drug coverage management, and predictive modeling. The Contractor should identify how these activities fit within its recommended disease management program.
5. New, innovative and effective programs for clinical and disease management activities.
6. The introduction of innovative services that improve physician prescribing and treatment.
7. Comprehensive beneficiary and provider (pharmacy and physician) education services.

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8. Ongoing physician education programs on proper drug and dosage prescribing protocols.
9. The education of physicians to choose particular medications for certain diagnoses, prescribe proper dosages, select generics when available, and utilize preferred single source products as needed.
10. Utilization and health management programs that decrease inappropriate prescription and medical utilization while ensuring better compliance with best practice treatment guidelines and improved health care outcomes.
11. Systems capability to screen for drug therapy concerns, by specific drugs relative to high risk disease to include (but not be limited to): cardiovascular disease, endocrine disease, gastrointestinal disease, psychiatric disease, and respiratory disease.
12. The provision of physician profiling and other clinical effectiveness reports.
13. Methodology for establishing baseline data, tracking and recording outcomes and cost savings attributed to the programs.
14. Consultation not only with the State's DUR Board on its disease management activities, but also coordination with other State agencies responsible for providing or monitoring beneficiary care.

### **Additional Recommendations**

Please describe any additional suggestions or recommendations for Disease Management interventions.

### **3. Requirements**

In conjunction with the State's clinical staff, the Contractor shall provide disease management programs that will promote appropriate medical and pharmaceutical utilization. The Contractor shall identify and manage troublesome therapies for at least the following conditions:

1. Diabetes
2. Asthma
3. Obesity
4. Depression
5. Congestive heart failure
6. Coronary artery disease
7. Chronic obstructive pulmonary disease
8. Peptic ulcer disease
9. Rheumatoid arthritis

The Contractor shall provide a disease state management process by developing algorithms through predictive modeling, ranking patients' risk of preventable adverse therapeutic outcomes, providing interventions and education. The Contractor shall provide a disease management overview that includes broad based clinical programs, education of prescribers about matters of clinical practice, and measures to influence patient behavior to take an active role in own care. Annually, the Contractor shall provide a clinical and economic outcome assessment for the disease management programs.

The Contractor shall furnish the State with a schedule and implementation plan for each disease management program prior to implementation. The implementation plan shall include

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appropriate provider and beneficiary education. Implementation shall be subject to State approval.

### **III-L PRIOR AUTHORIZATION (PA)**

#### **1. Discussion and Overview**

An aggressive PA program in concert with a PDL has been demonstrated to provide savings to the program, without degrading quality of care. PA can be effectively employed for Medicaid beneficiaries if PA adheres to OBRA '90 rules. OBRA '90 rules require that Requests for Prior Authorizations for Medicaid recipients must be acted upon within 72 hours.

Through this RFP, the State is asking Bidders to continue the PA program for Medicaid and State program beneficiaries. Any recommendation for the expansion of or changes to the PA program will not be implemented until it has been reviewed by the DUR Board and approved by the State.

#### **2. RFP Response**

Bidders should address the following in their proposals:

1. Describe experiences with prior authorization services, including telephone access.
2. Identify drugs or categories of drugs the Bidder has included in any Prior Authorization program.
3. Describe the Bidder PA process.
4. Describe how the guidelines are developed.
5. Identify what type of personnel perform what types of review.
6. Describe the Bidder's ability to accept and systematically apply the State's existing PAs.
7. Identify technology driven solutions in administering the PA process; for example, IVR, internet applications, system applied step-therapies, etc. Describe each available solution.
8. Describe the tracking methodology.
9. Describe the Bidder's ability to notify prescribers, beneficiaries, and pharmacies of the status of a PA: pending, determined, and expiring.
10. Describe the appeals process used in the prior authorization program. Include sample provider and patient appeals correspondence.
11. Describe the reporting process and timelines. Please include sample reports.

Provide samples of standard operating procedures for prior authorization.

#### **3. Requirements**

The Contractor shall recommend drugs for prior authorization to the State consistent with the State's criteria in the OVHA Policy Manual at M106.2; the Preferred Drug List; and, in the case of HIV and AIDS-related medications used by individuals with HIV or AIDS, with the State's criteria as determined by the Vermont Department of Health. The Contractor shall have a process for informing providers and consumers of any additions to the list of drugs requiring PA. This process will be developed in conjunction with the State and may be modified over time as circumstances warrant.

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All PA requests will be processed as rapidly as possible, but in no case shall a PA request be dispositioned later than 72 consecutive hours after the request is filed.

The prior authorization program shall be fully automated and an integral part of the POS/ProDUR system. The PA system shall be operated in such a manner that there is not any unnecessary delay in access to appropriate medications by beneficiaries. The Contractor shall insure the integration of prior authorization and preferred drug list and any step therapy protocol.

The Contractor shall provide prior authorization tracking process so that providers do not have to submit a claim with a PA number.

