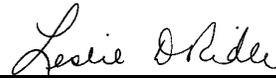


STANDARD AGREEMENT FORM FOR PROFESSIONAL SERVICES

The parties' contract comprises this Standard Agreement Form, as well as its referenced Articles and their associated Appendices

1. Agency Contract Number 180000053	2. Contract Title Pharmacy Benefit Management	3. Agency Fund Code	4. Agency Appropriation Code
5. Vendor Number	6. IRIS GAE Number (if used)	7. Alaska Business License Number 969517	
This contract is between the State of Alaska,			
8. Department of Administration	Division Retirement and Benefits	hereafter the State, and	
9. Contractor Optum Rx, Inc.		hereafter the contractor	
Mailing Address	City	State	ZIP
1600 McConnor Parkway	Schaumburg	IL	60173
10.			
ARTICLE 1. Appendices: Appendices referred to in this contract and attached to it are considered part of it.			
ARTICLE 2. Performance of Service:			
2.1 Appendix A (General Provisions), Articles 1 through 16, governs the general performance of services under this contract.			
2.2 Appendix B sets forth the indemnification, insurance, and HIPAA related provisions of this contract.			
2.3 Appendix C sets forth the services to be performed by the contractor.			
ARTICLE 3. Period of Performance: The period of performance for this contract begins January 1, 2019 and ends December 31, 2021 , with eight additional one-year renewal options. Renewal options will be exercised at the sole discretion of the state.			
ARTICLE 4. Considerations:			
4.1 In full consideration of the contractor's performance under this contract, the State shall pay the contractor a sum not to exceed \$80,000,000 in accordance with the provisions of Section 8 Financial.			
4.1 When billing the State, the contractor shall refer to the Authority Number or the Agency Contract Number and send the billing to:			
11. Department of Administration		Attention: Division of Retirement and Benefits	
Mailing Address P.O. Box 110203, Juneau, AK 99811-0203		Attention: Michele Michaud	
12. CONTRACTOR		14. CERTIFICATION: I certify that the facts herein and on supporting documents are correct, that this voucher constitutes a legal charge against funds and appropriations cited, that sufficient funds are encumbered to pay this obligation, or that there is a sufficient balance in the appropriation cited to cover this obligation. I am aware that to knowingly make or allow false entries or alternations on a public record, or knowingly destroy, mutilate, suppress, conceal, remove or otherwise impair the verity, legibility or availability of a public record constitutes tampering with public records punishable under AS 11.56.815-.820. Other disciplinary action may be taken up to and including dismissal.	
Name of Firm Optum Rx, Inc.			
Signature of Authorized Representative 	Date 8/31/2018		
Typed or Printed Name of Authorized Representative Jeff Grosklags			
Title CFO			
13. CONTRACTING AGENCY		Signature of Head of Contracting Agency or Designee	Date
Department/Division Administration/Retirement and Benefits	Date 9/4/2018		9/4/2018
Signature of Division Director Ajay Desai 		Typed or Printed Name Leslie Ridle	
Typed or Printed Name of Division Director Ajay M Desai		Title Commissioner	
Title Division Director			

NOTICE: This contract has no effect until signed by the head of contracting agency or designee.

APPENDIX A

GENERAL PROVISIONS

Article 1. Definitions.

- 1.1 In this contract and appendices, "Project Director" or "Agency Head" or "Procurement Officer" means the person who signs this contract on behalf of the Requesting Agency and includes a successor or authorized representative.
- 1.2 "State Contracting Agency" means the department for which this contract is to be performed and for which the Commissioner or Authorized Designee acted in signing this contract.

Article 2. Inspections and Reports.

- 2.1 The department may inspect, in the manner and at reasonable times it considers appropriate, all the contractor's facilities and activities under this contract.
- 2.2 The contractor shall make progress and other reports in the manner and at the times the department reasonably requires.

Article 3. Disputes.

- 3.1 If the contractor has a claim arising in connection with the contract that it cannot resolve with the State by mutual agreement, it shall pursue the claim, if at all, in accordance with the provisions of AS 36.30.620 – 632.

Article 4. Equal Employment Opportunity.

- 4.1 The contractor may not discriminate against any employee or applicant for employment because of race, religion, color, national origin, or because of age, disability, sex, marital status, changes in marital status, pregnancy or parenthood when the reasonable demands of the position(s) do not require distinction on the basis of age, disability, sex, marital status, changes in marital status, pregnancy, or parenthood. The contractor shall take affirmative action to ensure that the applicants are considered for employment and that employees are treated during employment without unlawful regard to their race, color, religion, national origin, ancestry, disability, age, sex, marital status, changes in marital status, pregnancy or parenthood. This action must include, but need not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The contractor shall post in conspicuous places, available to employees and applicants for employment, notices setting out the provisions of this paragraph.
- 4.2 The contractor shall state, in all solicitations or advertisements for employees to work on State of Alaska contract jobs, that it is an equal opportunity employer and that all qualified applicants will receive consideration for employment without regard to race, religion, color, national origin, age, disability, sex, marital status, changes in marital status, pregnancy or parenthood.
- 4.3 The contractor shall send to each labor union or representative of workers with which the contractor has a collective bargaining agreement or other contract or understanding a notice advising the labor union or workers' compensation representative of the contractor's commitments under this article and post copies of the notice in conspicuous places available to all employees and applicants for employment.
- 4.4 The contractor shall include the provisions of this article in every contract and shall require the inclusion of these provisions in every contract entered into by any of its subcontractors, so that those provisions will be binding upon each subcontractor. For the purpose of including those provisions in any contract or subcontract, as required by this contract, "contractor" and "subcontractor" may be changed to reflect appropriately the name or designation of the parties of the contract or subcontract.
- 4.5 The contractor shall cooperate fully with State efforts which seek to deal with the problem of unlawful discrimination, and with all other State efforts to guarantee fair employment practices under this contract, and promptly comply with all requests and directions from the State Commission for Human Rights or any of its officers or agents relating to prevention of discriminatory employment practices.
- 4.6 Full cooperation in paragraph 4.5 includes, but is not limited to, being a witness in any proceeding involving questions of unlawful discrimination if that is requested by any official or agency of the State of Alaska; permitting employees of the contractor to be witnesses or complainants in any proceeding involving questions of unlawful discrimination, if that is requested by any official or agency of the State of Alaska; participating in meetings; submitting periodic reports on the equal employment aspects of present and future employment; assisting inspection of the contractor's facilities; and promptly complying with all State directives considered essential by any office or agency of the State of Alaska to insure compliance with all federal and State laws, regulations, and policies pertaining to the prevention of discriminatory employment practices.
- 4.7 Failure to perform under this article constitutes a material breach of contract.

Article 5. Termination.

The project director or contracting officer, by written notice, may terminate this contract, in whole or in part, when it is in the best interest of the state. In the absence of a breach of contract by the contractor, the state is liable only for payment in accordance with the payment provisions of this contract for services rendered before the effective date of termination.

Article 6. No Assignment or Delegation.

The contractor may not assign or delegate this contract, or any part of it, or any right to any of the money to be paid under it, except with the written consent of the Project Director and the Agency Head.

Article 7. No Additional Work or Material.

No claim for additional services, not specifically provided in this contract, performed or furnished by the contractor, will be allowed, nor may the contractor do any work or furnish any material not covered by the contract unless the work or material is ordered in writing by the Project Director and approved by the Agency Head.

Article 8. Independent Contractor.

The contractor and any agents and employees of the contractor act in an independent capacity and are not officers or employees or agents of the State in the performance of this contract.

Article 9. Payment of Taxes.

As a condition of performance of this contract, the contractor shall pay all federal, State, and local taxes incurred by the contractor and shall require their payment by any Subcontractor or any other persons in the performance of this contract. Satisfactory performance of this paragraph is a condition precedent to payment by the State under this contract.

Article 10. Ownership of Documents.

All designs, drawings, specifications, notes, artwork, and other work specifically developed for the State of Alaska under a separate written agreement, such as a Statement of Work, are produced for hire and remain the sole property of the State of Alaska and may be used by the State for any other purpose without additional compensation to the contractor. The contractor agrees not to assert any rights and not to establish any claim under the design patent or copyright laws with the respect to work produced for hire. Nevertheless, if the contractor does mark such documents with a statement suggesting they are trademarked, copyrighted, or otherwise protected against the State of Alaska's unencumbered use or distribution, the contractor agrees that this paragraph supersedes any such statement and renders it void. The contractor, for a period of three years after final payment under this contract, agrees to furnish and provide access to all retained materials at the request of the Project Director. Unless otherwise directed by the Project Director, the contractor may retain copies of all the materials. OptumRx retains all ownership interest in its systems, including any enhancements thereto, as well as operational data.

Article 11. Governing Law; Forum Selection

This contract is governed by the laws of the State of Alaska. To the extent not otherwise governed by Article 3 of this Appendix, any claim concerning this contract shall be brought only in the Superior Court of the State of Alaska and not elsewhere.

Article 12. Conflicting Provisions.

Unless specifically amended and approved by the Department of Law, the terms of this contract supersede any provisions the contractor may seek to add. The contractor may not add additional or different terms to this contract; AS 45.02.207(b)(1). The contractor specifically acknowledges and agrees that, among other things, provisions in any documents it seeks to append hereto that purport to (1) waive the State of Alaska's sovereign immunity, (2) impose indemnification obligations on the State of Alaska, or (3) limit liability of the contractor for acts of contractor negligence, are expressly superseded by this contract and are void.

Article 13. Officials Not to Benefit.

Contractor must comply with all applicable federal or State laws regulating ethical conduct of public officers and employees.

Article 14. Covenant Against Contingent Fees.

The contractor warrants that no person or agency has been employed or retained to solicit or secure this contract upon an agreement or understanding for a commission, percentage, brokerage or contingent fee except employees or agencies maintained by the contractor for the purpose of securing business. For the breach or violation of this warranty, the State may terminate this contract without liability or in its discretion deduct from the contract price or consideration the full amount of the commission, percentage, brokerage or contingent fee.

Article 15. Compliance.

In the performance of this contract, the contractor must comply with all applicable federal, state, and borough regulations, codes, and laws, and be liable for all required insurance, licenses, permits and bonds.

Article 16. Force Majeure:

The parties to this contract are not liable for the consequences of any failure to perform, or default in performing, any of their obligations under this Agreement, if that failure or default is caused by any unforeseeable Force Majeure, beyond the control of, and without the fault or negligence of, the respective party. For the purposes of this Agreement, Force Majeure will mean war (whether declared or not); revolution; invasion; insurrection; riot; civil commotion; sabotage; military or usurped power; lightning; explosion; fire; storm; drought; flood; earthquake; epidemic; quarantine; strikes; acts or restraints of governmental authorities affecting the project or directly or indirectly prohibiting or restricting the furnishing or use of materials or labor required; inability to secure materials, machinery, equipment or labor because of priority, allocation or other regulations of any governmental authorities.

Appendix B Indemnification, Insurance, and HIPAA Requirements

Indemnification (RFP Section 3.20):

The contractor shall indemnify, hold harmless, and defend the state from and against any claim of, or liability for error, omission or negligent act of the contractor, its agents, or network pharmacies owned and/or operated by the contractor, under this agreement. The contractor shall not be required to indemnify the contracting agency for a claim of, or liability for, the independent negligence of the state. If there is a claim of, or liability for, the joint negligent error or omission of the contractor and the independent negligence of the state, the indemnification and hold harmless obligation shall be apportioned on a comparative fault basis. "Contractor" and "state", as used within this and the following article, include the employees, agents and other contractors who are directly responsible, respectively, to each. The term "independent negligence" is negligence other than in the contracting agency's selection, administration, monitoring, or controlling of the contractor and in approving or accepting the contractor's work.

Insurance (RFP Section 3.21):

Without limiting contractor's indemnification, it is agreed that contractor shall purchase at its own expense and maintain in force at all times during the performance of services under this agreement the following policies of insurance. Where specific limits are shown, it is understood that they shall be the minimum acceptable limits. If the contractor's policy contains higher limits, the state shall be entitled to coverage to the extent of such higher limits.

Certificates of Insurance must be furnished to the contracting officer prior to beginning work and must provide for a notice of cancellation, non-renewal, or material change of conditions in accordance with policy provisions. Failure to furnish satisfactory evidence of insurance or lapse of the policy is a material breach of this contract and shall be grounds for termination of the contractor's services. All insurance policies shall comply with and be issued by insurers licensed to transact the business of insurance under AS 21.

Workers' Compensation Insurance: The contractor shall provide and maintain, for all employees engaged in work under this contract, coverage as required by AS 23.30.045, and; where applicable, any other statutory obligations including but not limited to Federal U.S.L. & H. and Jones Act requirements. The policy must waive subrogation against the State.

Commercial General Liability Insurance: covering all business premises and operations used by the Contractor in the performance of services under this agreement with minimum coverage limits of \$300,000 combined single limit per claim.

Commercial Automobile Liability Insurance: covering all vehicles used by the contractor in the performance of services under this agreement with minimum coverage limits of \$300,000 combined single limit per claim.

Professional Liability Insurance: covering all errors, omissions or negligent acts in the performance of professional services under this agreement with minimum coverage limits of \$5,000,000 per claim/annual aggregate.

HIPAA Requirements:

The contractor shall adhere to the following requirements for handling all “Protected Health Information” (PHI) during the course of this contract. The term PHI has the same meaning given to that term by HIPAA, the HITECH Act, and the Privacy and Security Rule.

The contractor may use or disclose PHI for the following purposes: to provide pharmacy benefit management services to the state. The contractor may use or disclose PHI as required by law, and shall not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by the state, except for the specific uses and disclosures set out below.

Permitted uses and disclosures: The contractor may only use and disclose PHI owned by the state that it creates, receives, maintains, or transmits if the use or disclosure is in compliance with each applicable requirement of 45 C.F.R. 164.504(e) of the Privacy Rule or this contract. The additional requirements of Subtitle D of the HITECH Act contained in Public Law 111-5 that relate to privacy and that are made applicable with respect to Covered Entities shall also be applicable to the contractor and are incorporated into this contract.

To the extent that the contractor discloses the state’s PHI to a subcontractor, the contractor must obtain, prior to making any such disclosure: (1) reasonable assurances from the subcontractor that it will agree to the same restrictions, conditions, and requirements that apply to the contractor with respect to such information; and (2) an agreement from the subcontractor to notify the contractor of any breach of unsecured PHI, or security incident, promptly, and in any event within five business days of when it becomes aware of such breach or incident.

Safeguards: 45 C.F.R. 164.308 (administrative safeguards), 164.310 (physical safeguards), 164.312 (technical safeguards), and 164.316 (policies, procedures and documentation requirements) shall apply to the contractor in the same manner that such sections apply to the state, and shall be implemented in accordance with HIPAA, the HITECH Act, and the Privacy and Security Rule. The additional requirements of Title XIII of the HITECH Act contained in Public Law 111-5 that relate to security and that are made applicable to Covered Entities shall also apply to the contractor and are incorporated into this contract.

Unless the state agrees in writing that this requirement is infeasible with respect to certain data, the contractor shall secure all paper and electronic PHI by encryption or destruction such that the PHI is rendered unusable, unreadable or indecipherable to unauthorized individuals; or secure paper, film and electronic PHI in a manner that is consistent with guidance issued by the Secretary of the United States Department of Health and Human Services specifying the technologies and methodologies that render PHI unusable, unreadable or indecipherable to unauthorized individuals, including the use of standards developed under Section 3002(b)(2)(B)(vi) of the Public Health Service Act, as added by Section 13101 of the HITECH Act contained in Public Law 111-5.

Reporting Unauthorized Disclosures and Breaches: During the term of this contract, the contractor shall notify the state within three business days of discovering: (i) any use or disclosure of PHI not provided for in this agreement, including any use or disclosure of the state’s PHI in violation of any applicable federal or state law; (ii) any security incident of which contractor becomes aware; and/or (iii) any Breach of Unsecured PHI of which it becomes aware. The contractor shall identify for the state the individuals whose unsecured PHI has been, or is reasonably believed to have been, breached so that the state can comply with any notification requirements if necessary. The contractor shall also indicate whether the PHI subject to the breach; intrusion; or unauthorized acquisition, access, use or disclosure was encrypted or destroyed at the time. The contractor shall take prompt corrective action to cure any deficiencies that result in breaches of security; intrusion; or unauthorized acquisition, access, use, and disclosure. For the purposes of reporting under this provision, a reportable security incident shall not include unsuccessful or inconsequential incidents that do not represent

a material threat to the confidentiality, integrity or availability of PHI (such as scans, pings or unsuccessful attempts to penetrate computer networks).

If the unauthorized acquisition, access, use or disclosure of the state's PHI involves only secured PHI, the contractor shall notify the state within 10 days of discovering the breach but is not required to notify the state of the names of the individuals affected.

Contractor's Agents: If the contractor uses a subcontractor or agent to provide services under this contract, and the subcontractor or agent creates, receives, maintains, or transmits the state's PHI, the subcontractor or agent shall sign an agreement with the contractor containing substantially the same provisions as this Appendix. Contractor will indemnify the state in the event of any violation of the subcontractor or agent agreement. The contractor shall mitigate the effects of any violation of that agreement. Contractor is responsible for all subcontractor or agent's breach of the terms of this agreement, and for all acts or omissions of its subcontractors or agents with respect to the services provided to the State.

Availability of Information to the State: Within 15 days after the date of a written request by the state, the contractor shall provide any information necessary to fulfill the state's obligations to provide access to PHI under HIPAA, the HITECH Act, or the Privacy and Security Rule.

Accountability of Disclosures: If the contractor is required by HIPAA, the HITECH Act, or the Privacy or Security Rule to document a disclosure of PHI, the contractor shall make that documentation. If the state is required to document a disclosure of PHI made by the contractor, the contractor shall assist the state in documenting disclosures of PHI made by the contractor so that the state may respond to a request for an accounting in accordance with HIPAA, the HITECH Act, and the Privacy and Security Rule. Accounting records shall include the date of the disclosure, the name and if known, the address of the recipient of the PHI, the name of the individual who is subject of the PHI, a brief description of the PHI disclosed and the purpose of the disclosure. Within 15 days of a written request by the state, the contractor shall make the accounting record available to the state.

Amendment of PHI: Within 30 days of a written request by the state or an individual, the contractor shall amend PHI maintained, transmitted, created or received by the contractor on behalf of the state as directed by the state or the individual when required by HIPAA, the HITECH Act or the Privacy and Security Rule, or take other measures as necessary to satisfy the state's obligations under 45 C.F.R. 164.526.

Internal Practices: The contractor shall make its internal practices, books and records relating to the use and disclosure of the state's PHI available to the state and all appropriate federal agencies to determine the state's and the contractor's compliance with HIPAA, the HITECH Act and the Privacy and Security Rule. To the extent the contractor is to carry out one or more of state's obligations under Subpart E of 45 C.F.R. Part 164, the contractor must comply with the requirements of that Subpart that apply to the state in the performance of such obligations.

Breach: A breach of a material term of this Appendix by the contractor that is not cured within a reasonable period of time may be grounds for the immediate termination of the contract.

Effect of Termination: Upon termination of the contract, the contractor will, at the direction of the state, either return or destroy all PHI received from the state or created, maintained, or transmitted on the state's behalf by the contractor in any form. Unless otherwise directed, the contractor is prohibited from retaining any copies of PHI received from the state or created, maintained, or transmitted by the contractor on behalf of the state. If destruction or return of PHI is not feasible, the contractor must continue to extend the protections of this Appendix to PHI and limit the further use and disclosure of the PHI. The obligations in this

Appendix shall continue until all of the PHI provided by the state to the contractor is either destroyed or returned to the state.

Appendix C **Scope of Work**

The terms and conditions of this contract in addition to Appendix A and B, including the scope of services and payment provisions, are contained in the following documents, incorporated by reference:

- RFP 180000053, as amended, issued by the Department of Administration, Division of Shared Services and Division of Retirement and Benefits.
- Proposal submitted by OptumRx.
- Clarification Document developed by OptumRx and agreed to by the state.

In the case of conflict, the following order of precedence shall govern:

- This contract document, excluding the Clarification Document, OptumRx, Inc.'s proposal, and RFP 180000053.
- Clarification Document.
- RFP 180000053.
- OptumRx's proposal.

The Clarification Document begins on the next page, followed by RFP 180000053 and OptumRx's proposal.



State of Alaska
Pharmacy Benefit Management Services
Clarification Period Draft Document
RFP# 180000053

June 2018





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SCOPE OF WORK AND KEY ASSUMPTIONS

EXHIBIT A

PBM SERVICES

The State engages OptumRx as its exclusive provider of the prescription drug benefit services set forth in this Exhibit to support the State's Benefit Plans, and OptumRx accepts this engagement, subject to the terms of this Agreement.

1. CORE PRESCRIPTION DRUG BENEFIT SERVICES

1.1 Administrative Support

- 1.1.1 General. OptumRx will provide administrative, management, consultative, claims processing and other general pharmacy benefit management support services to State in conjunction with administration and operation of the Benefit Plans as set forth in this exhibit. OptumRx will administer and support the Benefit Plans in accordance with the most current Plan Specifications that State has provided to OptumRx as required by this Agreement.
- 1.1.2 Reporting. OptumRx will provide the State with OptumRx's standard reporting package and reports, as well as other reports outlined in this Agreement. OptumRx will provide the State with ad-hoc reports that require IT programming for the fee set forth in the pricing Exhibit. Ad-hoc reports run by the Account Management team will not be subject to additional fees.
- 1.1.3 Benefit Plan Responsibility. Although OptumRx will perform Services under this Agreement to support the Benefit Plans, the State retains complete and exclusive discretionary authority over the Benefit Plans and, and is the "administrator" (as defined in 29 U.S.C. § 1002(16)) of the Benefit Plans. The parties specifically agree that, except as otherwise set forth in this Agreement, neither party will name OptumRx or any of its affiliates as a "plan fiduciary." The State further acknowledges and agrees that: (a) neither OptumRx or its affiliates have any discretionary authority over any Benefit Plan's management or operations or plan assets (if any); (b) State has selected and is solely responsible for each Benefit Plan's benefits and design; and (c) State retains all discretionary authority for each Benefit Plan, Benefit Plan assets (if any) and administration of each Benefit Plan.
- 1.1.4 Benefit Plan Eligibility Data. State will provide OptumRx with electronic eligibility data in HIPAA 834 format, or another format agreed to by the parties, as well as Member personal address, phone number and email and work email, if available, for all Members who are entitled to Covered Prescription Services under the Benefit Plans. OptumRx will load correctly formatted Member eligibility data no later than one (1) business day after receipt from State. OptumRx will be entitled to rely on the accuracy and completeness of the Member eligibility data. State will be solely responsible for any errors in Member eligibility data that State furnishes to OptumRx. All eligibility data and Prescription Claims records are the sole property of and must be made available upon request to the State and its representatives. Except for the provision of the State's data to outside entities for the purpose of performing the Services set forth in this Agreement (e.g., to Drug Manufacturers



for the purpose of obtaining Rebates), Selling or providing of the State's data to any outside entities is not permitted under any circumstances.

1.1.5 Member Notification. State will make available to Members the type, scope, restrictions, limitations and duration of Covered Prescription Services to which Members are entitled under an applicable Benefit Plan. OptumRx will provide and distribute, as appropriate, ID cards, a list of Network Pharmacies, Home Delivery brochures, the Formulary and other pharmacy benefit related materials to Members, providers and other appropriate third parties. State reserves the right to review, edit, or customize any communication from OptumRx to Members, unless otherwise set forth in this Agreement or prohibited by CMS rules or statutes. OptumRx will not distribute communications to Members without State's consent, which will not be unreasonably withheld. The State agrees that an approved template constitutes approval for those communications then contemplated which use the approved template. The State further agrees that prior review may not be reasonably practical in circumstances where communication to the Members is of an urgent nature (e.g. FDA notice) and, in such cases, OptumRx may send the communication to the Member and will notify the State as promptly as reasonable be possible.

1.1.6 Plan Specifications. State will provide OptumRx with the technical assistance and information OptumRx reasonably needs to perform the Services, including information regarding Members, Benefit Plans and Plan Specifications. State will provide OptumRx with the Plan Specifications no later than forty-five (45) days before the Effective Date, unless the parties otherwise agree. State may amend or terminate the Plan Specifications upon forty-five (45) days' prior notice to OptumRx, unless a Governmental Authority requires that the amendment or termination occur in a shorter time period. State's failure to provide the Plan Specifications within the time periods stated in this section may delay OptumRx's implementation of the Services and guarantees. State is responsible for the accuracy, completeness and timeliness of all Plan Specifications, and acknowledges OptumRx's reliance on the Plan Specifications.

1.2 Pharmacy Network Administration

1.2.1 Pharmacy Network.

1.2.1.1. OptumRx will establish and maintain a network of pharmacies to provide the Services to the State ("**Pharmacy Network**"). OptumRx will make available to the State and its Members a current list of Network Pharmacies in the Pharmacy Network. Such list will be made available to Members via the OptumRx member portal or will be provided to Members in hardcopy upon their request. Additionally, call center representatives will provide Members with a list of Network Pharmacies in their area upon request.

1.2.1.2. OptumRx may add or remove Network Pharmacies from the Pharmacy Network subject to the terms of this Section. OptumRx will not remove a Network Pharmacy from the Pharmacy Network that impacts greater than 2% of the State's Prescription Drugs without communicating to the State at least ninety (90) days in advance of the scheduled change. If any change to the Pharmacy Network is not agreeable to the State, the State will have the right to terminate this Agreement without penalty with ninety (90) days' advance notice. OptumRx will offer improved pricing terms to the State if greater than 2% of Members are impacted by proposed changes to the Pharmacy Network. Additionally, if there is a decrease in the number or composition of OptumRx's Pharmacy Network, OptumRx will: (1) provide the State with an analysis showing the impact of the change in the Pharmacy Network to (a)



Members, (b) the Guaranteed Ingredient Cost Discounts, and (c) the Guaranteed Dispensing Fee; (2) allow the State to perform its own analysis; and (3) if the State (a) disagrees with OptumRx's analysis or the proposed change in the Guaranteed Ingredient Cost Discounts and Guaranteed Dispensing Fee, or (b) determines that the change to the Pharmacy Network is unacceptable, the State may terminate this Agreement without financial consequence (e.g., no loss of Rebates earned but not yet paid) upon sixty (60) days' notice.

1.2.1.3. OptumRx agrees to customize the Pharmacy Network, including the Retail 90 network, based on the State's specifications and needs with no additional charge.

1.2.1.4. OptumRx agrees to add Network Pharmacies to the Pharmacy Network to provide medication in bubble wrap/blister packaging to Members.

1.2.1.5. OptumRx will retain cash management responsibilities to help support prompt payment of Network Pharmacies.

1.2.2 Network Pharmacy Credentialing. OptumRx will establish and maintain a reasonable process for credentialing Network Pharmacies. OptumRx agrees that its contracts with participating pharmacies require participating pharmacies to be in compliance with all applicable local, state and federal laws and regulations and if a participating pharmacy is out of compliance with these contractual requirements (e.g. dispensing counterfeit drugs) the participating pharmacy would be subject to removal from the Pharmacy Network.

1.2.3 Standard Pharmacy Audit Services. OptumRx will, in accordance with its standard audit program and as required by Laws, conduct real-time and retrospective desk audits and selected on-site audits of the Network Pharmacies to determine whether the Network Pharmacies are submitting appropriate billings for payment by State or Members. OptumRx will report the results of the audits to State. OptumRx will credit the State 100% of any audit recoveries of the Pharmacy Network, including Home Delivery and Specialty Pharmacies. Any recoveries will be disclosed and credited to the State no less than annually. State will be financially responsible for all expenses incurred in connection with audits of Network Pharmacies requested by State that are not required by Laws. OptumRx will use commercially reasonable efforts to collect amounts owing as a result of these standard pharmacy audits.

1.2.4 Advanced Pharmacy Audit Services. OptumRx will, in accordance with its pharmacy audit program, provide advanced pharmacy audit services including designated audit staff, quarterly business reviews, and State-specific pharmacy audits to determine whether Network Pharmacies are submitting appropriate billings for payment by State or Members. OptumRx will report the State-specific results of the audits to State. OptumRx will pay State, or apply as a credit to invoices payable by State to OptumRx, the amounts OptumRx recovers from these audits.

1.3 **Prescription Claims Processor Fees**. OptumRx may retain any Prescription Claims processor or other fees received from Network Pharmacies in connection with the Prescription Drugs dispensed to Members under the Benefit Plans, including: (a) a per claim communications charge for on-line electronic claims processing by point-of-service communication; (b) a charge for each Prescription Claim submitted to OptumRx via paper, tape or a medium other than point-of-service communication; (c) surcharges for canceled or reversed claims; (d) a charge if a Network Pharmacy requests an evidence of benefits report in a tape medium and (e) charges for marketing and administrative services.



1.4 Prescription Claims Process

- 1.4.1 Prescription Claims Adjudication. OptumRx will adjudicate, process or pay Prescription Claims for Covered Prescription Services in accordance with the Plan Specifications. OptumRx will pay in accordance with Plan Specifications and applicable Laws, only Clean Claims (a) submitted by the Network Pharmacies in a timely manner through OptumRx's point-of-service system in accordance with NCPDP guidelines; and (b) properly submitted by Members as requests for reimbursement for Covered Prescription Services. For each Clean Claim submitted by a Network Pharmacy, OptumRx will reimburse the Network Pharmacy the amount specified in the Network Pharmacy Agreement for the dispensed Prescription Drug less any Cost-Sharing Amounts.
- 1.4.2 Delays. OptumRx will not be responsible for any loss, omission or delay of any Prescription Claim by a Network Pharmacy (other than OptumRx's Home Delivery Pharmacy or Specialty Pharmacy) or other health care professional.
- 1.4.3 Administrative Grievances and Appeals. At State's request, and subject to section 1.1.3, OptumRx will process initial Benefit Plan coverage determinations and exception requests and support State in connection with Benefit Plan appeals and grievances in accordance with Plan Specifications and this section 1.3 and to the extent required by Laws.
- 1.4.4 Prior Authorization Appeals.
- 1.4.4.1. OptumRx shall conduct first level appeals and will coordinate with third parties, including external review organizations, to conduct second level medical necessity appeals, as applicable, for the fees set forth in the Clinical Documentation Form. OptumRx will handle claims/appeals processing in accordance with requirements of ERISA as amended by the Patient Protection and Affordable Act (PPACA) unless otherwise agreed by the Parties.
- 1.4.4.2. OptumRx agrees to allow the State to be given access for at least five (5) of the State's staff members to enter Prior Authorizations for non-covered drugs approved for medical necessity.
- 1.4.4.3. OptumRx has a dedicated appeals staff and the State will have a single point of contact for appeals related inquiries.
- 1.4.5 OptumRx agrees to allow the State to override their individual plan rules (e.g. brand/generic/mail copayments, emergency prescriptions).
- 1.4.6 Inaccurate Payments. To the extent permitted by the Benefit Plans and OptumRx's Network Pharmacy contracts, and as otherwise permitted by Law, OptumRx shall use commercially reasonable efforts to offset the amount of any overpayment made to a Network Pharmacy due to OptumRx's error and credit the State accordingly. OptumRx will reimburse State or Members for the full amount of the overpayment by State or Members, respectively, when the overpayment was directly caused by OptumRx's negligence, recklessness, intentionally wrongful act or omission, or breach of this Agreement. OptumRx will promptly use commercially reasonable efforts to recover any overpayment made to a Network Pharmacy due to OptumRx's error. If OptumRx commences litigation to recover such amounts, then all expenses incurred by OptumRx with regard to such litigation shall be borne by OptumRx. If the overpayment is not the result of OptumRx's negligence, recklessness, intentionally wrongful act or omission, or breach of this Agreement, OptumRx shall provide written notification to State of the overpayment and documentation showing



the overpayment was not due to OptumRx's negligence, recklessness, intentionally wrongful act or omission, or breach of contract. For clarity, recoveries from Network Pharmacy audits will be handled in accordance with Section 1.2.3 of this Agreement.

1.5 Benefits Administration and Support

1.5.1 Utilization Management Program

1.5.1.1. Development and Support. OptumRx will implement and maintain all existing utilization management/clinical edits and all OptumRx standard utilization management/clinical edits at no additional charge to the State. The State may implement OptumRx's standard utilization management programs for the Benefit Plans designed to promote cost-effective drug utilization management and to discourage Prescription Drug over and under-utilization. OptumRx may, on behalf of State: (a) communicate with Members to describe health-related products or services (or payment for the products or services) provided by or included in the Benefit Plan through the Services, including communications about Network Pharmacies, replacement or enhancement to the Benefit Plan, and health-related products or services available only to Members that add value to and are not part of the Benefit Plan; (b) conduct population-based activities relating to improving the health of Members and reducing their healthcare costs; and (c) contact Members with health education information and information about Prescription Drugs, treatment alternatives, and related functions. Upon State's request and at an additional charge to State in accordance with the Clinical Documentation Form, OptumRx, in consultation with State, will develop non-standard utilization management policies, procedures, guidelines or programs for the Benefit Plans. Upon State's request, OptumRx will communicate State's utilization program requirements to Members through State-approved information and outreach materials.

1.5.1.2. OptumRx's Prior Authorization Services. OptumRx will respond to properly submitted prior authorization requests from providers, Members or pharmacies using utilization management standards and guidelines established in accordance with section 1.5.1.1 of this exhibit. State retains complete and exclusive discretionary authority over approval of prior authorization requests, including Benefit Plan overrides; however, to the extent that State overrides impact OptumRx's compensation, cost to provide Services, or ability to satisfy a guarantee under this Agreement, OptumRx may make mutually agreed upon changes to the Compensation. If a Member obtains an excluded prescription through a prior authorization, it will not impact the Rebate guarantees.

1.5.2 State Prior Authorization and Overrides. If State chooses to perform prior authorizations or benefit overrides, then OptumRx will provide State access to the information in OptumRx's computer systems that State needs to perform these functions.

1.5.3 Quality Assurance Program. OptumRx will implement its standard quality assurance program for the Benefit Plans that includes quality measures and reporting systems targeted at reducing medical errors and adverse drug interactions. In addition, OptumRx will develop and implement systems or require Network Pharmacies to implement systems to: (a) offer Member counseling, when appropriate; (b) identify and reduce internal medication errors; and (c) maintain up-to-date Member quality assurance and patient safety



program information.

- 1.5.4 Targeted Disease Intervention Program. Upon State's request and for an additional charge to State as referenced in the Clinical Documentation Form, OptumRx will help State develop and operate a targeted disease intervention program for the Benefit Plans that is designed to promote appropriate use of medications and improve therapeutic outcomes for targeted Members. OptumRx, on State's behalf, will coordinate and implement the targeted disease intervention program. Also, upon State's request and at an additional cost to State, OptumRx will communicate with Members about the targeted disease intervention program through State-approved information and outreach materials.
- 1.5.5 Changes Due to Shortages, Recall or Public Health and Safety Concern. In the event of a Prescription Drug shortage or recall or public health and/or other material safety concerns impacting or related to the distribution or dispensing of Prescription Drugs, OptumRx is authorized by State to make temporary clinically appropriate changes to the Formulary status and/or tiering of Prescription Drugs, days' supply limitations, Pharmacy Network access, utilization management programs or similar programs or initiatives to address such concerns. Prescriptions Drugs impacted by such changes shall be excluded from all financial and performance guarantees. Such changes shall cease as soon as administratively feasible following the cessation of the reason for which the changes were made.
- 1.5.6 Other Clinical Services. Upon State's request and for an additional charge to State, OptumRx will help State develop and implement additional quality initiatives, intervention programs or other clinical services.
- 1.5.7 OptumRx agrees to support pilot programs and other strategic State initiatives.

1.6 Formulary

- 1.6.1 Formulary Adoption. OptumRx agrees to grandfather the State's current formulary for the State's commercial line of business for up to ninety (90) days following the contract Effective Date; such grandfathering will not impact Rebate guarantees. Thereafter, the State will adopt as the Formulary one or more of OptumRx's formularies, including the Open Formulary, that are developed and maintained by OptumRx's Pharmacy & Therapeutics Committee.
- 1.6.2 Formulary Management. OptumRx will make the Member-facing Formulary document available to the State, Members, plan providers or other appropriate parties semi-annually via public portal, secure Member portal, and in hard-copy, if requested. Except as provided in this Agreement, State will not copy, distribute, sell or otherwise provide OptumRx's formularies, including the Formulary, to another party without OptumRx's prior written approval. The foregoing shall not prohibit the State from providing the Member-facing Formulary to Members or providers as required to implement the Benefit Plan.
- 1.6.3 Formulary Changes. OptumRx will include in the Formulary new FDA-approved medications as specified in the Plan Specifications according to the following schedule: (a) if an open formulary, all new covered FDA-approved medications (formulary and non-formulary) will be included in the Formulary upon publication in the Medi-Span pricing index and loading into OptumRx's systems; or (b) if a closed formulary (if selected by the State), all new covered FDA-approved medications (formulary only) will be included in the



Formulary after review and addition to the Formulary by OptumRx's Pharmacy & Therapeutics Committee. Prior to OptumRx's P&T Committee making semi-annual changes to the Formulary, OptumRx, at State's request, will provide or make available appropriate notifications of Formulary changes to State, Members, prescribing physicians, Network Pharmacies and state pharmaceutical assistance programs as required by Laws and agreed to by the parties; the foregoing notification requirement shall not apply with respect to Formulary changes made due to automatic additions or deletions in the Medi-Span pricing index. OptumRx agrees to remove drugs from coverage or the Formulary at most one-time per year and no greater than two percent (2%) of Members will be disrupted by any Formulary deletions or all deletions in total, on an annual basis. Up-tier Formulary changes are limited to twice per year, January 1 and July 1, unless due to new Generic Drug availability. OptumRx will provide the State with ninety (90) days' notice of negative Formulary changes, including negative up-tier changes; such notice will include a summary of customer-specific Member disruption.

1.6.4 Pharmaceutical and Therapeutics Committee. OptumRx's Pharmacy & Therapeutics Committee will develop and maintain OptumRx's formularies by: (a) selecting Prescription Drugs to include in OptumRx's formularies; (b) periodically reviewing OptumRx's formularies, evaluating new and therapeutically equivalent Prescription Drugs for inclusion in the formularies; (c) establishing programs and procedures to address cost-effective drug therapy; (d) reviewing requests to include non-formulary Prescription Drugs in OptumRx's formularies; (e) implementing client educational programs; (f) advising OptumRx on other matters about the use of Prescription Drugs; (g) overseeing drug utilization review programs or quality assurance programs or auditing and reviewing the programs' results; and (h) reviewing adverse drug reactions and making recommendations to minimize their occurrence. OptumRx's Pharmacy & Therapeutics Committee's functions, deliberations and results, including development and maintenance of OptumRx's formulary, constitute opinions only of OptumRx's Pharmacy & Therapeutics Committee and will not bind OptumRx.

1.7 Rebate Management

1.7.1 Rebate Eligibility. State authorizes OptumRx to contract with Drug Manufacturers for Rebates as a group purchasing organization. OptumRx, in its sole and absolute discretion, may enter into agreements for Rebates concerning Prescription Drugs on OptumRx's or any of its customers' formularies. Rebates are negotiated based upon OptumRx's book of business rather than a client-specific basis. Many factors affect the amount of Rebates, including benefit design, arrangements with Drug Manufacturers, volume of Prescription Claims, formulary structure, patent expiration, and OptumRx's overall business strategy. State understands that not all Brand Drugs and not all Prescription Drugs are eligible for Rebates, and OptumRx is not obligated to submit for Rebates Prescription Claims that it does not believe are eligible to receive Rebates.

1.7.2 Collection. OptumRx will use commercially reasonable efforts to collect Rebates. OptumRx will not be responsible for any non-payments or partial payments of amounts owing under an agreement for Rebates. OptumRx may, but is not required to, initiate collection action to seek to collect Rebates from a Drug Manufacturer. If OptumRx initiates an action to collect Rebates, OptumRx may offset against the Rebates any reasonable costs, including reasonable attorneys' fees and expenses, arising from any such action. To the extent of any overpayment or erroneous payment to State by OptumRx, State will refund immediately the payment or OptumRx may recoup the payment from other sums due State in accordance with section 3.6 of this Agreement. If requested, OptumRx will provide reporting



outlining any uncollected rebates specific to the State's utilization.

1.7.3 **Disbursement.** OptumRx will reconcile Rebate guarantees to verify that the State is receiving the guaranteed Rebates and provide Rebate payments and reports listing detailed Rebate utilization and calculations to the State quarterly, within sixty (60) days of the quarter's close, without a request being made by the State. OptumRx will provide the annual Rebate report to the State within sixty (60) days of the end of the Agreement year. Any shortfall between the actual result and the minimum Rebate guarantees will be paid, dollar-for-dollar, to the State within sixty (60) days of the end of the Agreement year. Lag Rebates will continue to be paid to the State until 100% of earned Rebates are paid.

1.7.4 **Other Pharmaceutical Relationships.** Nothing in this Agreement shall preclude OptumRx from pursuing other sources of revenue from Drug Manufacturers or engaging in other revenue-producing relationships with Drug Manufacturers. OptumRx and its affiliates may receive and retain, except as otherwise stated in this Agreement, payments from Drug Manufacturers for items and services provided. Additionally, OptumRx, in its capacity as a Home Delivery Pharmacy or a Specialty Pharmacy, purchases Prescription Drugs from wholesalers, and may also purchase Prescription Drugs directly from Drug Manufacturers for inventory purposes, and receives certain discounts in connection with these purchases. OptumRx retains these discounts and, in turn, provides the State aggressive discounts off AWP at mail and Specialty as set forth in the pricing exhibits of this Agreement.

1.8 **State Rebate Arrangements.** The State acknowledges that it will be eligible to receive Rebates under this Agreement only so long as the State, its affiliates, and its agents do not contract with a Drug Manufacturer, for a discount, utilization limit, rebate or other incentive associated with the utilization of a Prescription Drug. If the State negotiates or arranges with a Drug Manufacturer for Rebates or similar discounts, then OptumRx may, in addition to any other remedies available under this Agreement, adjust or eliminate any guarantees described in this Agreement. State will accept only amounts due under this Agreement on account of eligible Members. Upon request, State will cooperate fully with OptumRx or a Drug Manufacturer to verify State's participation in any Rebate program and that all Rebate-related payments were made solely for Covered Prescription Services to eligible Members.

1.9 **E-Prescribing.** Upon State's request and as set forth in the Clinical Documentation Form, OptumRx will provide prescribers with electronic access to Member Benefit Plan information, including: (a) Member eligibility status; (b) Member medication history; (c) Formulary status of the Prescription Drug being prescribed; (d) listing of Generic Drug or Brand Name Formulary alternative medications; (e) Member coverage information where applicable; (f) applicable Cost-Sharing Amount; and (g) drug classification information required by the Centers for Medicare & Medicaid Services or successor Governmental Authority.