Any medication requiring prior authorization will be entered into the system to reject at the point of sale. This rejection will include messaging describing the reason for the denial and the Contractor's toll-free telephone number for the pharmacist or the prescriber. The prescriber must initiate a prior authorization request. A certified pharmacy technician shall manage initial PA requests. If the information furnished by the prescriber satisfies criteria, the technician may grant an approval.

If there is any doubt that the criteria have been met, the technician will refer the PA to a licensed clinical pharmacist who will review the patient specifics with the prescriber. The Contractor shall assist the prescriber in changing to a more appropriate therapy rather than simply denying the initial request. If the prescriber is unwilling to switch the patient to an acceptable therapy, the pharmacist will issue a denial, or as indicated consult with the Contractor's Medical Director or clinical staff for resolution. If still unresolved, the case will be referred to the OVHA Medical Director or clinical staff as directed by the State. If the recommendation of the Contractor is overridden by the State, an authorization will be entered into the system. All clinical decisions remain the final responsibility of the State. If a request for prior authorization is denied, the Contractor shall issue a notice to the beneficiary notifying them of the denial and of their rights to a fair hearing. The format for such notices will be approved in advance by the State. If requested by the State, the Contractor shall provide the clinical criteria and rationale for each denial.

The Contractor shall provide personal computer software that permits State staff, including member services staff, to view in real-time, prior authorization requests and the status and disposition of requests. Information will be accessible based on a variety of key elements including, but not limited to patient name, drug name, and drug class. The Contractor will work with State staff to create an interface with the State's global clinical record system.

The Contractor shall provide a reporting process to summarize PA activity, both in detail and in summary. The clinical manager provided by the Contractor will review medical necessity with the State's clinical staff.

## **III-M MEDICARE PART D**

### **1. Discussion and Overview**

The State is committed to ensuring, to the extent supported by State appropriations, that Medicare beneficiaries of current state funded pharmacy programs will not be disadvantaged

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with respect to pharmacy coverage when the Medicare Part D drug program is implemented. To this end, the State is exploring models for interfacing with Part D that will achieve this goal and that is described in the following.

Through a State Pharmacy Assistance Programs (SPAP), the State will amend current state legislation to provide wraparound pharmacy coverage to Medicare Part D. The wraparound coverage may be provided as a benefit coordinated with the Medicare Pharmacy Drug Provider (PDP) or it may be provided in concert with a preferred PDP serving Vermont enrollees. For the latter, Vermont would seek auto-enrollment authority for all SPAP members in the preferred PDP using the CMS requirement that SPAPs facilitate enrollment.

The State would seek PDP rebate commitments or financial concessions as a condition of securing preferred status and therefore a significant number of enrollees from the State. The State may seek federal approval to obtain supplemental rebates on SPAP coverage.

The PDP sponsor would agree to create a formulary that matches the formulary of the SPAP to attempt to assure that coverage applies to out-of-pocket and “donut-hole” limits, paying part of each prescription in the form of deductibles, co-payments, and coinsurance. The SPAP may cover premiums for enrollees or may charge premiums selectively. The degree of coverage will vary according to current limitation included in Vermont’s different plans.

In the event that the SPAP benefit is only coordinated with the PDPs, the Contractor shall perform coordination of benefit activities, editing against coverage and cost sharing conditions.

In the case of a preferred PDP, the PDP will process the claims for Medicare and transmit a crossover or crossover-like claim to the Contractor for the payment of the balance under the SPAP coverage. The PDP sponsor would use commercial pharmacy reimbursement rates and the PDP sponsor would meet TRICARE access standards.

The Contractor will be required to accept crossover claims to the extent permitted under Part D regulation. This is to protect pharmacies from having to file multiple claims and to provide claims data to the SPAP on services provided to facilitate case management opportunities for the State in coordinating care.

The State will enroll their Medicaid and/or publicly funded pharmacy program eligibles with Medicare Part D coverage in the SPAP. The Vermont plans that would participate include:

- Plan A: Medicaid
- Plan B: VHAP
- Plan C: VHAP Pharmacy
- Plan D: VScript
- Plan E: VScript Expanded
- Plan F: Healthy Vermonters and other Vermont Medicare beneficiaries

The State will collect Medicaid OBRA’90 equivalent rebates wherever possible and supplemental rebates with CMS approval.

## **2. RFP Response**

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The State is asking Bidders to describe their capabilities in regard to the program description outlined above. As applicable, the Bidder should describe any intent to participate in the CMS designated region as a PDP. If the Bidder does not intend to seek designation as a PDP serving Vermont, the Bidder should describe their ability to interface with a PDP in the model described above. The State would be interested in any unique or innovative method the Bidder proposes that might improve on the proposed approach to Part D. If the Bidder is not able or sees limitations in its capacity to participate in the manner described above, it should describe in detail those limitations.