2. HOME DELIVERY PHARMACY SERVICES

Home Delivery Services. Home Delivery Pharmacies will provide Home Delivery Pharmacy Covered Prescription Services to Members in accordance with the Plan Specifications for the Compensation established in this Agreement. Once a prescription for a Covered Prescription Service has been transmitted to a Home Delivery Pharmacy in accordance with Laws, such Home Delivery Pharmacy will promptly prepare, package and ship the applicable Covered Prescription Service to the Member or other authorized person or entity. Home Delivery will notify the individual Member or the State as soon as administratively possible prior to substituting products that will result in higher Member Cost-Sharing Amounts. Home Delivery Pharmacies will provide customer



service support for Members who use Home Delivery Pharmacy Services. Upon request, OptumRx will make available to State Home Delivery brochures for distribution to Members. OptumRx will be responsible for collecting any outstanding Member Cost-Share Amounts for Prescription Drugs dispensed through the Home Delivery Pharmacy. OptumRx will not invoice the State for any uncollected Member Cost-Share Amounts even if there is a debit threshold in place. OptumRx agrees to arrange and pay for expedited shipping of a Home Delivery prescription due to delays caused by OptumRx; this shall not include delays outside of OptumRx's control, including provider delays or drug shortages. In addition, OptumRx agrees that neither State nor a Member will be charged for any incremental shipping costs associated with expedited delivery as a result of such delays. OptumRx will ensure that it has the ability to: (i) override Home Delivery prescriptions and provide greater than three (3) month's supply for overseas travel/vacation; and (ii) override Home Delivery prescriptions and provide the drug from a Network Pharmacy if approved by State due to out of stock and/or back ordered medications.

2.1 **Control by OptumRx.** OptumRx will solely and exclusively control and supervise the operation and maintenance of OptumRx's Home Delivery Pharmacies and their respective facilities and equipment and provision of Home Delivery Covered Prescription Services. All decisions respecting the operation of Home Delivery Covered Prescription Services by OptumRx's Home Delivery Pharmacies will be made solely by OptumRx's Home Delivery Pharmacy and its duly authorized personnel, and not by State. The relationship between a Member and a Home Delivery Pharmacy will be subject to the rules, limitations and privileges incident to the pharmacist-patient relationship; for purposes of clarity, the foregoing shall not prohibit the Home Delivery Pharmacy from communicating with the State regarding a Member receiving Home Delivery Covered Prescription Services. OptumRx may exclude from coverage by a Home Delivery Pharmacy under this Agreement a Prescription Drug that cannot be dispensed under OptumRx's Home Delivery pharmacy dispensing protocols or requires special record-keeping procedures.

2.2 Home Delivery Rates.

2.2.1 Prices for Prescription Drugs dispensed by the Home Delivery Pharmacy are specified in the pricing exhibit. Specialty Drugs are not available at home delivery rates, even if dispensed by a Home Delivery Pharmacy. Postage, shipping and handling for OptumRx's standard shipping method, as well as alternative shipping methods required to provide access/delivery to Prescription Drugs from the Home Delivery Pharmacy to Members in rural/remote areas, are included in the pricing for Home Delivery and will not be subject to additional charges. Postage, shipping and handling for Prescription Drugs dispensed by the Home Delivery Pharmacy will not be increased for any increase in U.S. postage charges throughout the life of this Agreement. If a Member requests or requires expedited shipping or alternative shipping methods, other than those required to provide access to Members in rural/remote areas or due to OptumRx error, the Member will be solely responsible for those costs.

2.2.2 OptumRx will guarantee Retail/Home Delivery unit cost equalization meaning that Home Delivery unit costs prior to Member Cost-Sharing Amounts, dispensing fees, and sales taxes charged will be no greater than the unit cost for the same NDC-11 at Retail for each matching mail order generic prescriptions, adjusted for quantity and day supply. OptumRx will produce a date-sensitive comparison report showing unit costs charged to the state at a GPI-level, and reimburse the State on a dollar-for-dollar basis for all instances where mail order unit costs exceed retail unit's costs. Report and reconciliation will be provided on an annual basis, without a request being made by the State.

3. SPECIALTY PHARMACY SERVICES



3.1 **Specialty Services.** OptumRx will provide State with Specialty Drug Covered Prescription Services to Members as follows:

3.1.1 Exclusive Specialty Pharmacy Program. If State is part of OptumRx's Exclusive Specialty Pharmacy Program, State will receive Specialty Drug Covered Prescription Services exclusively from OptumRx's Specialty Pharmacy and not from any other retail, mail, specialty or other pharmacy, including a Network Pharmacy, provided that Limited Distribution Drugs not dispensed by OptumRx's Specialty Pharmacy are excluded from the Specialty Services or excluded from any Specialty Drug pricing guarantees.

3.1.2 Open Specialty Pharmacy Program. If State is part of OptumRx's Open Specialty Pharmacy Program, State will receive Specialty Drug Covered Prescription Services from a Network Pharmacy, including OptumRx's Specialty Pharmacy, and not from any other mail or specialty pharmacy, provided that Limited Distribution Drugs not dispensed by OptumRx's Specialty Pharmacy are excluded from the Specialty Services or excluded from any Specialty Drug pricing guarantees.

3.1.3 Postage, shipping and handling for OptumRx's standard shipping method is included in the pricing for the Specialty Pharmacy. Additionally, OptumRx guarantees access/delivery of fragile Specialty Drugs to Members in rural/remote areas, at no additional charge to the State. Postage, shipping and handling for Prescription Drugs dispensed by the Specialty Pharmacy will not be increased for any increase in U.S. postage charges throughout the life of this Agreement.

3.2 **New Specialty Drugs**

3.2.1 When feasible, the State will be provided at least ninety (90) days' prior notice of any new Prescription Drug that is identified and categorized by OptumRx as a Specialty Drug ("**New Specialty Drug**"). OptumRx will make available the New Specialty Drug to Members as part of the Specialty Drug Covered Prescription Services. During this period, State will compensate OptumRx for the New Specialty Drug at the default rate for New Specialty Drugs specified in the pricing exhibit. Upon OptumRx's notice to State, State will compensate OptumRx at the revised rate for the New Specialty Drug specified in OptumRx's notice to State.

3.2.2 On a periodic basis, OptumRx will review the Specialty Drugs covered under this Agreement. OptumRx will notify impacted Members at least ninety (90) days prior to any down-tier change to the Specialty Drug List. Upon request, OptumRx will make available to State the list of Specialty Drugs, including any New Specialty Drug. If State provides notice to OptumRx of rejection of any New Specialty Drug, OptumRx will provide the State with a financial impact analysis, if applicable, and make such change within 45 days of receipt of such notice, and State will have deemed to have custom Specialty Drug Covered Prescription Services and be subject to additional fees for administering such services.

3.2.3 State may not change the designation of whether or not a Prescription Drug is a Specialty Drug, unless the parties mutually-agree to such a change in writing, including the additional fees for the change in the scope of services.

3.2.4 The State will not be responsible for any Member Cost-Share owed to OptumRx through the Specialty Pharmacy. Collecting such fees will be the responsibility of OptumRx.



3.2.5 The State may limit Specialty Drug Prescription Claims to a 30-day supply (including those dispensed by OptumRx Specialty Pharmacies), with no modifications to the pricing terms.

3.3 **OptumRx Control.** OptumRx will solely and exclusively control and supervise the operation and maintenance of OptumRx's Specialty Pharmacies and their respective facilities and equipment and provision of Covered Prescription Services. All decisions respecting the provision of Covered Prescription Services by OptumRx's Specialty Pharmacies will be made solely by OptumRx and its duly authorized personnel, and not by State. The relationship between a Member and a Specialty Pharmacy will be subject to the rules, limitations and privileges incident to the pharmacist-patient relationship.

4. IMPLEMENTATION

4.1 **SPD Support.** OptumRx will provide draft SPD language for any clinical programs that are to be implemented.

4.2 **Loading of Plan Files.** OptumRx will load all current prior authorizations (commercial), open mail order refills (commercial and EGWP), specialty transfer files (commercial), claims history files (commercial and EGWP) and accumulator files (commercial and EGWP) that exist for current members from the existing PBM at NO charge to the state (with no charges being deducted from the implementation allowance for file loading or IT).

4.3 **Data Analytics Vendors.** OptumRx agrees to provide weekly and/or monthly data transmissions (may include feeds to data warehouses) to any qualified health data analytics vendors at no charge and two full, annual electronic claims files, in NCPDP format, at no charge as needed. OptumRx will also interact/exchange data with all vendors as needed at no additional charge.

4.4 **Third Party Administrator Connection.** OptumRx agrees to waive any charges to the State or the State's medical plan claims administrators such as a set-up fee, a programming fee or a monthly fee, for establishing a connection with a Third Party Administrator/Claims processor for real-time, bidirectional data integration, including non-standard data integration formats.

4.5 **Third Party Coordination.** OptumRx will coordinate clinical management with the State's medical administrator, wellness and disease management vendor, and any other vendor or administrator the State contracts with to provide services for its Members health administration and management services. Additionally, upon request by the State, OptumRx will design exports to the FSA vendor to process FSA claims based off medical claim data files.

5. MEMBER AND ACCOUNT SERVICE

5.1 **Designated/Dedicated Account Resources.** OptumRx will provide dedicated account resources including, but not limited to, a dedicated account executive, clinical pharmacist, account manager, claims advocate and financial analyst, and assuming the State decides to proceed with EGWP on 1/1/2019, with a separate designated team for the enhanced EGWP. The account manager shall be available to respond to State needs, questions, and/or issues. The State must approve a change in account manager in its reasonable discretion. In all cases, State reserves the right to interview the proposed replacement personnel and, at State's sole reasonable discretion, to refuse the proposed replacement personnel.

5.2 **OptumRx Call Center.**



5.2.1 **Call Recordings.** OptumRx agrees to document 100% of the State's Member service calls through call recordings and call notes. Upon request, OptumRx will provide call recordings to the State for review. In addition, OptumRx will forward written transcripts of applicable calls at the State's requires within two (2) business days of the request being made.

5.2.2 **Call Center Meeting.** OptumRx agrees to a minimum of one annual meeting with call center executives to discuss services regarding enrollment and Member issues.

5.2.3 **Call Center Locations.** OptumRx agrees that that they will use call centers located within the United States (no outsourcing to non-U.S. based locations) for all the State's Members. OptumRx call center will be configured to provide services based on Alaska Standard Time.

5.3 System Access.

5.3.1 OptumRx will have system access security processes with Members, providers and the State.

5.3.2 OptumRx agrees to allow the State access to its Member website with a dummy login prior to the go-live date.

5.3.3 OptumRx will provide the State with a virtual tour of its CSR system and any custom messaging system.

5.3.4 OptumRx agrees to provide online, real-time, claim system access to the State or its designee, including access, to historical claims data and eligibility data for up to three (3) years following termination of the agreement.

5.3.5 OptumRx agrees that all future edits required because of plan design changes implemented by the State shall be completed, after testing, by the PBM within 30 days of receiving notice unless agreed to by the state, at no additional charge.

5.4 **Member Service Issues.** OptumRx agrees to ad-hoc calls with the State to review Member service issues. OptumRx agrees to allow the State to review member service quality issues to the resolution endpoint. In addition, OptumRx agrees to, at a minimum, quarterly in-person meetings with the account team, to review overall performance and trends.

5.5 **Major Changes.** Major changes to organizational structure or outstanding legal action against OptumRx and/or owners, if any, will not disrupt business operations.

6. INFORMATION TECHNOLOGY

6.1 **Maintenance of Data.** OptumRx shall maintain the identified State's list of data elements necessary to meet the State's claims review and reporting requirements.

6.2 Provision of Data.

6.2.1 OptumRx shall provide all necessary data for the State to comply with or participate in programs (whether optional or mandated) implemented as part of any local, state or federal government health care reform legislation. Required data shall be provided at no additional cost to the State. This includes future program options such as enhanced EGWP or wrap plans that the State determines are advantageous to the State, if benefit plan and/or membership decide to participate.



6.2.2 OptumRx must make all data available in a State-approved electronic format. In addition, all schemata and file definitions must be made available to the State upon request.

6.2.3 OptumRx will release detailed claims data to the State's data warehouse.

6.3 **System, Programming or Transfer Issues.** Upon determination and identification of system problems, programming problems, or transfer problems, OptumRx shall notify the State immediately upon identification of any issue. OptumRx shall also make every effort necessary to correct such problem immediately or as soon as possible, including but not limited to: working nights, weekends, and holidays, to minimize any negative impact to employees, retirees, or dependents and to maintain continual operations of the program.

6.4 **Disaster Recovery Plan.** OptumRx has a Computer Disaster Recovery Plan and will provide their most recent outside assessment of readiness upon request.

6.5 **Third Party Data Transmissions.** OptumRx will accept data transmissions from designated state vendors and agrees there will be no additional fees, unless outlined in the Administrative Fee table in the cost proposal, to establish the interface and/or any other IT services in the initial set-up or to accept changes to the file layout during the term(s) identified as part of the award. OptumRx will reconcile each data feed and work with the appropriate vendors to keep the data accurate and consistent among all parties, at no additional cost to the State. In addition, OptumRx will work with the State and its respective vendors to identify opportunities to improve data transmission requirements that will result in improved operational efficiencies and program effectiveness.

6.6 **System Capabilities.** OptumRx's data processing system has the ability to interface with the State's health reporting eligibility system. OptumRx's data processing system allows the State to assign different levels of access internally.

7. COORDINATION OF BENEFITS

7.1 OptumRx will coordinate COB information electronically with other vendors such as the medical provider, dental network, and health management provider, for their use in coordinating benefits.

7.2 OptumRx PBM will maintain internal coordination when a claimant is covered under more than one state benefit plan such as being covered as the member and also as a dependent.

7.3 OptumRx will store COB history online for three (3) years and, at State's request, will electronically transfer such history to State at the end of OptumRx's retention period for such data.

7.4 OptumRx will maintain COB administrative procedures to ensure all Prescription Claims are paid consistently with the correct order of benefit determination.

7.5 OptumRx will perform an annual validation process to identify other health insurance coverage requirements.

7.6 OptumRx will maintain edits in its system to identify potential COB cases on a continual basis.

7.7 OptumRx will maintain computer edit checks or triggers to initiate COB.



- 7.8 Medicare COB: OptumRx will maintain an electronic system to allow Medicare Part B claims filed with the Medicare carrier to automatically coordinate (crossover) with the retiree plans so that retirees are not required to submit secondary Part B claims to this plan.

8. LEGAL RESPONSIBILITIES

- 8.1 **Compliance with Laws.** OptumRx will comply with all Laws applicable to its respective business and the performance of its obligations under this Agreement, including the following:
- 8.1.1 OptumRx is compliant with the Electronic Data Interchange (“EDI”), Privacy and Security Rules of the Health Insurance Portability and Accountability Act (“HIPAA”).
- 8.1.2 OptumRx is in compliance with and will administer the proposed benefit plan(s) in accordance with all applicable legal requirements, including, but not limited to the ACA, HIPAA, COBRA, ERISA, and state and local mandates.
- 8.1.3 OptumRx will respond to and incorporate future health care reform changes and future Affordable Care Act requirements as committee to in the RFP at no additional cost to the State.

9. TERMINATION REQUIREMENTS

- 9.1 **Market Check.** OptumRx agrees to a mid-contract term market check, that may start as soon as the second quarter of the second contract year to ensure the State is receiving appropriate current pricing terms competitive with the industry (as compared to other PBMs) based on its volume and membership and will improve pricing in the event that the State's contract terms are less than current. The State will have the right to terminate without penalty if the pricing terms are not industry competitive. The market check shall be based upon the same financial assumptions as this Agreement, including plan design and scope of pharmacy benefit management services, and the market check will be based upon substantially similar clients in size and market as the State. Substantially similar clients include those with a similar number of enrolled individuals and comparable demographics (e.g., age, sex, and geographic location), utilization patterns, Prescription Claim volume, and call volume. Substantially similar pharmacy benefit management services include those covering similar lines of business (e.g., commercial, Medicaid, Medicare) and types of services (e.g., retail, home delivery, and specialty); and those based upon similar assumptions (e.g., formulary and network attributes, service levels, and contract term comparable to the remaining Term of this Agreement). Any improvements to current pricing resulting from the parties' negotiations will be effective as of the next anniversary of the Effective Date unless otherwise agreed to by the parties, and upon execution of an amendment to this Agreement. If the State does not agree to any resulting pricing improvements after good faith negotiations, the State may terminate this Agreement upon 90 days prior notice of termination, without penalty.
- 9.2 **Rebate Payment Post Termination.** All Rebate revenue earned by the State will be paid regardless of its termination status as a client. All earned but lagged Rebates will continue to be paid to the State after termination until 100% of earned Rebates are paid.



- 9.3 **Transition Information.** OptumRx will send at least twelve (12) months of claims history data, all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for the State's Members to any successor PBM at no charge if the State terminates the contract with or without cause.
- 9.4 **Run Out Claims.** OptumRx shall be responsible to process only those Claims that are for prescriptions dispensed before the termination date and received by OptumRx from pharmacies and/or Members up to twelve (12) months after the termination date. Services will include appeals support for claims incurred during the service period and submitted within the run out period.
- 9.5 **Termination Events.**
- 9.5.1 Termination For Convenience. State may terminate this Agreement upon ninety (90) days' prior written notice to OptumRx. Termination of this agreement will not change, relieve or release OptumRx from providing the pricing discounts and rebate guarantees represented in this Agreement to State.
- 9.5.2 Termination For Cause. Either State or OptumRx may terminate this Agreement, at any time, upon not less than sixty (60) days' written notice if: (1) the other party makes an assignment for the benefit of creditors, is the subject of a voluntary or involuntary petition for bankruptcy or is adjudged to be insolvent or bankrupt, or a receiver or trustee is appointed for any portion of its property; or (2) the other party commits a material breach of this Agreement, unless the breach is cured prior to the expiration of such notice.

10. AUDIT RIGHTS

- 10.1 The State or its designee will have the right to audit annually upon thirty (30) days' notice, with an auditor of their choice, (for both Prescription Claim and Rebate audits), with full cooperation of OptumRx, the Prescription Claims, Services and pricing and/or Rebates, including the manufacturer rebate contracts held by OptumRx, to verify compliance with all program requirements and contractual guarantees, at no additional charge from OptumRx.
- 10.2 The State or its designee will have the right to audit up to 36 months of Prescription Claims data at no additional charge from the OptumRx.
- 10.3 The plan sponsor or its designee will have the right to conduct an audit at any time during the year, at any point during the contract term, and OptumRx will provide all documentation necessary to perform the audit.
- 10.4 OptumRx will provide complete Prescription Claims files and documentation (i.e., full Prescription Claims files, financial reconciliation reports, inclusion files, and plan documentation) to the auditor within 30 days of receipt of the audit data request as long as a reasonable non-disclosure agreement is in place between the auditor and OptumRx.
- 10.5 OptumRx agrees to a 30-day turnaround time to provide the full responses to all the sample Prescription Claims and Prescription Claims audit findings.
- 10.6 The State or its designee will have the right to audit at least 12 pharmaceutical manufacturer contracts during an on-site rebate audit. Any third party that is auditing OptumRx's pharmaceutical manufacturer contracts must be mutually agreed upon.
- 10.7 The audit provision shall survive the termination of the Agreement between the parties for a period of three (3) years.
- 10.8 The State will not be held responsible for time or miscellaneous costs incurred by OptumRx in association with any audit process including, all costs associated with provision of data, audit



finding response reports, or systems access, provided to the State or their individual designees by OptumRx during the life of the contract.

- 10.9 OptumRx agrees to allow a Pre-Implementation Audit to be conducted at least sixty (60) days prior to the start of claims adjudication. OptumRx will work with the auditor to run test claims in a test environment utilizing the State's actual plan parameters. The test environment will mirror the live environment.
- 10.10 OptumRx agrees to allow the State or their agent, to audit performance guarantees in accordance with the terms of this Section.

11. PAYMENT

- 11.1 **Payment Terms.** OptumRx will invoice the State for Prescription Claims and for administrative fees at semi-monthly billing cycles that run from the 1st through the 15th and from the 16th through the end of the month. OptumRx will submit invoices to the State that reflect the Services performed during the invoice period and include Prescription Claims information to support the invoiced amounts at no charge. The State will pay OptumRx all undisputed invoiced amounts, via electronic fund transfer or other reliable means, no later than two (2) business days, as determined by the Alaska calendar, after Client receives the invoice and supporting claims detail file ("**Payment Due Date**").
- 11.2 **Invoice Disputes.** If the State disputes all or a portion of any invoice, the State will pay the undisputed amount by the Payment Due Date and notify OptumRx, in writing, of the specific reason and amount of any dispute before the due date of the invoice. OptumRx and the State will work together, in good faith, to resolve any invoice dispute. Upon resolution, the State or OptumRx will remit the amount owed to the other party as the parties agree based on the resolution.
- 11.3 **Payment Disputes.** In the event of a dispute between the parties, about the payment or entitlement to receive payment, or any administrative fees hereunder, OptumRx and the State shall endeavor to meet and negotiate a reasonable outcome of said dispute. In no event will OptumRx undertake unilateral offset against any monies due and owed to the State, whether from Rebates, credit adjustment or otherwise.
- 11.4 **Payment Default.** If the State fails to pay any amount due on a validly submitted invoice (for which no dispute is filed) within two (2) business days, determined by the Alaska calendar, after the applicable Payment Due Date and fails to make such payment within three (3) business days, determined by the Alaska calendar, after OptumRx's notice to the State of such non-payment (notice may occur via email and/or telephone call), then OptumRx shall have the right to suspend performance of any or all of OptumRx's obligations under or in connection with this Agreement, including processing of Prescription Claims.

12. MISCELLANEOUS

- 12.1 **Responsibility for Services.** OptumRx will be completely responsible for all Services that OptumRx and its officers, employees, directors, principals, representatives, subsidiaries, affiliates, agents, partners, assigns, successors, and subcontractors are required to perform under the Agreement and will specifically assume all liability for any and all such Services provided by officers, employees, directors, principals, representatives, subsidiaries, affiliates, agents, partners, assigns, successors, and subcontractors hired by OptumRx. OptumRx shall be



liable for any violation of the Agreement by any of its officers, employees, directors, principals, representatives, subsidiaries, affiliates, agents, partners, assigns, successors, and subcontractors.

12.2 **Merger and Acquisitions Notice.** Without contravening applicable law, OptumRx warrants and represents that it shall notify State immediately upon the public announcement of reaching any form of binding agreement in connection with and prior to any merger, acquisition, business reorganization, or other material change of OptumRx's management, ownership or business structure or similar change of control. State agrees to maintain the confidentiality of such information to the extent permitted under Alaska law.

12.3 **Entire Contract.**

12.3.1 The parties hereto acknowledge and agree that, in connection with the Benefit Plan, State issued an initial RFP and thereafter, issued a series of additional information requests and additional clarifying questions (together, the "RFP"). OptumRx submitted its initial and subsequent responses to the RFP, including, but not limited to a "Clarification Document" (together, the "RFP Response") to State. Therefore, this Agreement consists of this document, and the exhibits and appendices hereto, the RFP, and the RFP Response. This Agreement contains the final, complete, and exclusive understanding of the parties hereto. This Agreement shall supersede all prior contemporaneous agreements, understandings, representations, and negotiations, whether written or oral, between the parties hereto relating to the subject matter of this Agreement. The parties hereto further agree that this Agreement may not in any way be explained or supplemented by prior or existing course of dealings between the parties hereto, by usage of trade or custom, or by any prior performance between the parties hereto pursuant to this Agreement or otherwise.

12.3.2 OptumRx represents and warrants that the statements and representations made and information submitted to State prior to the selection of OptumRx to provide the Services specified herein, including those in the RFP Response, as defined above, or those made during the negotiation of this Agreement, were true and accurate in all material respects when OptumRx submitted such statements, representations and information. OptumRx acknowledges that State relied on such statements, representation, and information in selecting OptumRx and when entering into this Agreement.

12.3.3 If there is a conflict between the provisions of this document (together with its exhibits and appendices) and any provision in the RFP or RFP Response, the provisions of this this document (together with its exhibits and appendices) shall prevail. If there is a conflict between the provisions of the RFP and the RFP Response such that the provisions of the RFP Response cannot be reconciled with the RFP, the provisions within the RFP shall prevail over the RFP Response.



SCHEDULE OF DEFINITIONS

EXHIBIT B

SCHEDULE OF DEFINITIONS

Capitalized terms used in this Agreement are defined below or elsewhere in this Agreement.

"ACA" means the Patient Protection and Affordable Care Act of 2010, as amended.

"AWP" means the average wholesale price, as reflected on the Pricing Source, of a Prescription Drug or other pharmaceutical products or supplies based on the NDC of the Prescription Drug dispensed. AWP is based on date sensitive, 11-digit NDC as supplied by a nationally-recognized pricing source (i.e., Medi-Span) for retail, mail order, and specialty adjudicated Prescription Claims. The State will be notified of any switch to the source of the aggregate AWP with at least a 180-day notice. In the event that a switch is made, it must be price neutral to the State. In the event a switch is made that is not price neutral, the State will have the right to terminate the Agreement with no penalty.

"Benefit Plan" means the benefit plan sponsored by Client that includes the prescription drug benefit for Members as reflected, under which Client is obligated to provide Covered Prescription Services.

"Clean Claim" means a Prescription Claim prepared in accordance with the NCPDP-promulgated standard format that contains all information necessary for processing for a Prescription Claim and submitted for payment no later than one hundred eighty (180) days after the date of service, or a longer period of time if required by Laws.

"Clinical Documentation Form" means the document describing the clinical services elected by Client to be provided by OptumRx as mutually agreed to by the Parties.

"COBRA" means the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Compound Prescription Drug" means a Prescription Drug that is prepared by a pharmacist who mixes or adjusts one or more Prescription Drugs and other ingredients to customize a medication to meet a Member's individual medical needs.

"Cost-Sharing Amount" means the coinsurance, copay, deductible or other cost sharing amount, either a specified dollar amount or a percentage of eligible expenses, that a pharmacy may collect from a Member for Covered Prescription Services in accordance with the Member's Benefit Plan. Members will



pay the lowest of the following: Cost-Sharing Amount, plan-negotiated discounted price plus dispensing fee, usual and customary (U&C), MAC (maximum allowable cost) or retail cash price.

“Covered Prescription Services” means Prescription Drugs or other pharmaceutical products, services or supplies dispensed by a pharmacy to a Member for which coverage is provided in accordance with the Member’s Benefit Plan.

“DOL” means the United States Department of Labor.

“Drug Manufacturer” means an entity that manufactures, sells, markets or distributes Prescription Drugs; provided “Drug Manufacturer” shall not include wholesalers engaged in the sale and distribution of Prescription Drugs.

“ERISA” means the Employee Retirement Income Security Act, as amended, 29 U.S.C. § 1001 *et seq.*

“FDA” means the United States Food and Drug Administration or any successor Governmental Authority.

“Formulary” means the list of Prescription Drugs covered by the applicable Benefit Plan as developed by OptumRx and approved and adopted by Client for use with the Benefit Plans. The Formulary will be made available to physicians, pharmacies and other healthcare persons or entities to guide the prescribing, dispensing, sale and coverage of Covered Prescription Services.

“Generic Drug” means a Prescription Drug, whether identified by its chemical, proprietary or non-proprietary name, that is therapeutically equivalent and interchangeable with a Prescription Drug having an identical amount of the same active ingredient(s) and approved by the Federal Drug Administration (FDA). For purposes of this Agreement, the Generic Drug determination is made based upon indicators included in the Pricing Source. Administrator labels drugs as generics when Medi-Span has a generic indicator of “Y”. Drugs with “M”, “N” or “O” will be classified as brand drugs.

“Governmental Authority” means the Federal government, any state, county, municipal or local government or any governmental department, political subdivision, agency, bureau, commission, authority, body or instrumentality or court that regulates the applicable party’s activities or operations. The State of Alaska as a party to this Agreement shall not be deemed a Governmental Authority for purposes of this definition, unless it is acting in its regulatory capacity.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“HHS” means the United States Department of Health and Human Services.

“Home Delivery Pharmacy” means a facility that is duly licensed to operate as a pharmacy at its location and to dispense Prescription Drugs via postal or commercial courier delivery to individuals, including Members. Home Delivery Pharmacy includes pharmacies that OptumRx, or its affiliates, owns or operates.

“Laws” means all applicable common law and any and all state, Federal or local statutes, ordinances, codes, rules, regulations, restrictions, orders, procedures, standards, directives, guidelines, instructions, bulletins, policies or requirements enacted, adopted, promulgated, applied, followed or



imposed by any Governmental Authority, as amended, modified, revised or replaced, interpreted or enforced by any Governmental Authority, as applicable to each respective party.

“Limited Distribution Drugs” means Specialty Drugs which are distributed to either one or a very limited number of pharmacies, distributors or wholesalers.

“MAC” means the maximum allowable cost of a Prescription Drug as specified on a list established by OptumRx.

“Manufacturer Administrative Fees” means the administrative fees paid by Drug Manufacturers to OptumRx for OptumRx’s provision of Rebate administration services.

“Member” means all eligible participants and their eligible dependents enrolled under the State’

“NCPDP” means National Counsel for Prescription Drug Programs.

“NDC” means the 11-digit National Drug Code that is the identifying Prescription Drug number maintained by the FDA.

“Network Pharmacy” means a retail pharmacy, Home Delivery Pharmacy, Specialty Pharmacy or other facility that is duly licensed to operate as a pharmacy at its location and to dispense Prescription Drugs to individuals, including Members, and for third-party pharmacies, have entered into a Network Pharmacy Agreement. OptumRx, through its affiliates, in their capacity as Home Delivery Pharmacies or Specialty Pharmacies are Network Pharmacies.

“Network Pharmacy Agreement” means the Agreement between a Network Pharmacy and OptumRx or Client to provide Covered Prescription Services.

“Paid Claim” means all transactions made on eligible Members that result in the payment to pharmacies or Members from the State or the State’s Member Cost-Sharing Amounts. The term does not include reversals, rejected claims and adjustments. Each unique Prescription Claim that results in payment shall be calculated separately as a Paid Claim.

“Pharmacy & Therapeutics Committee” means the committee formed by OptumRx or Client that reviews a legend drug for inclusion on the Formulary and creates criteria, policies and procedure for such inclusion including, but not limited to, clinically-appropriate quantity restrictions, step therapies and prior authorizations.

“PHI” means any information Administrator receives or provides on behalf of the Benefit Plan that is considered Protected Health Information, as defined in the privacy regulations of the Health Insurance Portability and Accountability Act of 1996.

“Plan Specifications” means Client’s requirements for its Benefit Plan that OptumRx needs to carry out its obligations under this Agreement as reflected in OptumRx’s plan design document and approved in writing by both parties, including written Benefit Plan descriptions, Member eligibility and identification requirements, benefit definitions, Formulary, Pharmacy Network, utilization management programs, applicable Cost-Sharing Amounts, number of days’ supply for acute and maintenance medications, dispensing and other limitations, manuals and other Benefit Plan or Member information.

“Prescription Claim” means a single request for payment for, or a bill or invoice relating to, a Covered Prescription Service that a Network Pharmacy, other health care provider or Member submits, whether the request, bill or invoice is paid or denied.



"Prescription Drug" means a Generic Drug or Brand Drug that is approved by the FDA and required under Laws to be dispensed only as authorized by a written or oral order to dispense a Prescription Drug by an appropriately licensed and qualified health care professional in accordance with Laws.

"Pricing Source" means the Medi-Span Prescription Pricing Guide (with supplements) or another nationally recognized pricing source determined by OptumRx and agreed upon by the State.

"Prior Authorization" means a prospective review to verify that certain criteria required by State are satisfied for specific Covered Prescription Services prior to processing the claim for such Covered Prescription Services.

"Rebate" [Redacted]

"Specialty Drugs" [Redacted]

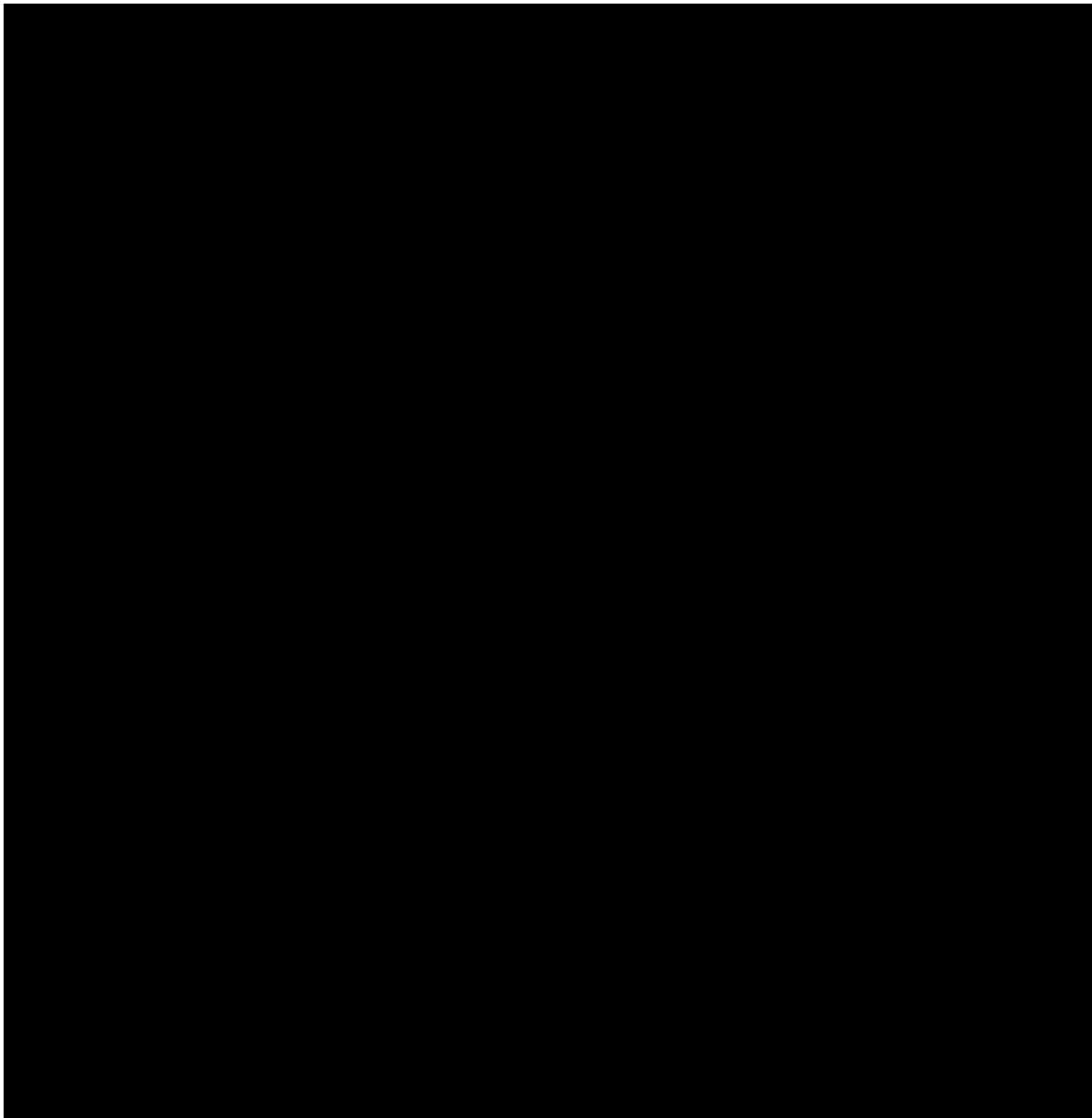
"Specialty Pharmacy" means a facility that is duly licensed to operate as a pharmacy at its location and to dispense Specialty Drugs to individuals, including Members. Specialty Pharmacy includes pharmacies that OptumRx owns or operates.

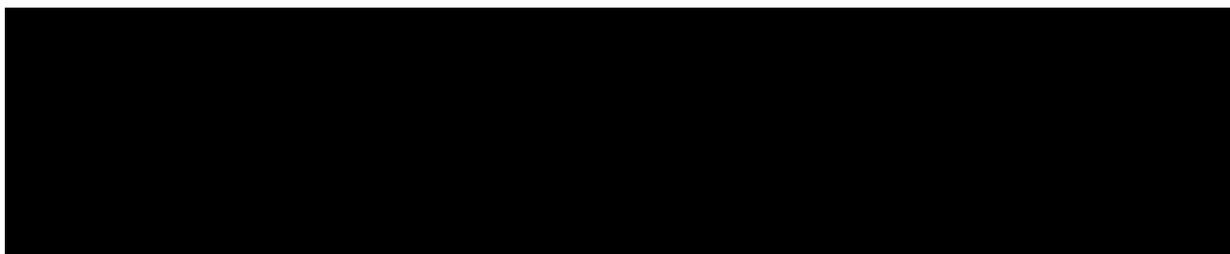
"Usual and Customary Charge" means the price, including all applicable customer discounts, such as special customer, senior citizen and frequent shopper discounts, that a cash paying customer pays a pharmacy for Prescription Drugs.