### **III-N BENEFICIARY AND PROVIDER TELEPHONE SUPPORT**

#### **1. Discussion and Overview**

The State presently provides telephone support for its Medicaid beneficiaries through its Member Services Unit (MSU). The State maintains provider services functions for provider enrollment and payment through the MMIS Contractor. The Bidder must have an interface with the State's MSU to assist in addressing beneficiary issues. This should include telephone response and an electronic capacity to provide coverage, including PA status, and claims status information. The current PBM vendor provides telephone support for prescribers and network pharmacies on all PBM matters other than enrollment and payments. It is expected that these activities will continue to be carried out by the Contractor.

#### **2. RFP Response**

The Contractor shall provide access to appropriate staff to support Member Services activities. The Contractor must provide toll-free telephone access to support system (technical) operations. Bidders should provide detailed explanations as to the manner in which telephone support will operate in order to respond to claims, inquiries, questions and problems regarding operations. The Contractor shall supply all required information systems, telecommunications, and personnel to perform these operations. The Contractor shall appropriately staff its systems hotline, with positions such as a manager, hotline team leaders, and hotline representatives, all of whom shall be extensively trained. The Contractor's hotline staff shall have complete on-line access to all computer files and databases that support the system for applicable pharmacy programs. The Contractor's hotline should provide sufficient telecommunications capacity to meet the State's existing needs with acceptable call completion and abandonment rates. It shall also be scalable to future demand. It shall also possess an advanced telephone system that provides the State with extensive management tracking and reporting capabilities. A QA program shall be in place that samples calls and follows up to confirm efficient handling and caller satisfaction. The Contractor must maintain toll-free telephone access (available for in-state and out-of-state providers) to support prior authorization. The Contractor must have professional (licensed) medical and pharmacological advisory staff and other resources necessary to provide pharmacists at the point of sale with advice pertaining to the proper use of prescription drugs, consistent with Prospective Drug Utilization and other medical standards, as they apply to each beneficiary's unique needs and medical conditions. The Contractor must produce reports on usage of the hotline(s), including number of inquiries, types of inquiries, and timeliness of responses.

#### **3. Requirements**

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For the State's publicly-supported health care programs and the Healthy Vermonter Program, the Contractor shall provide ongoing training and support to Member Services staff. For beneficiaries enrolled in the State's publicly-supported health care programs, Member Services is the single point of contact for ongoing consumer member services at this time. The State's Member Services Unit will be that contact. The Contractor, though, shall be responsible for prescription drug program announcement letters; prescription drug program benefit brochures; and patient profile order forms and pre-addressed envelopes. The Contractor shall be available to the Unit if need be to resolve beneficiary questions or issues. The contractor shall provide:

1. The system ability to identify if individual drugs are covered and any conditions of coverage; for example, if PA is required, any beneficiary limits (e.g., annual, lifetime, etc.); if cost sharing applies, etc.
2. The system ability to identify why some drugs are not covered; for example, not covered in the coverage program, not covered because of rebate, etc.
3. The system ability to identify the status of a PA; for example, if it is pending and if so, when a decision is due; if it is active and if so, when it expires; etc.
4. The system capacity to identify claims status information including reasons for denial that can be translated into beneficiary terms.

For the State's publicly-supported health care programs and the Healthy Vermonter Program, the Contractor shall provide ongoing training and support to existing and new prescribers and providers:

1. Network providers shall continue to be enrolled through the State's fiscal agent. Upon receipt of enrollment notification, the Contractor shall supply providers with information on PBM program specifics and on claim filing preparation and will issue an up-to-date, relevant provider manual. The contractor shall also be responsible for provider education as program changes are implemented. The Contractor shall handle all questions on these matters.
2. In the event that a mail order option (generally or as part of a specialized pharmacy service) is made available, the following may be required of the Contractor on a ongoing basis for consumers: a prescription drug program announcement letter, customized and printed on State specified letterhead announcing that a new mail order prescription benefit is available and providing a toll-free customer service number; a mail order prescription drug program benefit brochure customized with the State specified name and logo highlighting features of the option including convenience, quality, and the benefits of the use of generics and containing information on how to participate, ordering instructions, using the toll-free customer service number and a 24 hours per day/7 days per week refill request line.

## **III-O ID CARDS AND MEMBER MATERIALS**

### **1. Discussion and Overview**

The contractor will use the identification cards used by issued by the State for its publicly-supported health care programs, and provide identification cards for other populations. The State presently plans to continue to issue ID cards and other member or recipient materials for the

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State Medicaid Program. It is possible, however, that the Contractor will be required to issue ID cards and other member or recipient materials for some portions of the recipients to be covered pursuant to this RFP. The National Council for Prescription Drug Programs (NCPDP) has issued a specification for Pharmacy ID cards.

### **2. RFP Response/Requirements**

- Please indicate if Bidder ID cards conform to NCPDP specification.
- Provide turn around time for issuing an ID card.
- Please list prices for these materials, and provide samples. Assume that the Contractor will assemble such materials.
- Please quote prices for ID cards in two ways: first, by assuming that the State will be responsible for all mailings and second, assuming that the Contractor will perform all mailings. This information should be included in the Bidder's Price Proposal.

## **III-P EDUCATIONAL AND PUBLIC RELATIONS FUNCTIONS AND OTHER**

### **1. Discussion and Overview**

Provider and beneficiary education are essential to the success of the program. The Contractor is expected to provide a variety of educational strategies for prescribers and beneficiaries in order for them to understand the need for pharmacy program and its requirements. Any member education material will be reviewed and approved by the State prior to distribution.

The Contractor will support the implementation of the commercial product Epocrates® for communication of the Vermont Preferred Drug List to prescribing physicians, pharmacists and any other parties wishing to download this information. The State may opt to contract for Epocrates® directly or rely on the Contractor to establish a contract.

The Contractor shall develop working relations with groups including but not limited to professional pharmacy associations such as the Vermont Pharmacy Association and National Association of Chain Drug Stores (NACDS); medical groups such as the Vermont Medical Society; and other groups including advocacy and consumer groups, the Medicaid Advisory Board, and any other group designated by the State. The Contractor shall have ongoing working relations with the State's fiscal agent, EDS. The Contractor shall attend Legislative or Legislative Oversight Committee meetings or other meetings designed to explain the Pharmacy Benefit Management (PBM) program or address issues raised by this contract.

### **2. RFP Response**

Working relations with pharmacy providers and prescribers are a key component of the selection process. Please describe the Bidder's relationship with these providers. Describe the Bidders approach to provider education. Provide samples of educational material used and the success and limitations of educational programs in other settings. Describe other services that the Bidder could perform in the context of this RFP, for any or all of the identified populations. Be as specific as possible. Identify any cost savings associated with these suggestions in the Price Proposal. Space has been provided in the Section I-H to identify the costs associated with these suggestions.

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The Bidder should describe in detail the processes and techniques it will employ to educate providers/prescribers concerning the Preferred Drug List, claim filing, PA process, DUR program, program benefits and benefit changes, changes in the provider manual, and other contract provisions requiring provider education. The Bidder should likewise describe the processes and techniques it will use in educating program beneficiaries.

There should be a description of how the Bidder proposes to keep pharmacies informed of participating prescriber ID numbers, and the method and frequency of distributing updated numbers. Describe if this can be done electronically and if so, using what systems.

### **3. Requirements:**

The State will be responsible for enrolling pharmacy providers for its publicly-supported health care programs. The Contractor may be responsible for enrolling pharmacy providers for uninsured enrollees if a limited network is used.

The contractor will be responsible for the education of prescribers on program specifics and benefits, the preferred drug list, and the program's utilization review and prior authorization procedures.

The Contractor will perform education of network providers on program specifics and on claim filing preparation and drafting and issuing up-to-date provider manuals to every pharmacy in the network. The provider manuals shall be consistent with other State provider manuals and shall be subject to State approval. The Contractor shall also be responsible for provider education as each program change is implemented.

The Contractor will be responsible for Consumer education activities, including such items as prescription drug program announcement letters; prescription drug program benefit brochure; and patient profile order forms and pre-addressed envelopes. Patient profile order forms are used to obtain both mailing and medical information about the patient, such as drug allergies and/or existing health conditions, and in the event that a mail order option becomes available, serves as the order form. Pre-addressed envelopes will be supplied for the participant's convenience.

The Contractor shall provide beneficiary brochures and text for Member Handbooks for all beneficiaries that provide information about the beneficiary's pharmacy benefits. Emphasis should include, but not be limited to information regarding the preferred drug list and the use of generics. Any member education material will be reviewed and approved by the State prior to distribution.

The Contractor shall assign one (1) Program Representative to be responsible for the execution of the communication strategies and training plans that will be developed for each identified impacted group. The Contractor in conjunction with the State will identify the groups to be contacted.

These strategies will be implemented by:

- Direct involvement with physician prescribers and pharmacy providers to educate them about the program intent, the process that was used to determine the PDL and

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the content of the PDL, the processes to be followed to obtain a PA if necessary, resolution of issues that arise, and how they can assist to make the program a success.

- Direct involvement with constituent groups to help facilitate their understanding of the program and the processes that will be followed.

The Program Representative will also act as a point of contact for the provider community to get additional information on the program as well as being a focal point for issues that need to be addressed.

The Contractor will support the implementation of the commercial product Epocrates® for communication of the Vermont Preferred Drug List to prescribing physicians, pharmacists and any other parties wishing to download this information. The State may opt to contract for Epocrates® directly or rely on the Contractor to establish a contract. The Contractor will maintain this information through the provision of quarterly updates for Epocrates®.