**CREDITS AND ALLOWANCES- CONFIDENTIAL, PROPRIETARY AND
TRADE SECRET INFORMATION**

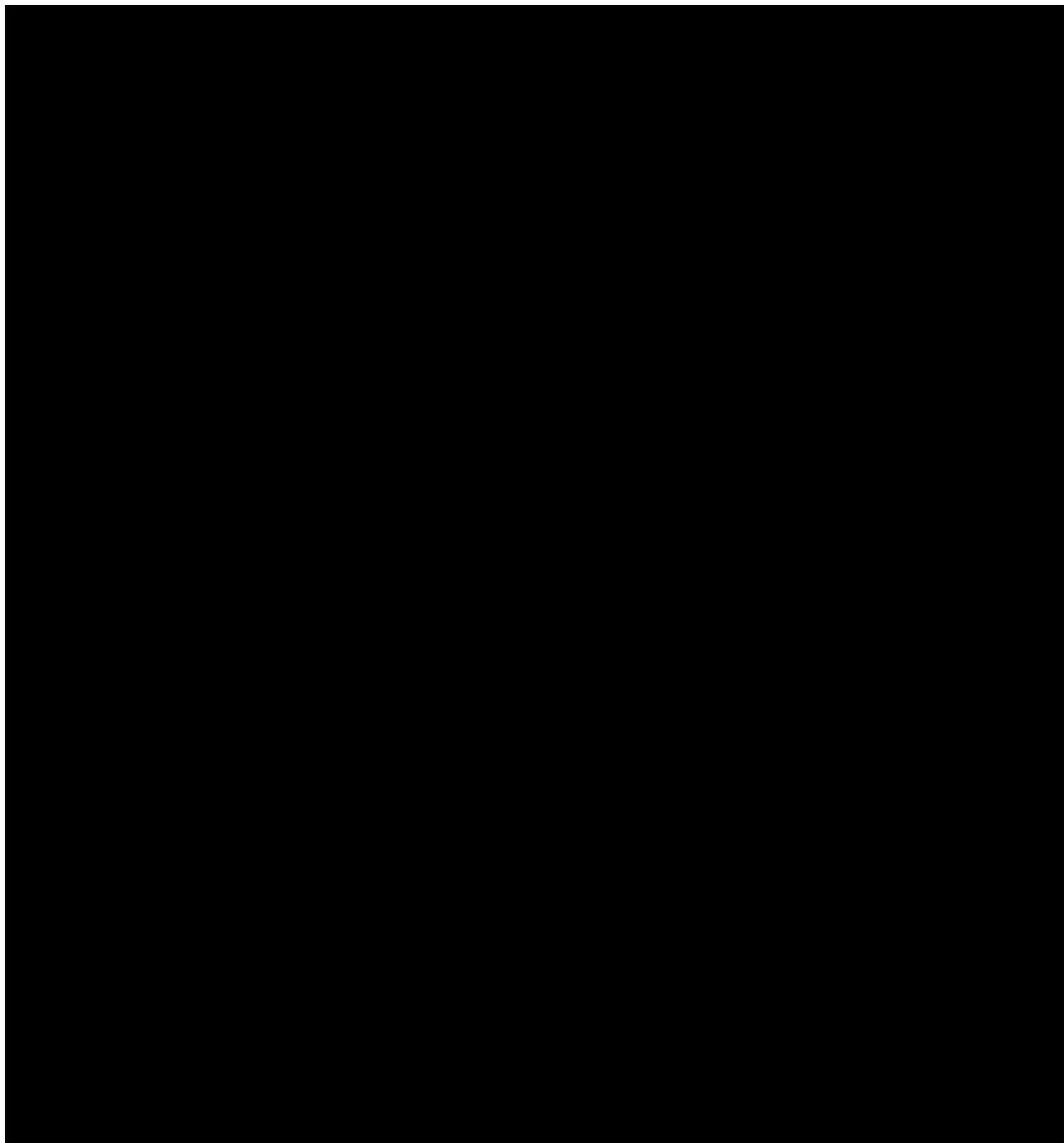
EXHIBIT C

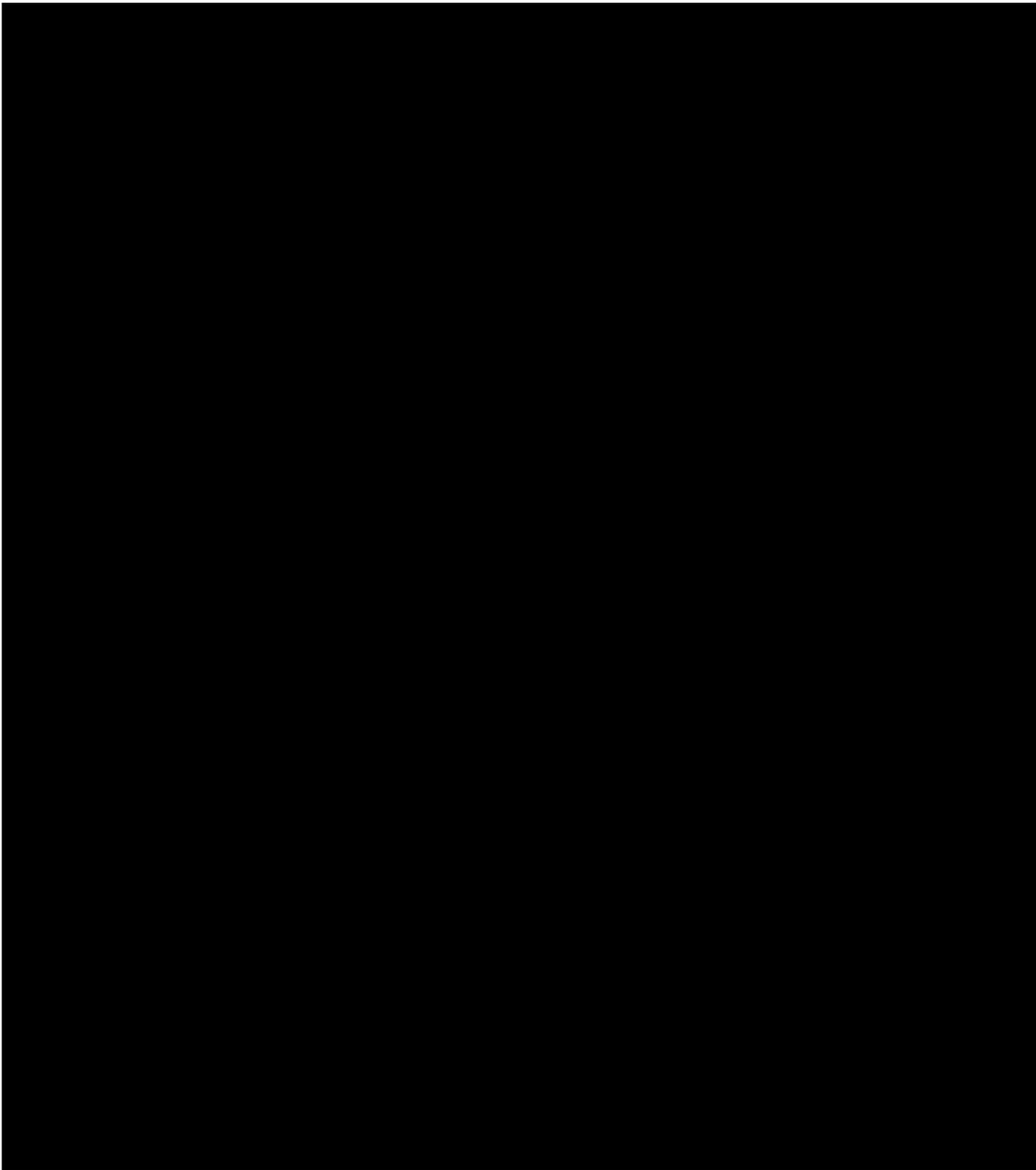


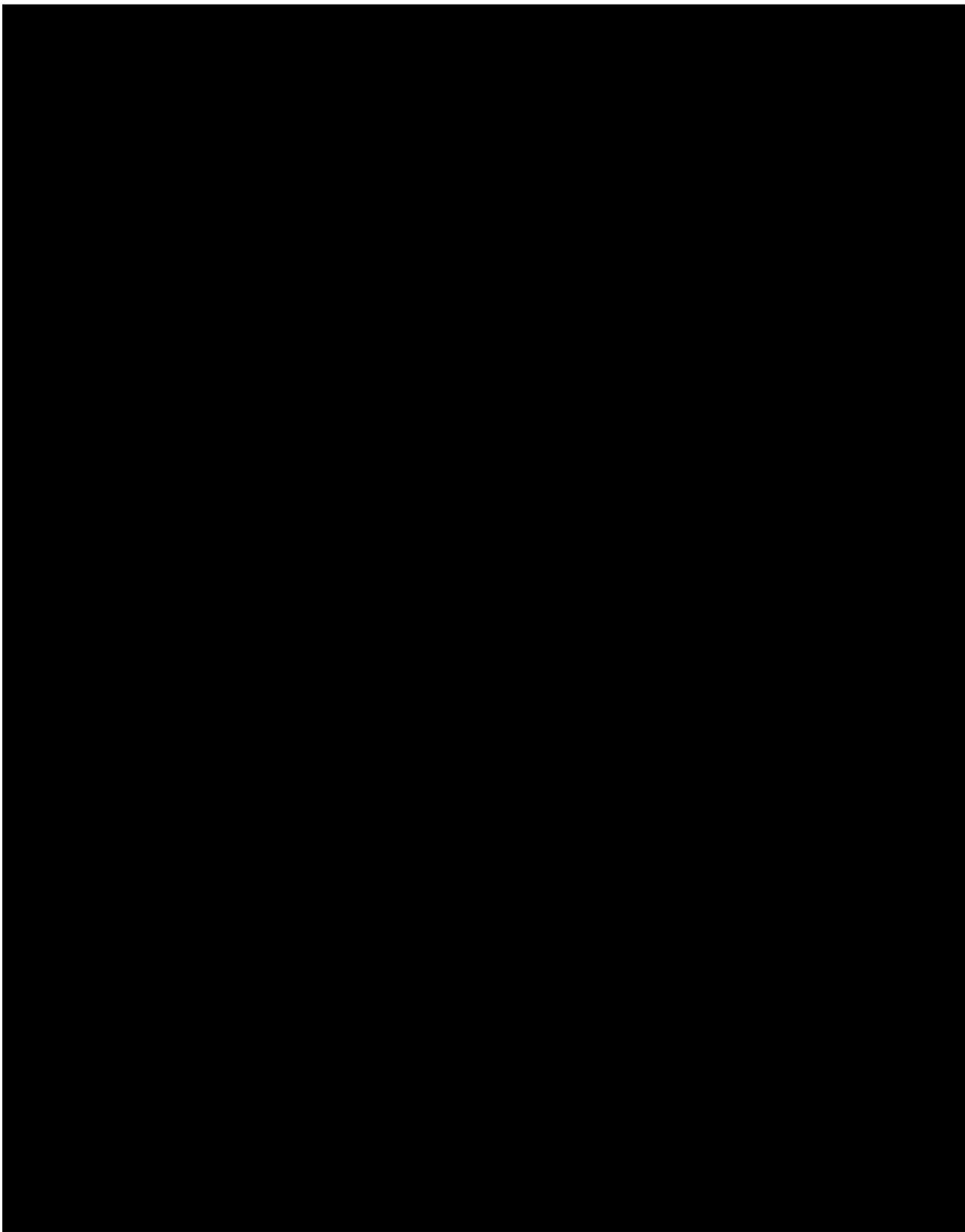


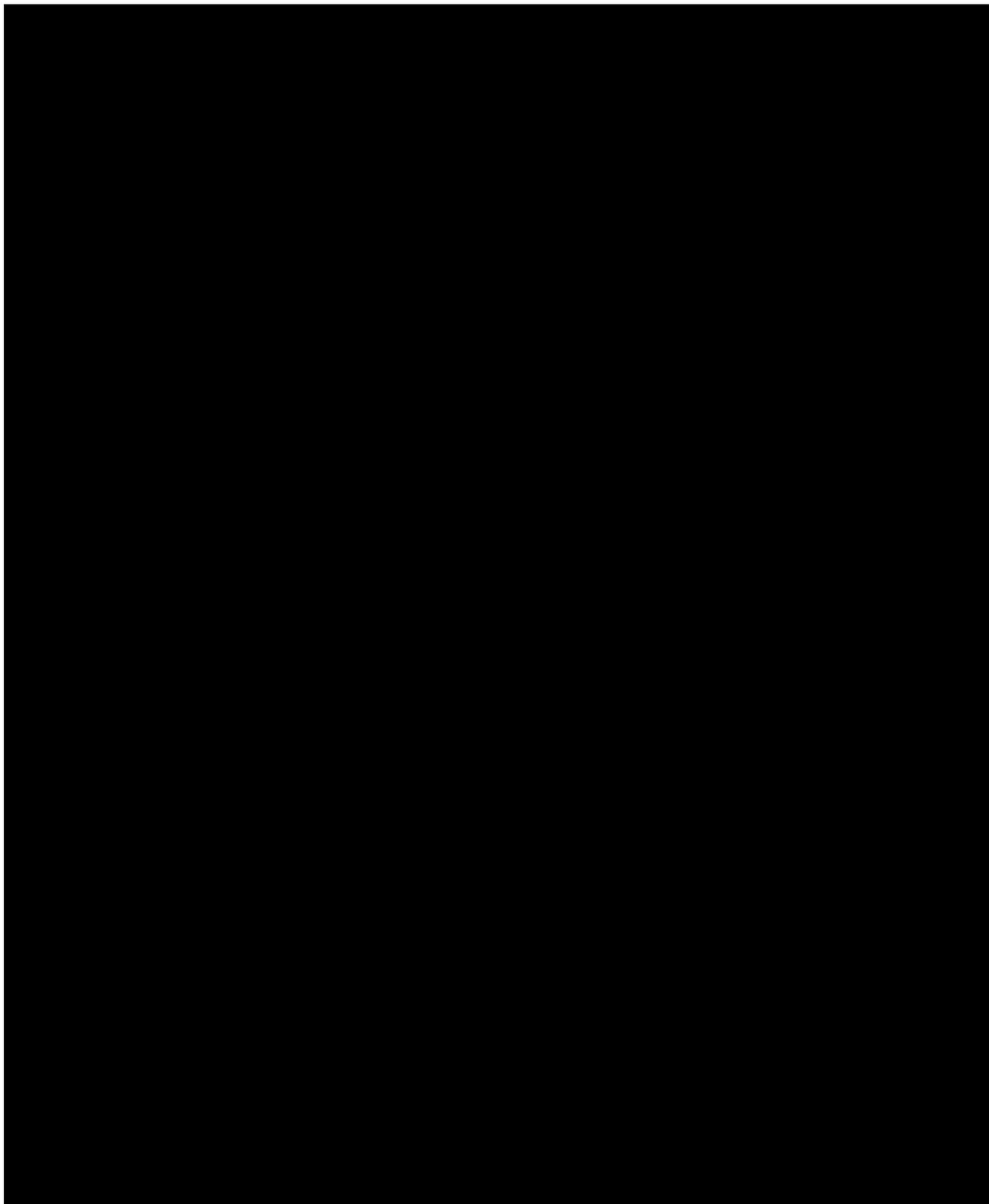


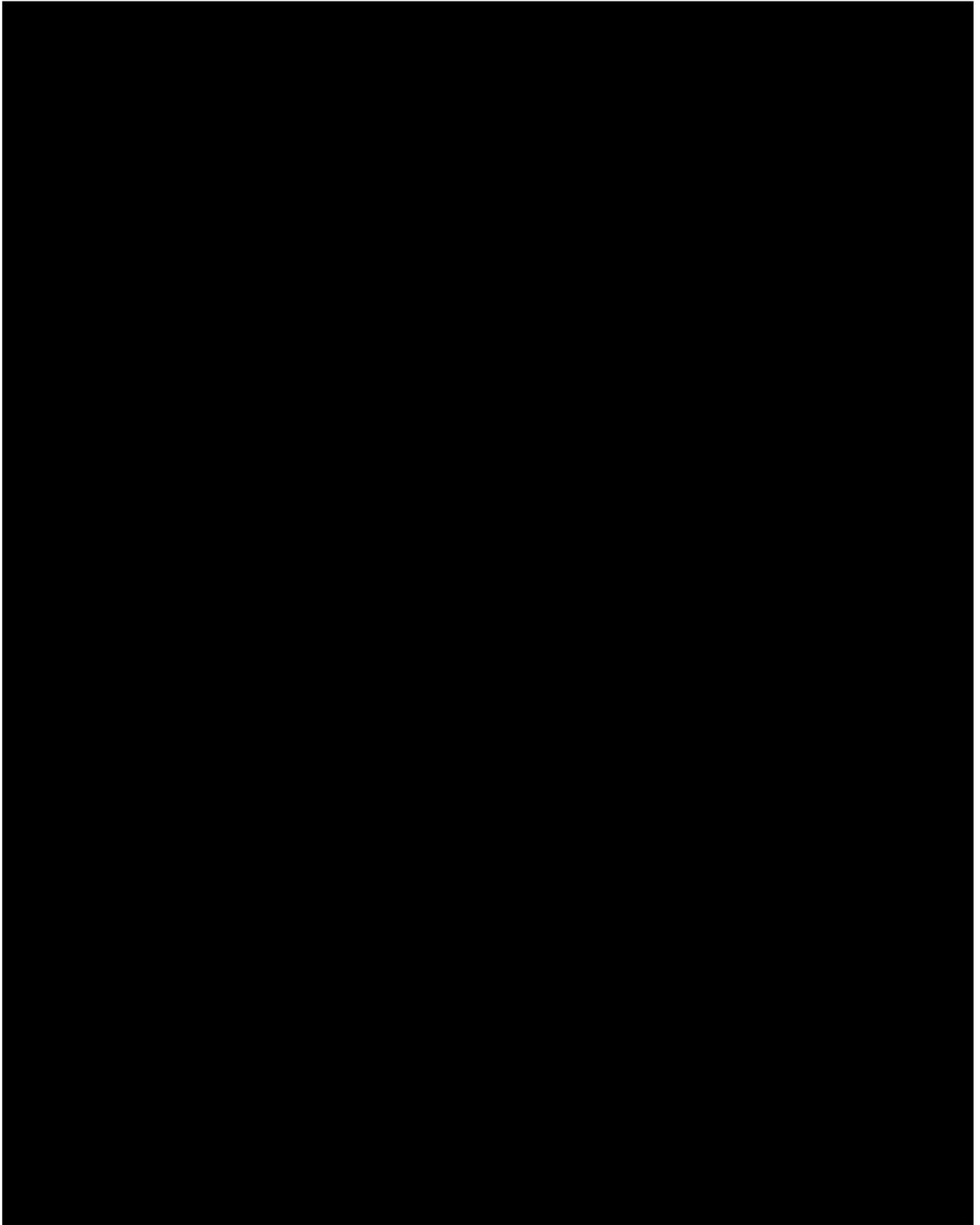
**COMMERCIAL PRICING- - CONFIDENTIAL, PROPRIETARY AND
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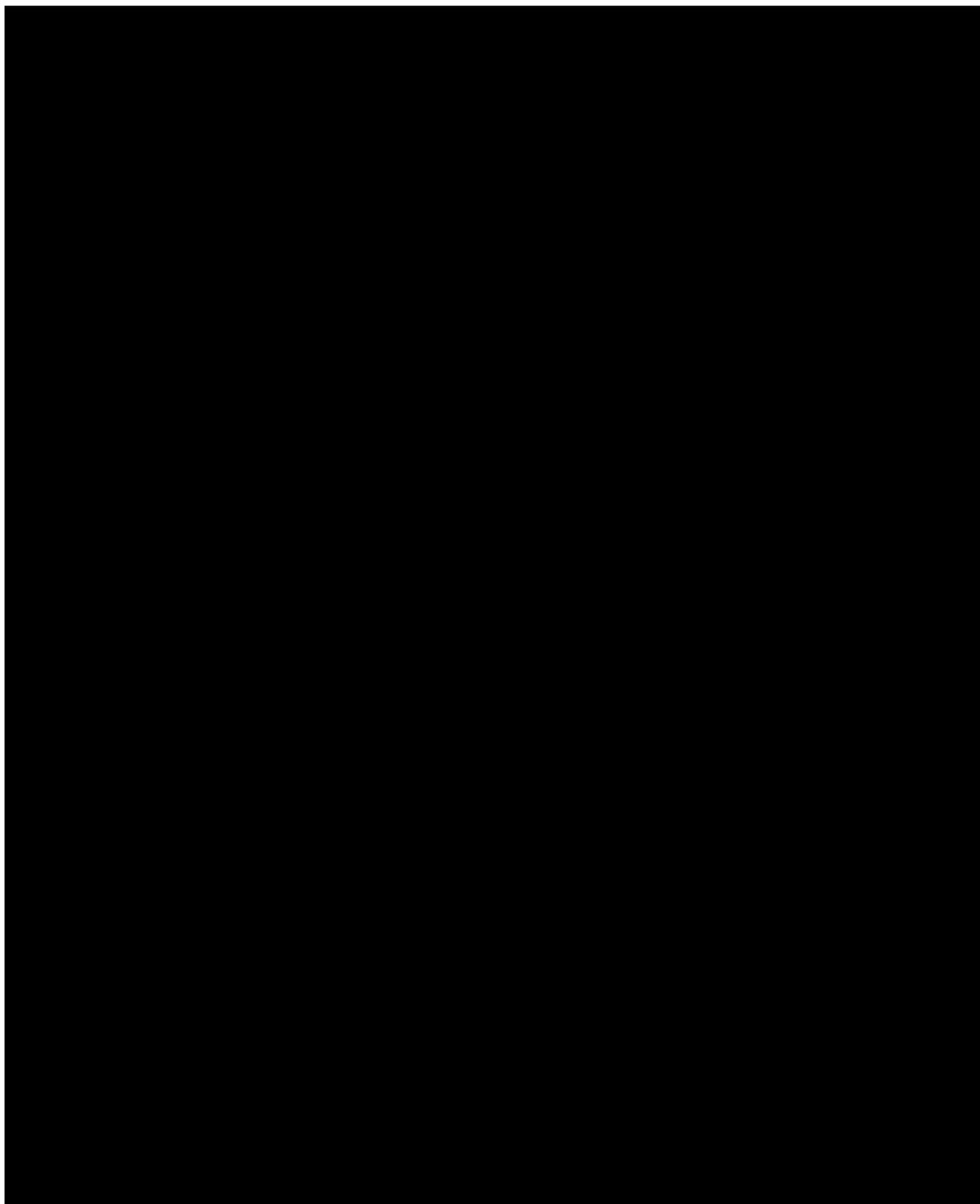


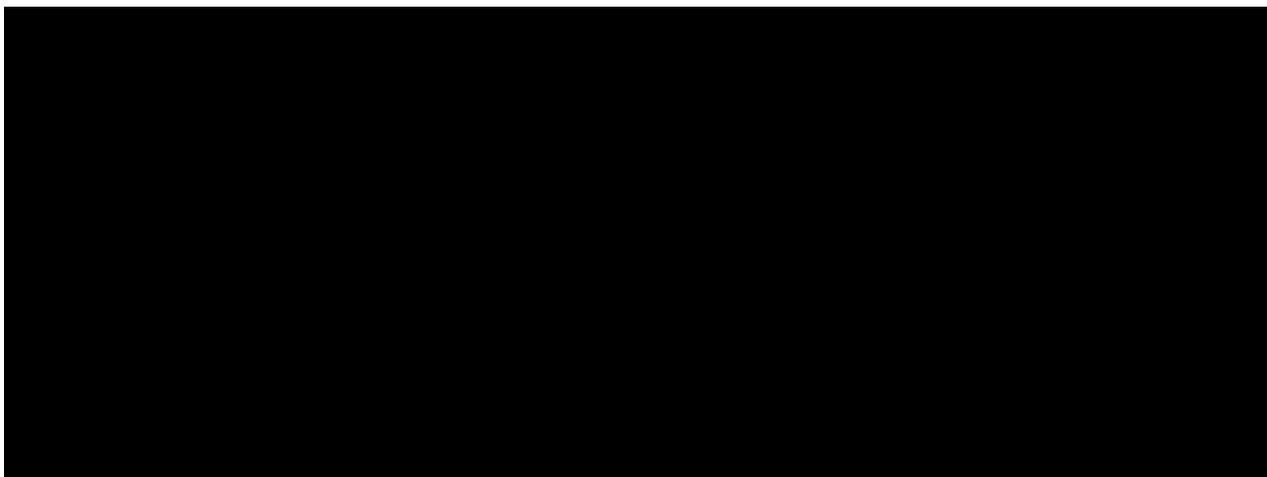














EGWP SERVICES ADDENDUM

EXHIBIT E

EGWP SERVICES ADDENDUM

If the State determines enhanced EGWP or wrap plans are advantageous to the State, and decides to participate in an enhanced EGWP, this Employer Group Waiver Plan (“**EGWP**”) Services Addendum (the “**EGWP Addendum**”) is entered into on January 1, 2019 between **Optum Insurance of Ohio, Inc.** (“**Administrator**”) and The State of Alaska (“**Client**”), each a “**Party**” and together the “**Parties**”. Administrator shall commence processing claims under this EGWP Addendum on January 1, 2019 (the “**EGWP Commencement Date**”).

WHEREAS, Administrator has entered into an EGWP 800 Series Contract with the Centers for Medicare & Medicaid Services (“**CMS**”) dated October 3, 2006, as amended (the “**CMS Contract**”); and

WHEREAS, Administrator is a Medicare Prescription Drug Plan (PDP) Sponsor and provides, through itself and its downstream entities, EGWP services to those retired employees or dependents of such retired employees who have met CMS regulations and guidance requirements to enroll in the EGWP; and

WHEREAS, Client is a union or employer group or trustee(s) of a fund who desires to contract with Administrator for EGWP services for its retired employees or dependents of such retired employees who have not opted out of enrollment in Client’s EGWP and who have met CMS regulations and guidance requirements to enroll in the EGWP;

NOW THEREFORE, the Parties agree as follows:

Defined terms used throughout the Prescription Drug Benefit Administration Agreement between Administrator or its affiliate and Client (the “**Agreement**”) within this EGWP Addendum are incorporated herein by reference. Any term capitalized in this EGWP Addendum and not defined shall be defined as it is in the CMS Medicare Managed Care Manual and/or Prescription Drug Benefit Manual.

1. OBLIGATIONS OF ADMINISTRATOR

- 1.1. **EGWP PBM Services.** Administrator shall maintain its status as a Prescription Drug Plan Sponsor with CMS under the CMS regulations set forth in 42 C.F.R. Parts 423 et seq. implementing the Medicare Prescription Drug Benefit (“Part D”) established by Section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 as codified in Section 1860D-1 through 1860D-41 of the Social Security Act and shall maintain a CMS-approved EGWP PDP. Administrator shall comply with all applicable laws, regulations, and binding guidance (including, without limitation, the Medicare Prescription Drug Benefit Manual) in its administration of the EGWP PDP. Administrator will notify Client in writing of any changes in applicable laws, regulations, and guidance related to Part D and EGWP PDPs that may affect the Parties’ obligations under this Agreement, their obligations under Part D and in relation to EGWP PDPs, or the design of the EGWP PDP. Administrator shall provide, through its affiliated PBM providing services to Client, claims processing, retail, Home Delivery, Specialty, and Rebate services as detailed in the Services Exhibit and additionally in accordance with CMS requirements for Client’s EGWP Eligible Participants. “**Participants**”, “**Eligible Members**”, “**Members**”, “**Eligible Members**” or “**Enrollees**” shall mean those retired employees or dependents of such retired employees who have met CMS regulations and guidance requirements to enroll in the EGWP and



have not opted out of enrollment in Client's EGWP. Administrator will maintain a pharmacy network, which shall meet the pharmacy access requirements set forth in 42 C.F.R §423.120, as applicable to EGWPs, or other requirements as mandated by the CMS Contract.