If requested by the State, a pocket preferred drug list guide will be mailed to identified enrollees within 30 days after all preferred drug list decisions are finalized and communicated to the Contractor. On an ongoing basis, a pocket preferred drug list guide shall be mailed to new enrollees with their ID card, if requested by the State. This function will be coordinated with the State's fiscal agent who issues beneficiary ID cards.

A preferred drug list guide will be provided to all participating prescribers as soon as possible, but within 30 days after all preferred drug list changes and decisions are finalized and communicated to the Contractor. Changes in the preferred drug list will be communicated to prescribers prior to implementation.

### **III-Q STAFFING REQUIREMENTS**

The Contractor shall meet the staffing requirements as set out in this section in their response to the RFP.

The Contractor shall provide a dedicated Project/Account or Conversion Manager who will act as the single point of contact representing the Contractor during the conversion and implementation phase. The term "dedicated" is used to indicate that the Project/Account Manager or Conversion Manager is committed full-time to the conversion and implementation and is accessible to the State during work hours during the conversion and implementation phases. This individual must be authorized to commit the resources of the Contractor in matters pertaining to the implementation performance of the contract.

The Contractor shall provide specific staff dedicated to the operations of the contract. All positions will be located in Williston unless the bidder provides alternative solutions that meet with the State's approval. This staff includes:

- An account manager. Preference shall be given to an individual with a business degree, pharmacy related experience, and knowledge in state government affairs.
- A clinical manager (RPh or PharmD) to support clinical, PDL and DUR activities.
- A program representative responsible for program support activities, program performance review, the development of consumer education/communication strategies;

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the execution of provider communication strategies, provider training/education plans, and provider relations.

- A data manager to be responsible for all state data requirements and reporting needs including those that exceed the standard reporting package and the information available through decision support tool provided by the Contractor.

The Contractor shall inform the State of all proposed on-site employees prior to selection. The Contractor shall reconsider offering the position to an alternate candidate or initiating a new recruitment if the State provides the Contractor with sound reasons why the selection would not be in the best interests of the Contractor or the State.

The Contractor shall provide access to clinical and technical staff at the Contractor's home office. This staff should be available to the State and to the State's agents. The Contractor shall provide the State with a key contact list to include name, area of expertise/responsibility, telephone number/extension, and e-mail address.

### **Required On-Site Staffing Summary**

1. Account Manager: One FTE
2. Clinical Manager: One FTE
3. Program Representative: One FTE
4. Data Manager: One FTE

### **III-R DISASTER RECOVERY**

In the event of a natural disaster and unnatural disasters, including but not limited to hacking and acts of terrorism, the Contractor must have a system in place for processing claims so that beneficiaries are not denied access to prescriptions. The Contractor shall present to the State a disaster recovery and business continuity plan that must be approved as part of the implementation phase.

### **III-S POST IMPLEMENTATION**

The Contractor shall be responsible for routine system maintenance. Routine maintenance shall include changes required because of determinations by the State or by the Contractor that a deficiency exists with the operational system, including deficiencies found after the implementation of any modifications, or that continued efficiency could be maintained or achieved through the proposed activity. Modifications may be required that are outside routine system maintenance. They would result when the State or the Contractor determines that an additional requirement needs to be met or that a modification of the existing file structures or current processing is needed. Modifications costs shall be subject to negotiation.

**SECTION IV**  
**EVALUATION METHODOLOGY**

Responses to this RFP shall be evaluated using a three-step selection process, as follows:

- Step I – Mandatory Proposal Requirements: The State has established certain mandatory requirements. Failure to meet any one of these requirements shall result in disqualification.
- Step II – Merits of the Bidder and the Bidder’s Proposed Project: The Bidder shall be assigned a score based on the company’s experience, the Contractor personnel assigned to the project, and the proposed approach and methodology. This score shall comprise 75% of the overall scoring methodology.
- Step III – Price Analysis: The Bidder shall be assigned a score based on the prices provided by the Bidder. This score, combined with the score described in Step II will be used to evaluate each bid, and to determine the Bidder or Bidders with the highest overall score. The price proposal shall comprise 25% of the overall scoring methodology. These steps are described in more detail below.

**Step I – Mandatory Proposal Requirements**

**THESE ARE ABSOLUTE REQUIREMENTS. FAILURE TO MEET ANY ONE OF THE REQUIREMENTS LISTED BELOW SHALL RESULT IN DISQUALIFICATION FROM BEING FURTHER CONSIDERED IN THIS BID PROCESS.**

1. Minimum Capacity – The Bidder must describe and demonstrate that it has the capacity to fulfill the requirements and needs set forth in this RFP.
2. Minimum Experience –
  - Claims Processing - The Bidder must have at least five years of operating experience administering POS pharmacy benefit projects, including design, development, implementation, and operation. In addition, the Bidder must have previous experience with other plans of similar size and scope.
  - Other - The Bidder must have at least three years of operating experience administering comparative projects, including design, development, implementation, and operation. In addition, the Bidder must have previous experience with other plans of similar size and scope.
3. Minimum Program Requirements –
  - Claims Processing - The Bidder must demonstrate, through its proposal, that its program includes the following elements:
    - (a) An operational POS electronic adjudication process that shall be in compliance with all Federal and State regulations and mandates, as described herein, which include (but are not limited to) eligibility verification, POS edits and drug monitoring, prior authorization, drug utilization review, billing and reimbursement. The POS system must support reporting and audit requirements. The POS must be real time on-line adjudication twenty-four (24) hours per day, seven (7) days per week, and be HIPAA compliant.
    - (b) An automated system that can interface with the State.
    - (c) A proposed implementation timeline following execution of a contract with the State that meets the requirements as set out in this RFP.

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- Other - The Bidder must demonstrate, through its proposal, that its program includes the following elements:
  - (a) An operational process that shall be in compliance with all Federal and State regulations and mandates, as described herein, and be HIPAA compliant.
  - (b) The automated capacity to interface with the State's related contractors.
  - (d) A proposed implementation timeline following execution of a contract with the State that meets the requirements as set out in this RFP.
- 4. The Bidder must accept the performance standards, corrective actions, and liquidated damages identified in this RFP. Performance standards are part of this RFP.
- 5. The Bidder must identify all owners and subsidiaries that own more than five percent (5%) of the Bidder.
- 6. The Bidder must identify all subcontractors and the subcontractor scope of work, as specified in Section II-B.
- 7. The Bidder must meet all other submission requirements and complete the required disclosure statement.

### **Step II – Merits of the Bidder and the Bidder's Proposed Project**

Only proposals passing Step I shall be considered during Step II. The Step II review includes:

- Bidder Capability, Qualifications and Experience
- Qualified Personnel and Location
- Approach and Methodology for Implementation and Continued Operations
- Aptness and Brevity of Response

The Step II review will comprise 75% of the scoring methodology.

### **Step III – Cost Analysis**

A description of how Bidders should structure the cost proposal is provided in Section II-H of this RFP.

The Price proposal shall comprise 25% of the overall scoring methodology.

In discussing its price for clinical consultation and disease management, the Bidder shall also specifically identify any cost savings that the State shall be able to achieve, including methodologies for tracking and measuring results and proving proposed cost savings.

Since there will be no opportunity for Bidders to revise the pricing, and there will not be a Best and Final Offer (BAFO) process, the Bidder should carefully calculate and propose its prices for the services requested herein.

**SECTION V**  
**CONTRACTUAL SERVICES TERMS AND CONDITIONS**

In addition to the required provisions that relate to all state contracts, this section sets out additional provisions the bidders should be aware of in preparing their response to the RFP.

**V-A TERM OF CONTRACT**

The duration of the contract is three (3) years. There may be a one (1) or a two (2) year extension at the discretion of the State. Thus, the maximum term of the contract is five (5) years.

**V-B CONTRACT ADMINISTRATOR**

Upon State approval of a Contract, and following execution of said Contract, the State shall direct the Bidder to administer the Contract on a day-to-day basis during the term of the Contract. However, administration of any Contract resulting from this Request implies no authority to change, modify, clarify, amend, or otherwise alter the prices, terms, conditions, and specifications of such Contract. That authority is retained by the State.

The Contract Administrator and Project Manager for this project is:

Ann Rugg, Deputy Director  
Office of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, VT 05495  
Telephone: (802) 879-5911

An alternative project manager may be designated by the State.

**V-C COST LIABILITY**

Vermont assumes no responsibility or liability for costs incurred by the Contractor prior to the signing of any Contract resulting from this RFP. Total liability of the State is limited to the terms and conditions of this RFP and any resulting Contract.

**V-D CONTRACTOR RESPONSIBILITIES**

The Contractor shall be required to assume responsibility for all contractual activities offered in this proposal whether or not that Contractor performs them. Further, the State shall consider the Primary Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the anticipated Contract. If any part of the work is to be subcontracted, responses to this RFP should include a list of subcontractors, including firm name and address, contact person, complete description of work to be subcontracted, and descriptive information concerning subcontractor's organizational abilities. The State reserves the right to approve subcontractors for this project and to require the Primary Contractor to replace subcontractors found to be unacceptable. The Contractor is totally responsible for adherence by the subcontractor to all provisions of the Contract.

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The Contractor and any subcontractors must commit to the entire contract period stated within this RFP, unless a change of subcontractors is specifically agreed to by the State.

The Agreement between the Contractor and the State will not be assignable to another party without prior written permission from the State. The Contractor shall provide advance notice to the State on any intended sale of the contracting entity. The State will have the option of terminating the Contract with the Contractor upon the sale of the contracting entity.