- 1.2. **EGWP Formulary Services; CMS Custom EGWP Formulary.** Administrator shall create and publish a CMS custom EGWP Formulary (the "**Custom EGWP Formulary**") which shall be compliant with the Medicare Part D prescription drug program requirements and other applicable rules and regulations promulgated by CMS. Such Custom EGWP Formulary will be solely managed by Administrator and will include monthly management to accommodate new products to the marketplace.
- 1.3. **Pharmacy and Therapeutics ("P&T") Committee.** The Administrator P&T Committee is an external advisory committee comprised of healthcare professionals (physicians, pharmacists, nurses, etc.) that is responsible for managing and administering the Custom EGWP Formulary, including utilization management strategies. The P&T Committee will develop, maintain, and review the Custom EGWP Formulary and other Administrator formularies at least annually to ensure that the formularies are appropriate based on existing pharmacy practices and CMS requirements.
- 1.4. **EGWP Specific Clinical Services.** Administrator will provide Concurrent Drug Utilization Review, Prior Authorization, and Clinical Communication services described in the Services Exhibit of the Agreement. Client acknowledges that Administrator may contact prescribers, as appropriate, to obtain approval for substitution of formulary drugs and contact Participants regarding medication adherence, education or similar programs. The EGWP Clinical Services below will be provided under this EGWP Addendum:
- 1.5. **Administrator MTM Program.** The Administrator MTM Program consists of Administrator (in conjunction with necessary third parties) performing a comprehensive medication review and targeted medication review designed to ensure that medications prescribed to Eligible Participants are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse medication interactions. Administrator will identify Eligible Participants and will, if applicable, recommend changes in such Eligible Participants' drug regimens to the prescribing physicians and/or the dispensing pharmacists, and if applicable, to the Eligible Participants. This is a mandatory program in order to comply with CMS regulations.
- 1.6. **Administrator Basic RetroDUR Program.** The Administrator RetroDUR Program consists of Administrator (in conjunction with necessary third parties) performing a retrospective review of Eligible Participants' prescription claims and, if available and agreed to by the Parties, medical data, to evaluate the appropriateness of each Eligible Participants' therapy based upon generally accepted current clinical pharmacy practices. In the event Administrator identifies clinical concerns regarding an Eligible Participant's drug regimen, Administrator will communicate its findings to the prescribing physician and/or the dispensing pharmacist. Client acknowledges that services under this program shall be limited to basic retrospective review. This is a mandatory program in order to comply with CMS regulations.
- 1.7. **Administrator Med D Retrospective Overutilization Program.** The Administrator Med D Retrospective Overutilization Program consists of the Level 3 RetroDUR Program and APAP Refill Monitoring Program. The PBM Level 3 RetroDUR Program consists of Administrator (in conjunction with necessary third parties) performing a daily retrospective review of Eligible Participants' prescription claims and, if available and agreed to by the parties, medical data, to identify Eligible Participants filling multiple prescriptions written by different prescribers and



dispensed at different pharmacies as it relates to opioid narcotic medications that exceed all medically-accepted norms of dosing. The PBM APAP Refill Monitoring Program consists of Administrator (in conjunction with necessary third parties) performing a daily retrospective review of Eligible Participants' prescription claims and, if available and agreed to by the parties, medical data, to identify Eligible Participants filling early refills of acetaminophen-containing products. In the event Administrator identifies clinical concerns regarding an Eligible Participant's drug regimen, Administrator will communicate its findings to the prescriber(s). Administrator will provide case management which will include the necessary outreach to the prescriber, referral to the CMS fraud contractor for any identified fraudulent activity, implementation of point of sale edits, and beneficiary and prescriber notifications. This is a mandatory program in order to comply with CMS regulations.

- 1.8. **Administrator Basic Medicare Quality (Stars) Program.** Administrator creates and manages a set of programs designed to maximize Medicare Star ratings. The Medicare Five Star program was established by CMS to provide plan-to-plan comparisons of several critical measures of health plan quality and performance. These Star ratings monitor performance on several operational, compliance, and clinical measures. Examples of programs to support Stars include medication adherence programs, therapeutic interventions for specific disease states, and member satisfaction programs. These programs require written or telephonic contact with Members in Client's plan and/or their prescribing physicians. Administrator will provide Client with de-identified copies of any messaging communicated to Members.
- 1.9. **E-prescribing Services.** Administrator shall provide E-prescribing services, which shall be limited to eligibility information, medications history, and formulary benefit management. Electronic Prescription Program or "**E-prescribing**" program shall mean the electronic transmittal of prescriptions and certain other information required for drugs prescribed for Eligible Participants with designated uniform standards as set forth under Chapter 7 of the CMS Prescription Drug Benefit Manual. This is a mandatory program in order to comply with CMS regulations.
- 1.10. **Actuarial Equivalence Requirements.** Administrator will not be subject to the actuarial equivalence requirements set forth in 42 C.F.R §423.104(e)(5) with respect to the EGWP and may provide coverage deemed to be actuarially less than defined standard Medicare prescription drug coverage between the deductible and initial coverage limit. Administrator affirms that its basic prescription drug coverage under the EGWP will satisfy all of the other actuarial equivalence standards set forth in 42 C.F.R §423.104, including but not limited to the requirements set forth in 42 C.F.R §423.104(e)(3) that the EGWP has a total or gross value that is at least equal to the total or gross value of defined standard coverage.
- 1.11. **Client Group Enrollment Process.**
 - 1.11.1. Administrator shall enroll and disenroll Participants into the EGWP in accordance with applicable CMS regulations and guidance. Client will enroll Part D eligible individuals eligible for its EGWP through a group enrollment process (i.e., Client provides electronic files); as such, Administrator will not be subject to the individual enrollment requirements (i.e., paper, online, broker, fax, telephonic enrollment) set forth in 42 C.F.R §423.32(b). Administrator agrees that all Part D eligible individuals eligible for the EGWP will be advised that Client intends to enroll Participants into the EGWP through a group enrollment process unless the individual opts out of such enrollment. The Parties acknowledge that the information must include a summary of benefits offered under the EGWP, an explanation of how to get more information on such plan, and an explanation of how to contact Medicare for information on other Part D plans that might be available to the individual. The Parties acknowledge that,



except in cases of retroactive enrollment, all such individuals' will be provided this information in advance of the individuals' enrollment in the EGWP in order to comply with CMS requirements for notifying individuals at least twenty-one (21) calendar days prior to the effective date of the individual's enrollment in the EGWP, provided Administrator has received a timely, full/complete and accurate application for the Participant(s) via Client's electronic Eligible Participant File. The Parties agree that enrollment information shall be submitted to CMS only by Administrator. All CMS enrollment requirements are managed by Administrator (e.g. Opt Out, Returned Mail, Out of Area, etc.) in order to support compliance with CMS requirements and are not subject to delegation to Client. In addition, Client must provide Client's initial Participant full file no less than sixty (60) days prior to the EGWP Commencement Date. Client acknowledges that under CMS regulations, they must have policies and procedures in place to minimize retroactivity and ensure that any Member who is enrolled into the EGWP after the EGWP Commencement Date shall be provided to Administrator at least sixty (60) days' in advance of the effective date of the individual's enrollment into the EGWP.

- 1.11.2. Administrator shall submit the Participant File received from Client (as set forth in section 2.3 of this EGWP Addendum) to CMS for enrollment or disenrollment in the Plan within the time frame specified by CMS. Upon receipt of confirmation of acceptance, denial or rejection of an individual from CMS, Administrator shall load the accepted Eligible Participants into (and rejected or disenrolled Participants from) the Plan and report the rejected or denied members back to Client for correction or other action. Administrator shall not be liable for any prescriptions filled or processed for any ineligible persons due to incorrect or untimely eligibility data provided to Administrator.
- 1.12. **CMS Reporting.** Administrator shall produce and submit prescription drug event (PDE) files, HPMS reporting, and other required reporting to CMS as part of Administrator's obligation as a PDP Sponsor. As applicable, Client must address all eligibility-related rejections in a timely manner to ensure Administrator meets all CMS timeframes for submitting corrected PDE files during the plan year and prior to the end of the annual CMS reconciliation process in June.
- 1.13. **Eligible Participant Services.**
 - 1.13.1. **Eligible Participant Customer Service.** Eligible Participant customer service provides Participants with information regarding pharmacy locations, eligibility, drug coverage, copays/deductibles/out of pocket maximums, coverage determinations, appeals process in accordance with any applicable CMS regulations and guidance, direct member reimbursement instructions, claims status and general information regarding the Participant's prescription benefit plan as established by the Client. Where applicable, customer service support may include outreach to Participants to obtain required information needed to continue processing the Participant enrollment into the EGWP, or to confirm such information. Participant customer service is available 24 hours a day, 7 days a week, 365 days a year (including for TTY and non-English speaking Participants).
 - 1.13.2. **Participant Materials.** Administrator shall develop and mail Participant materials as required by 42 C.F.R 423.128. Such materials will consist of CMS compliant model templates. These materials may only be customized using Client branding, Client contact information (where required) and Client variable paragraphs that explain any Client-specific eligibility/plan rules. Administrator may update materials from time to time to comply with CMS requirements or due to changes in Administrator processes. Administrator will provide Client with template copies of such materials, including any updated materials. Should Client send any additional materials to Participants, such materials must first be approved by Administrator. As set forth



under the CMS Contract, the Parties agree that, with respect to the EGWP, Administrator will not be subject to the information requirements set forth in 42 C.F.R §423.48 and the prior review and approval of marketing materials and enrollment forms requirements by CMS set forth in 42 C.F.R §423.2260. Administrator will be subject to all other dissemination requirements contained in 42 C.F.R §423.128 and in CMS guidance, including Prescription Drug Manual Chapter 2 “Medicare Marketing Materials Guidelines for Medicare Advantage Plans (MAs), Medicare Advantage Prescription Drug Plans (MA-PDs), Prescription Drug Plans (PDPs), and 1876 Cost Plans” as amended (hereinafter “**Chapter 2**”) and Chapter 12 “Employer/Union Sponsored Group Health Plans” as amended (hereinafter “**Chapter 12**”). Additionally, as set forth in the CMS Contract, the dissemination requirements set forth in 42 C.F.R §423.128 will not apply with respect to the EGWP if Client is subject to alternative disclosure requirements (e.g., ERISA) and fully complies with such alternative requirements.

- 1.14. **Ancillary Services.** If Client requests additional or ancillary EGWP services, including consultative services, other than those described herein, Administrator shall attempt to accommodate Client at a mutually agreed upon rate under a separate Agreement or amendment signed by the Parties prior to the performance of services.

2. CLIENT OBLIGATIONS

- 2.1. **Plan Design Specifications.** Client will provide a Plan Design Document for the EGWP plan administered by Administrator in sufficient detail to permit Administrator to perform its duties and obligations under this EGWP Addendum. Client shall have the ultimate responsibility for approving any pharmacy benefit plan design; however, Client’s Plan Design must be compliant with CMS requirements. If Administrator determines that any aspect of Client’s Plan Design does not meet CMS requirements, Administrator will notify Client to discuss changes needed to bring the Plan Design into compliance. Administrator retains sole authority for determining whether Client’s Plan Design meets CMS compliance requirements. Administrator shall provide reasonable support in pharmacy benefit plan development, set up and administration on behalf of Client. If requested by Client, Administrator shall provide actuarial services to Client for the purpose of plan design recommendations and development at a mutually agreed upon fee. Administrator will establish and maintain pharmacy benefit plan designs as requested by Client via plan implementation documents provided and approved in writing by Client. Client and Administrator shall mutually agree on the format of the implementation documents. Any changes to the Plan Design Document will be submitted by Client to Administrator through a revised Plan Design Document as soon as administratively possible, and in any event no less than ninety (90) days prior to the intended implementation by Client to permit a timely implementation and minimal disruption of services to Eligible Participants. Client acknowledges that nothing in this EGWP Addendum shall be deemed to confer upon Administrator the status of fiduciary as defined in the Employee Retirement Income Security Act of 1974, as amended. All reasonably necessary Client documents (e.g. implementation form, benefit design specifications, etc.) must be signed by Client before any plan benefits will be implemented. Once the plan design document has been approved for the upcoming plan year, no additional changes shall be permitted except as mandated by a Governmental Authority. Should there be any plan design changes after approval and implementation, the Client shall be responsible for any costs associated with such changes, if applicable including changes to Participant Materials noted in Section 1.13.2 above.

2.2. Enrollment of Participants.

- 2.2.1. Enrollment in the EGWP shall be restricted to those Part D Eligible Participants (and/or their Part D eligible spouses and/or dependents) for Client’s employment-based retiree prescription drug coverage. Administrator agrees to provide basic prescription drug coverage,



as defined under 42 C.F.R §423.100, under the EGWP, in accordance with Subpart C of 42 C.F.R Part 423.

- 2.2.2. Client agrees that prior to submitting a Participant to PBM for enrollment, Client must validate and provide ongoing attestation that all members permanently reside within the United States or the territories of Puerto Rico or Guam. Client agrees that prior to submitting a Participant to Administrator for enrollment, Client must validate that Participant is Part D eligible and that Participant meets Client's plan requirements for an Eligible Participant. Client agrees Participant enrollment and disenrollment requests will be submitted to Administrator prospectively and must be accurate and complete records (including all Medicare required information such as the Member's Medicare ID/HICN/MBI and EGWP Commencement Date). Administrator requires Client to comply with the enrollment and eligibility requirements set forth in Chapter 3 of the CMS Prescription Drug Benefit Manual that ensure the timely submission of enrollment and disenrollment requests to mitigate or reduce the need for retroactivity and to help avoid errors pursuant to CMS regulations. Refer to Chapter 3, Section 60.5 of the guidance for reference. Client agrees Participant re-enrollment requests will be submitted to Administrator via request to Client's PBM account management team and not via the Eligible Participant File. Client will comply with Administrator's enrollment processes for Member ID changes, retro enrollments/disenrollments, and other administrative matters. If the Client is using a third-party eligibility vendor to perform this service, such third-party will be required to complete the attestation upon written authorization by Client of their ability to do so. Client further acknowledges, that any ID change or reenrollment requests must be approved in writing prior to Administrator taking further action.
- 2.2.3. Client agrees to attest to Administrator that each Participant submitted to Administrator upon initial enrollment has an attestation of creditable coverage history satisfying any potential uncovered months on file at CMS (which will be used to assess a late enrollment penalty ("LEP")). Alternatively, if agreed on by the Parties, Client agrees that Administrator will contact Participants directly to obtain attestations to some/all uncovered months. Client agrees that either Client will attest as to Members, or Administrator will reach out to Members, not a combination of the two. Client agrees that Administrator cannot attest to uncovered months on Client's or Participant's behalf. Client agrees to either adjust Participant premiums or pay the LEP on behalf of the Member as/when applicable for any late enrollment penalty assessed by CMS and must be consistent for all individuals enrolled in the EGWP. Administrator does not provide for direct invoicing of the LEP to Participants.
- 2.2.4. Client agrees to inform the Administrator's enrollment department upon initial enrollment if any Participants have other health coverage so that Administrator may provide CMS with any applicable information on other insurance coverage for the purposes of coordination of benefits.
- 2.2.5. Client agrees to review and process/correct all items in enrollment related reports provided by Administrator before submitting any subsequent Eligible Participant File (as hereinafter defined) to Administrator. Such review, processing, and submission must take place no later than seven (7) days following receipt of such reports.
- 2.3. **Participant File.** Client will provide Administrator with a full file (each an "**Eligible Participant File**") on electronic media acceptable to Administrator of all applicable Eligible Participants Benefit Plan to be serviced by Administrator hereunder. Each Eligible Participant File will include the valid enrollment effective dates per individual record for each new Eligible Participant, which effective date shall be for the current calendar month or not more than three (3) months following the current calendar month. Under CMS requirements, all enrollment effective dates must be effective on the



first day of a calendar month and all terminations must be on the last day of the calendar month. If Client provides any retroactive enrollment effective date for an individual record, Client represents and warrants to Administrator that Client has the original signed application from the Eligible Participant, that the date on such signed application is the same as the retroactive effective date and that Client will provide a copy of such original signed application to Administrator upon request. The Parties acknowledge that CMS will determine eligibility of Participants for the CMS Subsidy. The Parties further acknowledge that Participants are not enrolled in or disenrolled from the Administrator until CMS determination/approval is received. Additionally, Client will promptly furnish Administrator, on electronic media acceptable by Administrator, files containing records for all Eligible Participants whose enrollment has been terminated with termination dates and each new Eligible Participant for enrollment into the EGWP. Client acknowledges that Administrator does not perform Participant terminations or cancelations via "term by absence". Administrator shall not be liable for any prescriptions filled or processed for any ineligible persons due to incorrect or untimely eligibility data provided to Administrator.

2.4. **Participant Subsidy.** Administrator and Client acknowledge that Client may determine how much of a Participant's Part D monthly beneficiary premium it will subsidize, subject to any restrictions imposed by the CMS Contract set forth below, and CMS and other federal regulations, including all premium regulations set forth in Chapter 12.

2.4.1. Participants will not be permitted to make payment of premiums under 42 C.F.R §423.293(a) through withholding from the Participant's Social Security, Railroad Retirement Board, or Office of Personnel Management benefit payment. The foregoing does not apply to self-funded plans.

2.4.2. Client can subsidize different amounts for different classes of Participants in the EGWP provided such classes are reasonable and based on objective business criteria, such as years of services, date of retirement, business location, job category, and nature of compensation (e.g., salaried v. hourly). Different classes cannot be based on eligibility for the Low Income Subsidy.

2.4.3. Client cannot vary the premium subsidy for individuals within a given class of Participants.

2.4.4. Client cannot charge Participants for prescription drug coverage provided under the EGWP more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any). Client must pass through direct subsidy payment received from CMS to reduce the amount the Participant pays (or, in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of a Medicare eligible spouse or dependent, the amount the subscriber or participant pays).

2.4.5. For all those Participants eligible for the Low Income Subsidy, the low income premium subsidy amount will first be used to reduce any portion of the monthly beneficiary premium paid by the Participant (or in those instances where the subscriber to or participant in the employer plan pays premiums on behalf of a low income eligible spouse or dependent, the amount the subscriber or participant pays), with any remaining portion of the premium subsidy amount then applied toward the portion of any monthly beneficiary premium paid by Client. However, if the sum of the Participant's monthly premium (or the subscriber's/participant's monthly premium, if applicable) and Client's monthly premiums (i.e., total monthly premium) are less than the monthly low income premium subsidy amount, any portion of the low income subsidy premium amount above the total monthly premium must be returned directly to CMS. Similarly, if there is no monthly premium charged to the Participant (or subscriber/participant,



if applicable) or Client, the entire low income premium subsidy amount must be returned directly to CMS and cannot be retained by Administrator, Client, or the Participant (or the subscriber/participant, if applicable).

- 2.4.6. Administrator and Client may agree that Client will be responsible for reducing up front the premium contribution required for Participants eligible for the Low Income Subsidy. In those instances where Client is not able to reduce up front the premiums paid by the Participant (or the subscriber/participant, if applicable), Administrator and Client may agree that Client shall directly refund to the Participant (or the subscriber/participant, if applicable) the amount of the low income premium subsidy up to the monthly premium contribution previously collected from the Participant (or the subscriber/participant, if applicable). Client is required to complete the refund on behalf of Administrator within forty-five (45) days of the date Administrator receives from CMS the low income premium subsidy amount payment for the Participant eligible for the low income subsidy. Client, upon request from Administrator, will provide an attestation to Administrator regarding its compliance with the terms of this section.
- 2.4.7. If Administrator does not or cannot directly bill a Client's Participants, CMS will permit Administrator to directly refund the amount of the low income subsidy to the Participant. This refund must meet the above requirements concerning beneficiary premium contributions; specifically, that the amount of the refund may not exceed the amount of the monthly premium contribution by the Participant and/or Client. In addition, Administrator must refund these amounts to the Participant within a reasonable time period. However, under no circumstances may this time period exceed forty five (45) days from the date that Administrator receives the low income subsidy amount for that Participant from CMS.
- 2.4.8. The Parties agree that Administrator shall obtain written agreements from Client which provides that Client may determine how much of a Participants' Part D monthly beneficiary premium it will subsidize subject to the restrictions set forth in II. B.3(a) through (g) of the CMS Contract. Administrator agrees to retain these written agreements with Client, including any written agreements related to items (d) through (f) of the CMS Contract, and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with requirements of 42 C.F.R 423.504(d) and 423.505(d) and (e).
- 2.4.9. If the low income subsidy premium amount for which a Participant is eligible is less than the portion of the monthly Participant premium paid by the Participant (or subscriber/participant, if applicable), then Client should communicate to the Participant (or subscriber/participant) the financial consequences of the low income subsidy eligible Participant enrolling in the EGWP as compared to enrolling in another Part D plan with a monthly Participant premium equal to or below the low income premium subsidy amount.
- 2.4.10. Client attests that it has in place eligibility requirements and policies and procedures in place to manage and process reinstatement requests in accordance with CMS guidance. Upon Administrator's written request, Client will provide to Administrator documentation (including but not limited to Client policies and procedures) demonstrating Client's compliance with CMS guidance for the handling of reinstatement requests.
- 2.4.11. If Client is unable to determine or provide the amount of the annual premium that is solely related to the prescription drug benefit, Client agrees to provide Administrator with the amount of the illustrative premium and an actuarial certification annually to be used for CMS audit purposes and Administrator compliance oversight. For purposes of this attestation, the illustrative premium is equal to the premium Client would have paid if they had purchased an equivalent product offered by Administrator.



2.5. Coordination of Benefits.

- 2.5.1. If the Parties agree to include additional benefits in the EGWP, these benefits will be considered non-Medicare Part D benefits and that such additional benefits may not reduce the value of basic prescription drug coverage (e.g., additional benefits cannot impose a cap that would preclude Participants from realizing the full value of such basic prescriptions drug coverage).
- 2.5.2. Any additional non-Medicare Part D benefits offered under the EGWP will always pay primary to the subsidies provided by CMS to low income individuals under Subpart P of 42 C.F.R Part 423 (the "**Low Income Subsidy**").
- 2.5.3. Client is solely responsible for any and all coordination between plans should Client choose to allow Participants to enroll in a separate 800 series Medicare Advantage (MA) plan.
- 2.5.4. Client agrees that Administrator accepts and loads other comprehensive Primary and/or Secondary insurance information provided by CMS, and claims for Participants with other Primary coverage from this process will reject, informing the submitting pharmacy to first bill the member's primary coverage. Administrator will mail surveys to these Participants upon initial receipt of the information from CMS, and then annually after that, to request the Participant report any updates in the other coverage(s) directly to Administrator. Administrator will then report these updates to CMS.

3. PAYMENT. The payment terms set forth in Section 11 of the Services Exhibit shall apply to this this Exhibit.

- 3.1. **CMS Subsidy Payment Reporting.** Administrator shall issue to Client, on a monthly, quarterly, and annual basis, reporting related to CMS subsidies that are payable. Notwithstanding the foregoing, Client acknowledges that it will be responsible for payment of Administrative Fees, EGWP Participant per Month fees, and the Network Claims Funding even if CMS determines that a Participant is not eligible for the CMS Subsidy subsequent to a prior eligibility determination. To the extent CMS subsidies are issued for a Participant, who is subsequently determined to be ineligible by CMS, Administrator shall have the right to recoup such amounts from Client. "**CMS Subsidy**" shall mean the monthly Part D Direct Subsidy, Coverage Gap Discounts, Low-Income Cost Sharing Subsidy, Low-Income Premium Subsidy, and Catastrophic Reinsurance payments for each Participant from CMS as governed by the rules of Subpart G of 42 C.F.R Part 423 and the CMS Contract.

4. TERMINATION

- 4.1. **Termination for Cause.** Either Party may terminate this EGWP Addendum following a material breach by the other Party. The non-breaching Party shall notify the breaching Party of the breach and the breaching Party shall have thirty (30) days (the "**Cure Period**") to cure the breach to the reasonable satisfaction of the non-breaching Party. If the breaching Party fails to cure the breach within the Cure Period, then the non-breaching Party may terminate the EGWP Addendum effective immediately.
- 4.2. **Return of Materials.** Each Party will return to the other Party all papers, materials, and properties of the other Party related to this EGWP Addendum.

5. RECORD MAINTENANCE AND CMS ACCESS



- 5.1. **Record Maintenance.** For the longer of (1) the period required by law or (2) ten (10) years from the date of rendering any covered Prescription Drug Services, and as further required under 42 C.F.R §§423.505(b)(10) and 423.505(i)(2), the Parties will maintain records related thereto, including, but not limited to, prescription records and other documentation related to healthcare services provided to Participants.

- 5.2. **Administrator and/or CMS Audit.** Administrator and Client acknowledge that CMS may audit records under this EGWP Addendum. Client shall maintain records, including but not limited to, any data related to enrollment (i.e., enrollment data validation reports), disenrollment, eligibility, Participant communications, and other areas covered by this EGWP Addendum. Client agrees it will provide Administrator and CMS with prompt access to such records to the extent required by and in accordance with 42 C.F.R 423.504(d) and 423.505(d) and (e) as well as Chapter 2 and Chapter 12 of the CMS Prescription Drug Benefit Manual. To the extent allowed under law, all information and records reviewed pursuant to this section shall be considered Confidential Information for the purposes of this EGWP Addendum.

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The parties have accepted and agreed to this EGWP Addendum.

The State of Alaska

By: Leslie Ridle

Name: Leslie Ridle

Title: Commissioner of Administration

Date: 9/4/18

Optum Insurance of Ohio, Inc.

DocuSigned by:
Jeff Grosklags
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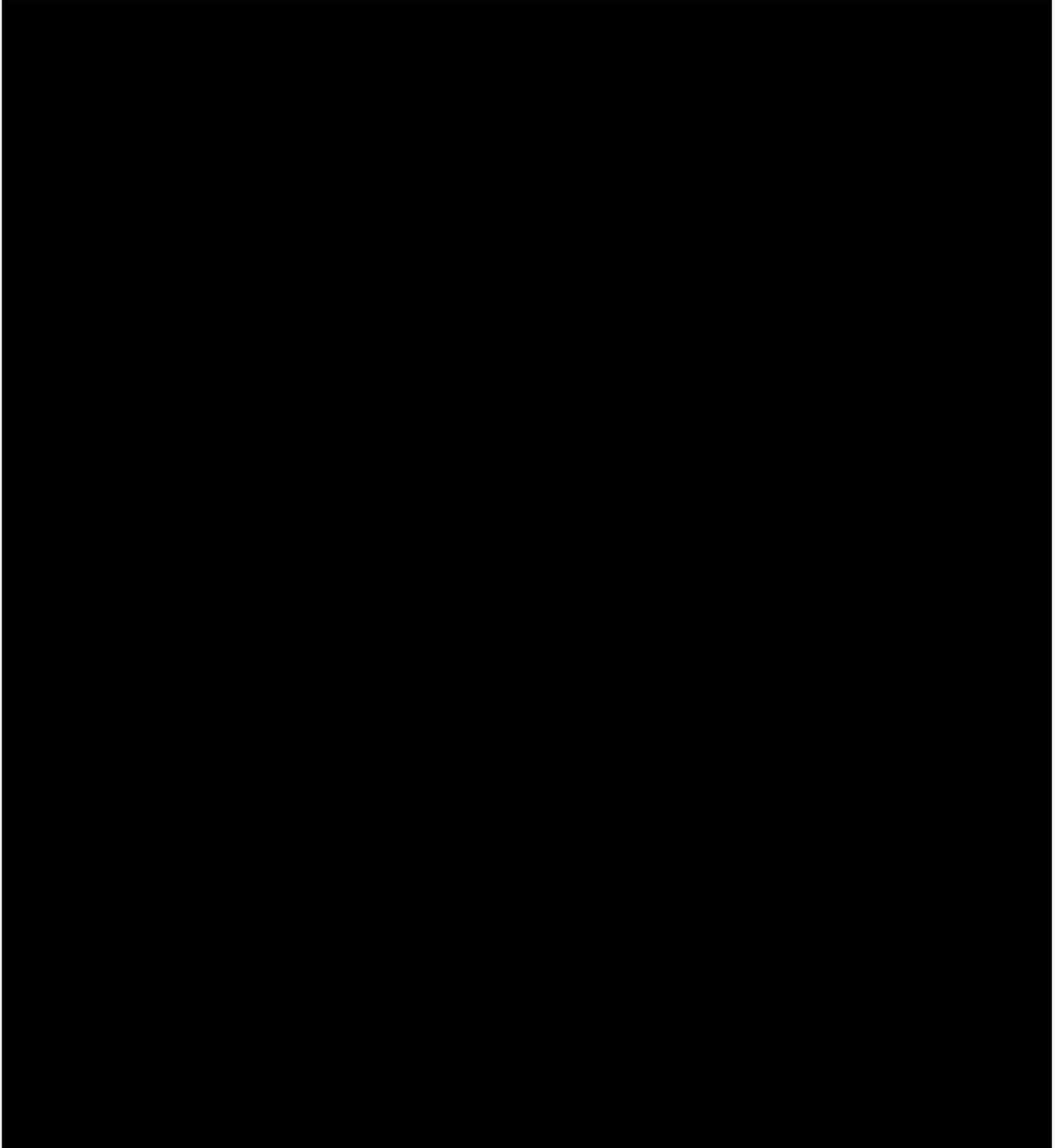
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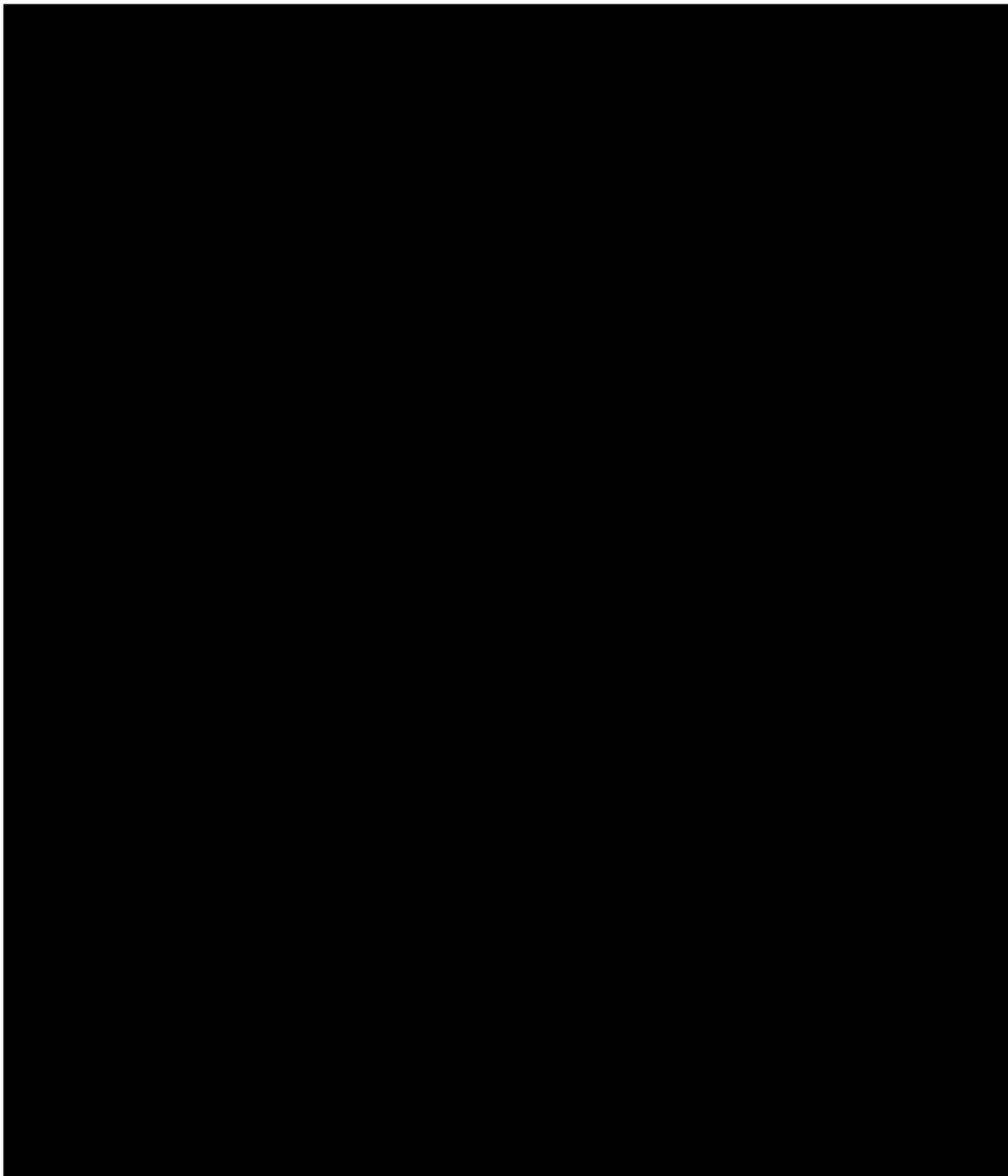
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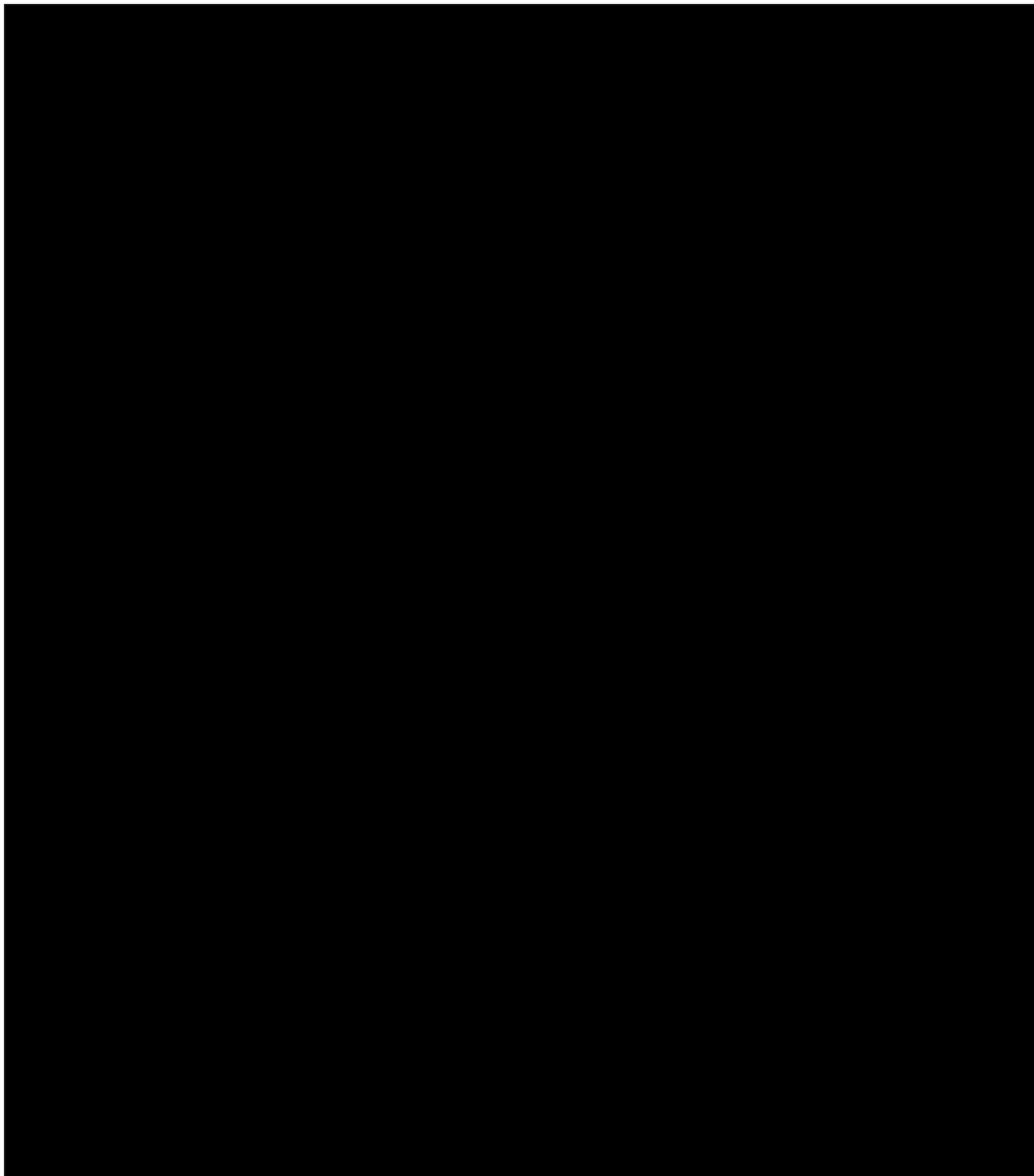
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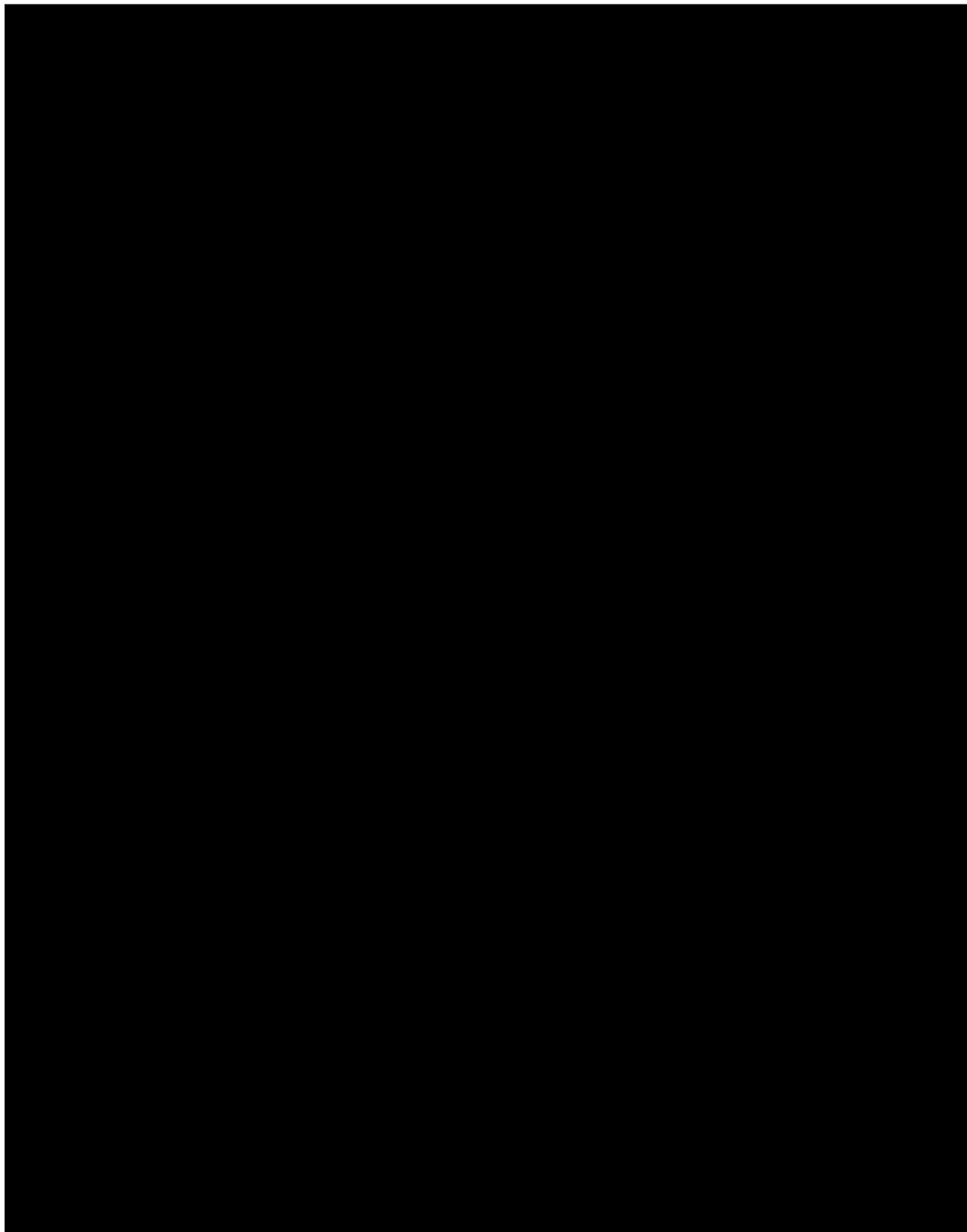


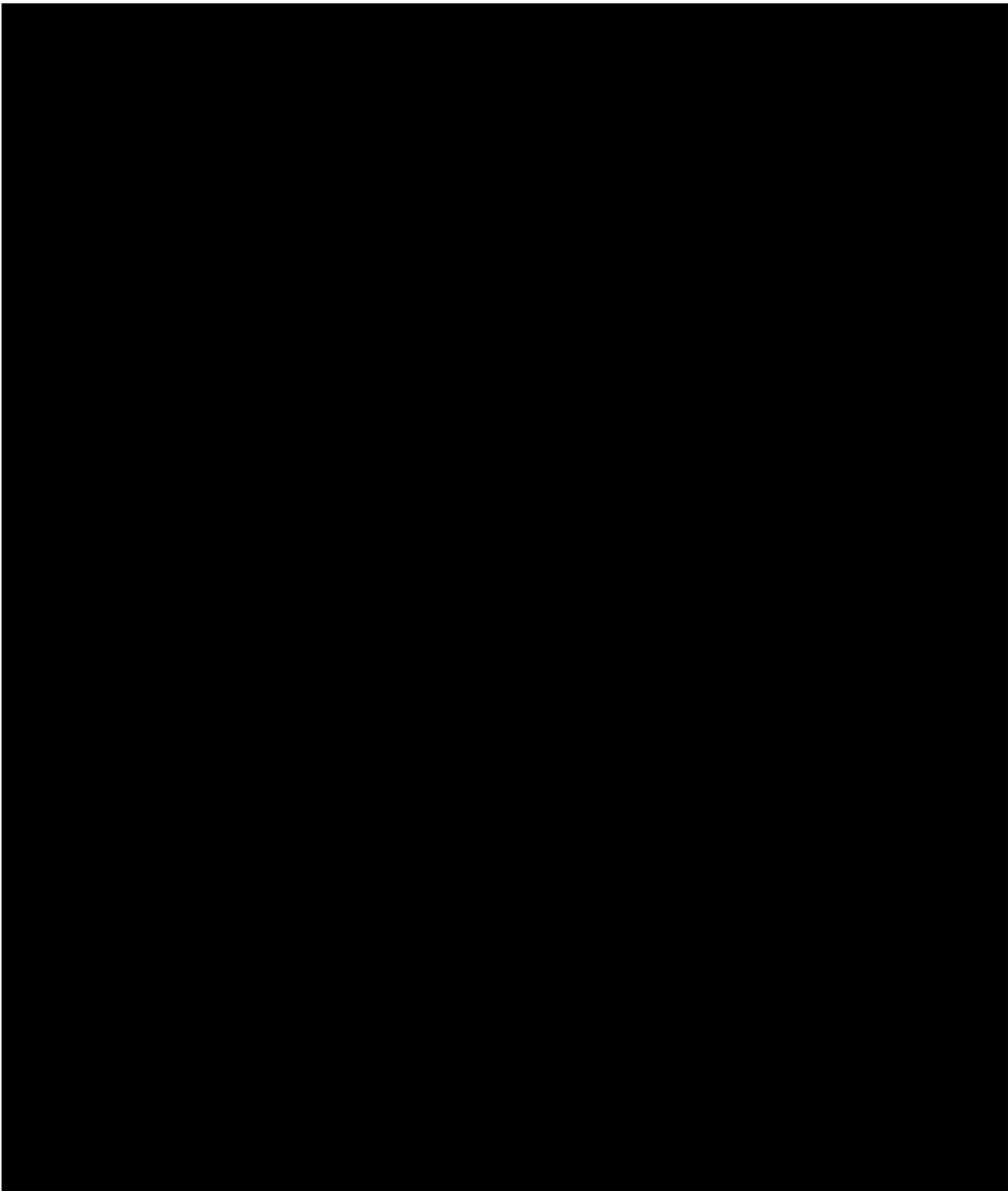
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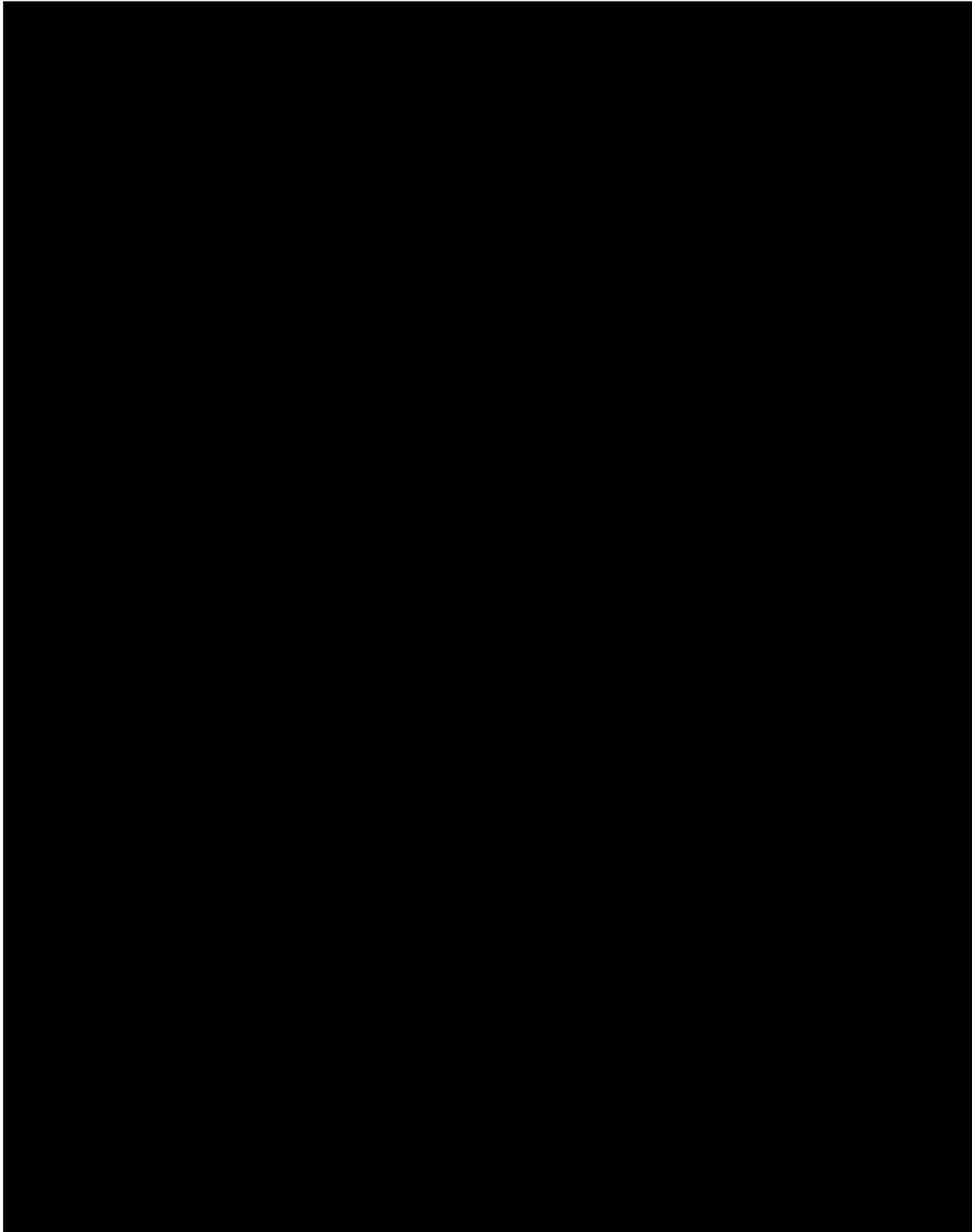