### **V-E NEWS RELEASES**

News releases pertaining to this document or the services, study, data, or project to which it relates, shall not be made without prior State approval (verbal or written as specified by the State), and then only in accordance with the explicit written instructions from the State. No results of the program are to be released without prior written approval of the State and then only to persons designated.

### **V-F FREEDOM OF INFORMATION AND PRIVACY ACT / DISCLOSURE**

All material submitted by Bidders becomes the irrevocable and sole property of the State of Vermont. The State reserves the right to use all concepts, data, ideas, or configurations, presented in any proposal, whether or not the proposal is selected.

All materials relating to this procurement are subject to the terms of the Freedom of Information Act, the Privacy Act, and all rules, regulations, and interpretations of these Acts, including those from the Offices of the Attorney General of the United States, Health and Human Services, Centers for Medicare and Medicaid Services, and the State of Vermont. The Bidder, by submitting a proposal, agrees that the Privacy Act of 1974, Public Law 93-579, and the Regulations and General Instructions issued pursuant thereto, are applicable to this contract, and to all subcontracts hereunder. Should the Bidder's proposal include any materials that are proprietary and are to be treated confidentially, those materials must be clearly and separately identified.

### **V-G GRATUITIES OR KICKBACKS**

The State prohibits Gratuities and Kickbacks.

### **V-H RETAINAGE**

The Bidder shall include an affirmative statement in the proposal agreeing to a retainage of ten percent (10%) of the total contract amount. Retainage may be made on each payment to the selected Bidder as described in this RFP.

Should the contract be terminated for any reason related to the Bidder's failure to perform Bidder duties to the satisfaction of the State, this retainage shall revert to the State as liquidated damages in addition to the other penalties and/or damages stated in this RFP or contract.

### **V-I APPROPRIATIONS**

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If the contract extends into more than one fiscal year (July 1 to June 30), and if appropriations are insufficient to support the contract, the State may cancel at the end of the fiscal year, or otherwise upon the expiration of existing appropriation authority.

**V-J OTHER PROVISIONS**

Vermont has specific contract language and requirements, as identified in the Bidders Library.

**V-K PERFORMANCE STANDARDS AND PENALTIES**

The Bidder must agree to abide by Performance Standards and Penalties.

The State would propose that the Bidder put at risk 20% of its administrative fees identified in II-H except for the Epocrates® contract, if applicable. If the Bidder is unwilling to put at risk 20% of fees, the Bidder must indicate what percentage they would be will to risk.

The Bidder should then describe the penalty that would apply to its risk pool for each listed performance standard should the Contract not meet the guarantee. The Bidder description should include the methodology for calculating the penalty and the frequency at which it would be applied.

| <b>Service Performance Standards</b>                        | <b>Guarantee</b>  | <b>Description of Penalty and Frequency</b> |
|---|---|---|
| <b>1. Network Size ( For Uninsured)</b>                     | Bidder must provide access to at least 90% of all plan members using the parameters of 2 pharmacies within 15 miles.                                    |   |
| <b>2. File Updates</b>                                      | Performs required file updates – eligibility, provider, drug coverage – as required based on the frequency established by the State, with 99% accuracy. |   |
| <b>3. Point-of-Sale Network System Downtime</b>             | Bidder must agree that unscheduled system downtime will be no greater than 2 hours per incident; not to exceed two times per contract year.             |   |
| <b>4. Prior Authorizations</b>                              | All requests for Prior Authorization shall be acted upon within 72 hours.   |   |
| <b>5. Retail Point-of-Sale Claims Adjudication Accuracy</b> | Bidder must agree to a financial accuracy rate of at least 99% for all pharmacy claims processed at point-of-sale.                                      |   |
| <b>6. Payment Accuracy</b>                                  | The MMIS contractor and   |   |

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| <b>Service Performance Standards</b> | <b>Guarantee</b>   | <b>Description of Penalty and Frequency</b> |
|--------------------------------------|--|---|
|                                      | PBM Contractor have the lead responsibility to ensure that erroneous payments from the MMIS are quickly identified, reported to OVHA and corrected to ensure that no overpayments or underpayments are made from State or Federal funds.   |   |
| <b>7. Formulary Rebates</b>          | Bidder must agree that, to the extent that it receives payments resulting from the formulary and rebate process, all rebate reporting and payments will be made within thirty days of the receipt, if any, of these rebates from drug manufacturers. Reporting must describe the source of the rebates at the item level, and the date payment was received from the manufacturer. |   |
| <b>8. Reporting Requirements</b>     | Bidder must agree to provide all the reports specified in this RFP within the stated time periods, and to provide the query capability described in the Bidder's response.   |   |
| <b>9. On-Site Audits</b>             | Bidder must agree to perform on-site audits on the number of pharmacy providers specified by the State in each year of the Contract.   |   |
| <b>10. Call Answering Time</b>       | At least 95% of all eligible persons' calls received will be answered within 30 seconds.   |   |
| <b>11. Call Abandonment Rate</b>     | Not more than 3% of all eligible persons' calls will   |   |

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| <b>Service Performance Standards</b> | <b>Guarantee</b>   | <b>Description of Penalty and Frequency</b> |
|--------------------------------------|--|---|
|                                      | be abandoned.  |   |
| <b>12. ID Cards</b>                  | Cards must be mailed within ten business days of the receipt of any card file. |   |



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|                                       |  |
|---------------------------------------|--|
| Adjudicated Claim                     | A claim that has been captured and as a result of processing the claim determined to be either paid or denied.   |
| First Data Bank                       | The drug pricing service which the Contractor uses for bi-weekly drug price updates.   |
| Claim                                 | A bill rendered by a provider to the State for a procedure, drugs, medical supplies and equipment, or services rendered for a given diagnosis or a set of related diagnoses. |
| Compounded Drug Prescriptions         | Commercially unavailable prescription drugs, which are compounds of multiple ingredients, prepared by a pharmacist.  |
| Cost Avoidance                        | An edit which rejects a claim when there is an identified liable third party.  |
| Current Claim                         | An unadjudicated (in-stream) claim that is currently being subjected to a system edit or audit.  |
| Data Element                          | A specific unit of information having a unique meaning.  |
| Eligibility Verification System (EVS) | EVS is the provision of eligibility status information by the selected Contractor to providers of medical services for those individuals seeking services.                   |
| Electronic Media Claims               | Claims submitted for processing on diskette, CD, DVD, tape, or by modem.   |
| History Claim                         | Claims that have been adjudicated and appear in the adjudicated claims history file.   |
| Lock-In                               | A term used to identify clients who are restricted, when obtaining drugs, medical services, or supplies, to one or more specified providers.                                 |
| Post Payment Recovery                 | Actions initiated subsequent to claim payment to recover Medicaid funds for which a third party is or may be liable.   |
| Prior Authorization                   | The pre-claim submission approval that must be given to providers by a designated professional for specified services for a specified client.                                |
| Provider                              | A person, organization, or institution certified to provide health or medical care services authorized under the State Medicaid Program.                                     |

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|   |   |
|---|---|
| Prospective Drug Utilization Review           | Referred to as pro-DUR; this includes the provision of certain information, on-line, to authorized providers prior to filling a prescription.   |
| Retrospective Drug Utilization Review         | Referred to as post-payment or retro-DUR; this includes the Retrospective Review of provider dispensing patterns and client use of drugs.   |
| Rejected Claim                                | Claims which are submitted with insufficient information to process, or for which Medicaid is not the primary pay source are rejected or returned to providers prior to entry into the system.  |
| Retroactive Claims                            | Claims that may be submitted for a prior period of time as allowed by State Medicaid policy.  |
| Third Party Liability (TPL)<br>Cost Avoidance | Liability of a third party (a person or organization other than the client or OVHA) for all or some portion of the costs of medical services incurred by a beneficiary.                         |
| Transaction                                   | Inclusive term that means a claim, or a rejected claim.   |
| Unit Dose Drug Distribution                   | Drugs that are dispensed in a unit of use quantity while the associated claims may be submitted at 30-day intervals. The distribution system is widely utilized in long-term care institutions. |

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**ATTACHMENT**

**COVERED LIVES AND CLAIMS VOLUME**

The tables below describe the various populations that are covered through this initiative. Please note the following with respect to this information:

All of the numbers are projections for SFY '06, except claim volumes. Actual numbers of lives, claims and dollars will vary, but these values will provide Bidders with the lives, claims and dollars expected to be associated with this RFP.

**VERMONT/MEDICAID/OTHER/STATE FUNDED/UNINSURED**

| <b>PLAN</b>                            | <b>ESTIMATED LIVES – SFY '06</b> | <b>PHARMACY CLAIMS VOLUME – CY '04 (paid and denied)</b> | <b>PROJECTED PHARMACY EXPENDITURES SFY '06 (prior to rebates)</b> |
|--|----------------------------------|--|---|
| Traditional Medicaid                   | 99,340                           | 2,564,919  | \$126,301,944   |
| VHAP Uninsured                         | 21,915                           | 552,167  | \$14,928,593  |
| VHAP Pharmacy                          | 8,818                            | 522,687  | \$28,663,297  |
| VScript                                | 2,847                            | 158,771  | \$8,443,554   |
| HIV/AIDS MAP                           | 83                               | 4,075  | \$844,031   |
| VScript Expanded (State funded)        | 2,695                            | 156,938  | \$8,184,591   |
| General Assistance (State funded)      | Included in other programs       | 4,114  | \$360,893   |
| Healthy Vermonters Program (Uninsured) | 11,355                           | 83,916   | \$-0-   |
| <b>TOTALS</b>                          | <b>147,053</b>                   | <b>4,047,587</b>   | <b>\$187,726,903</b>  |

**Note:** The above numbers are projections, and therefore subject to change.