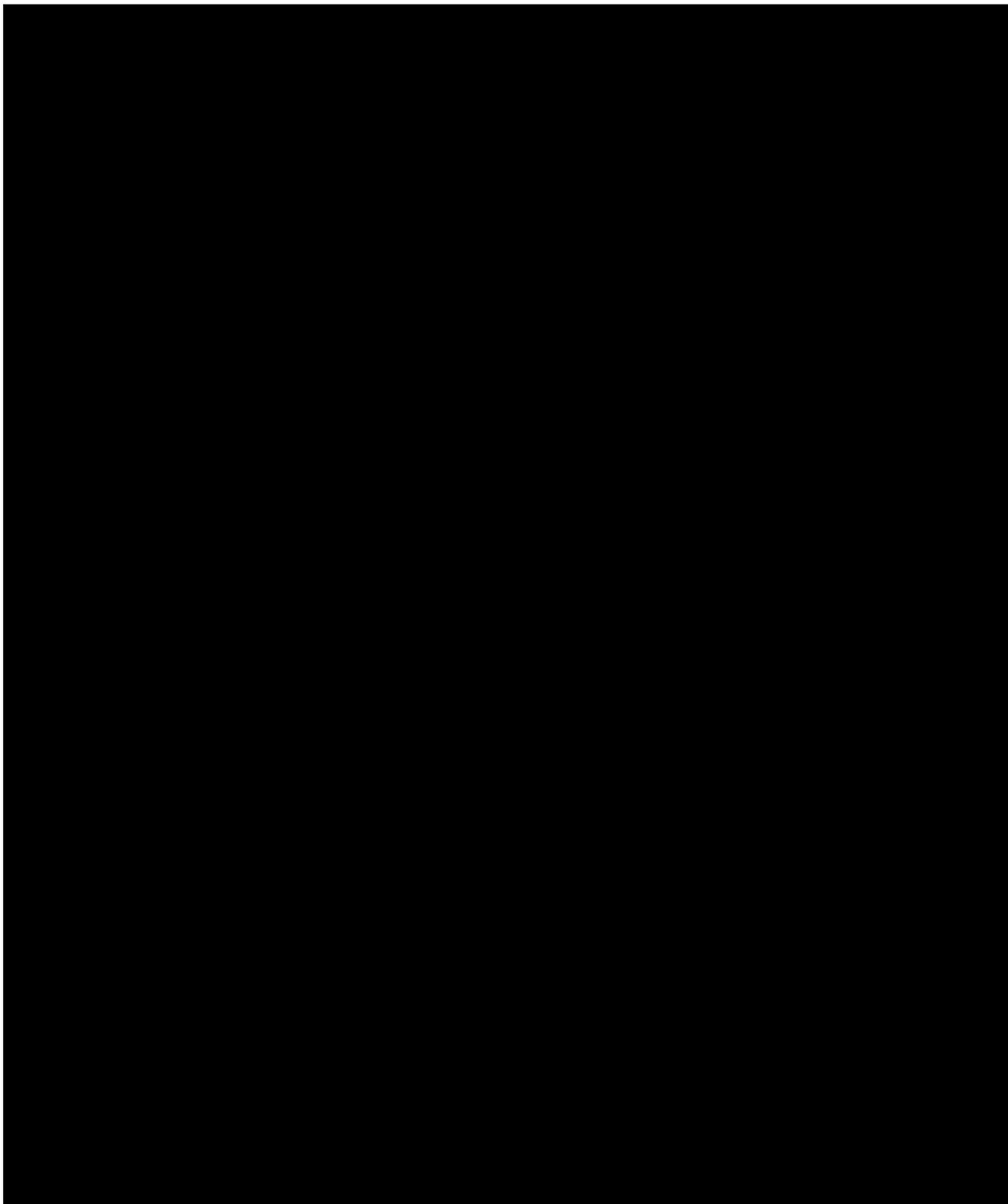


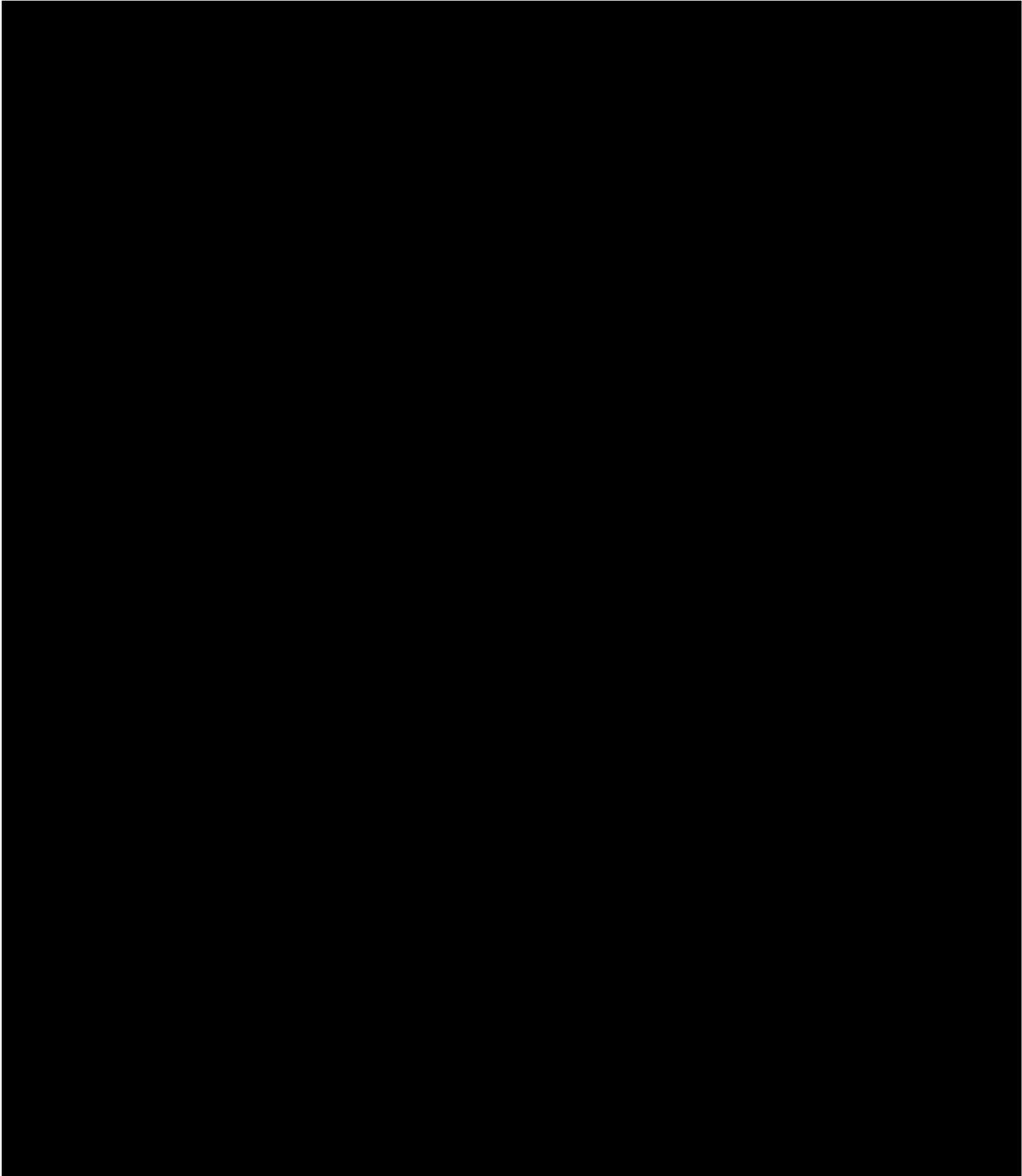


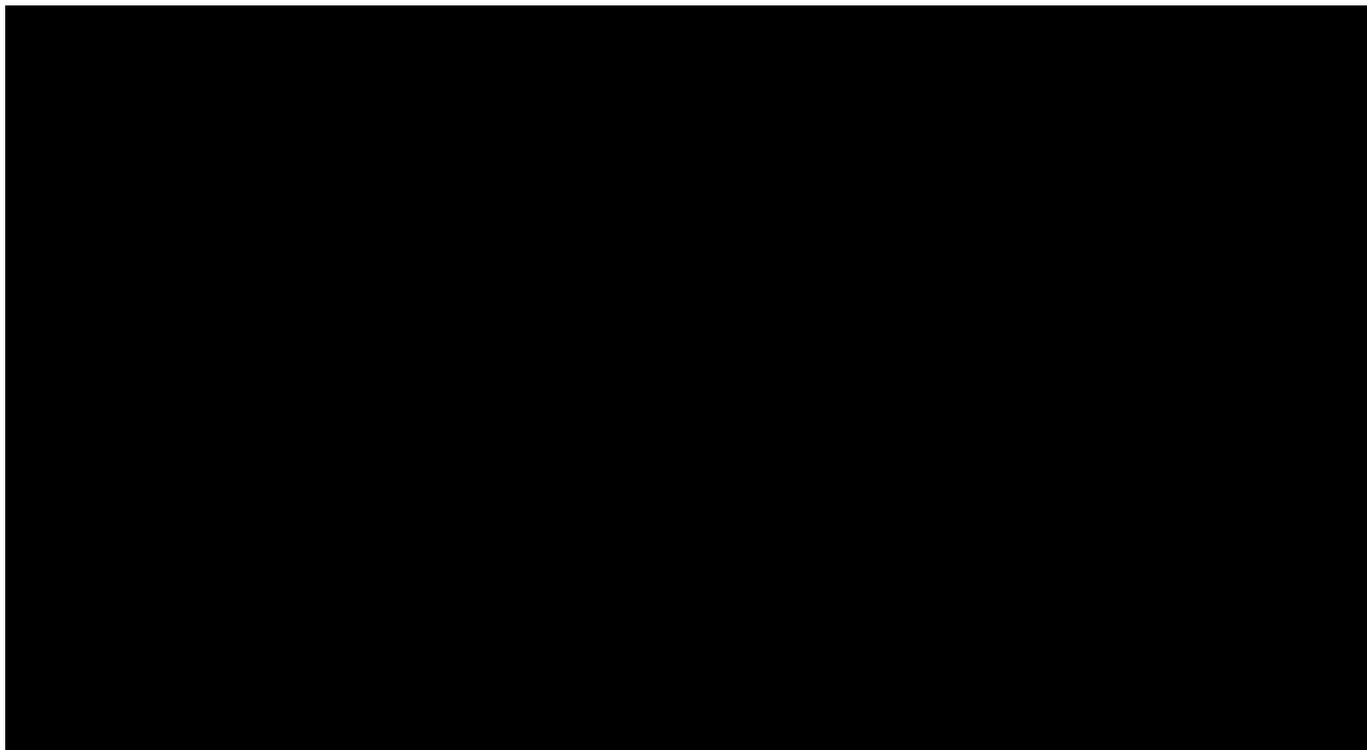








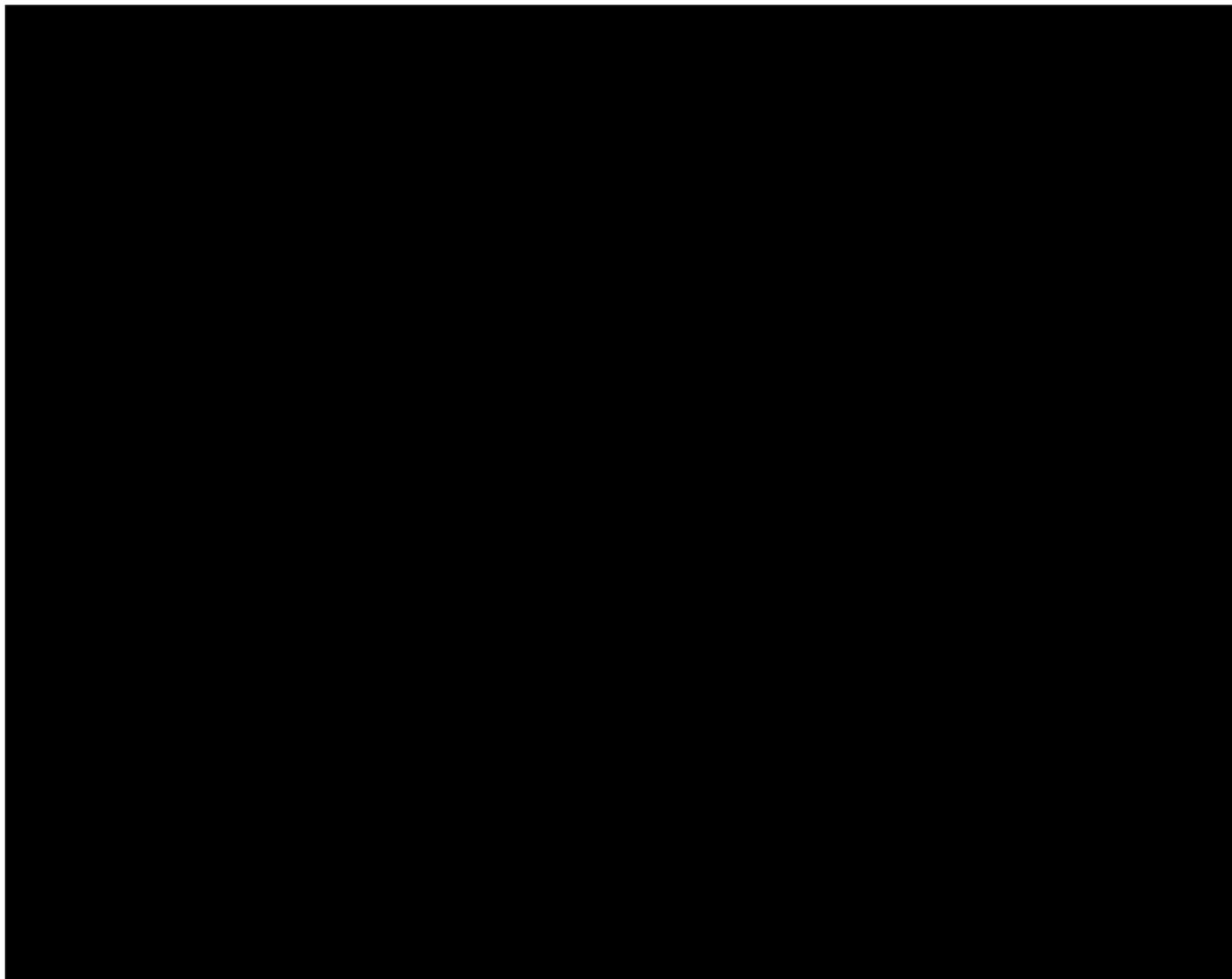


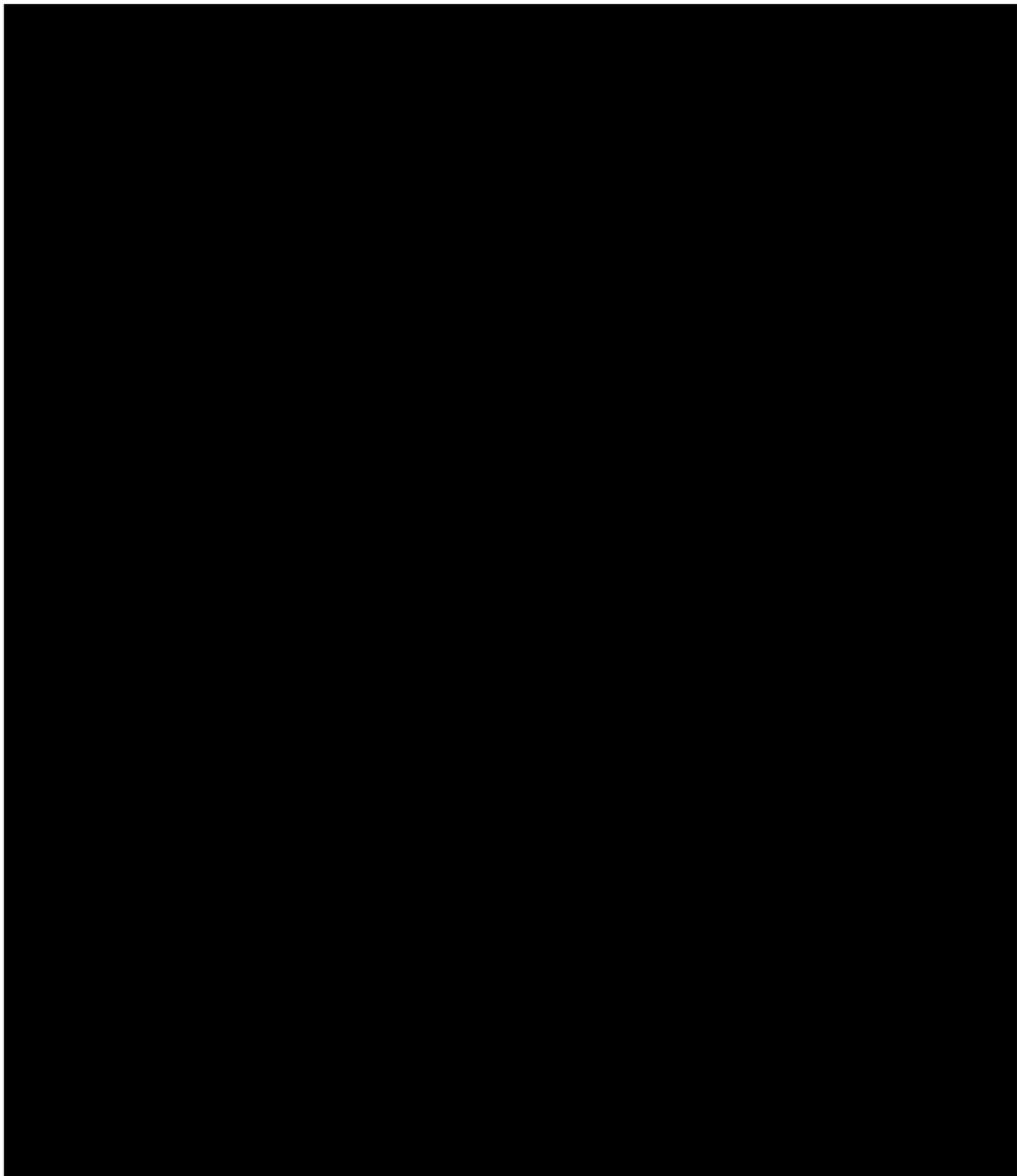


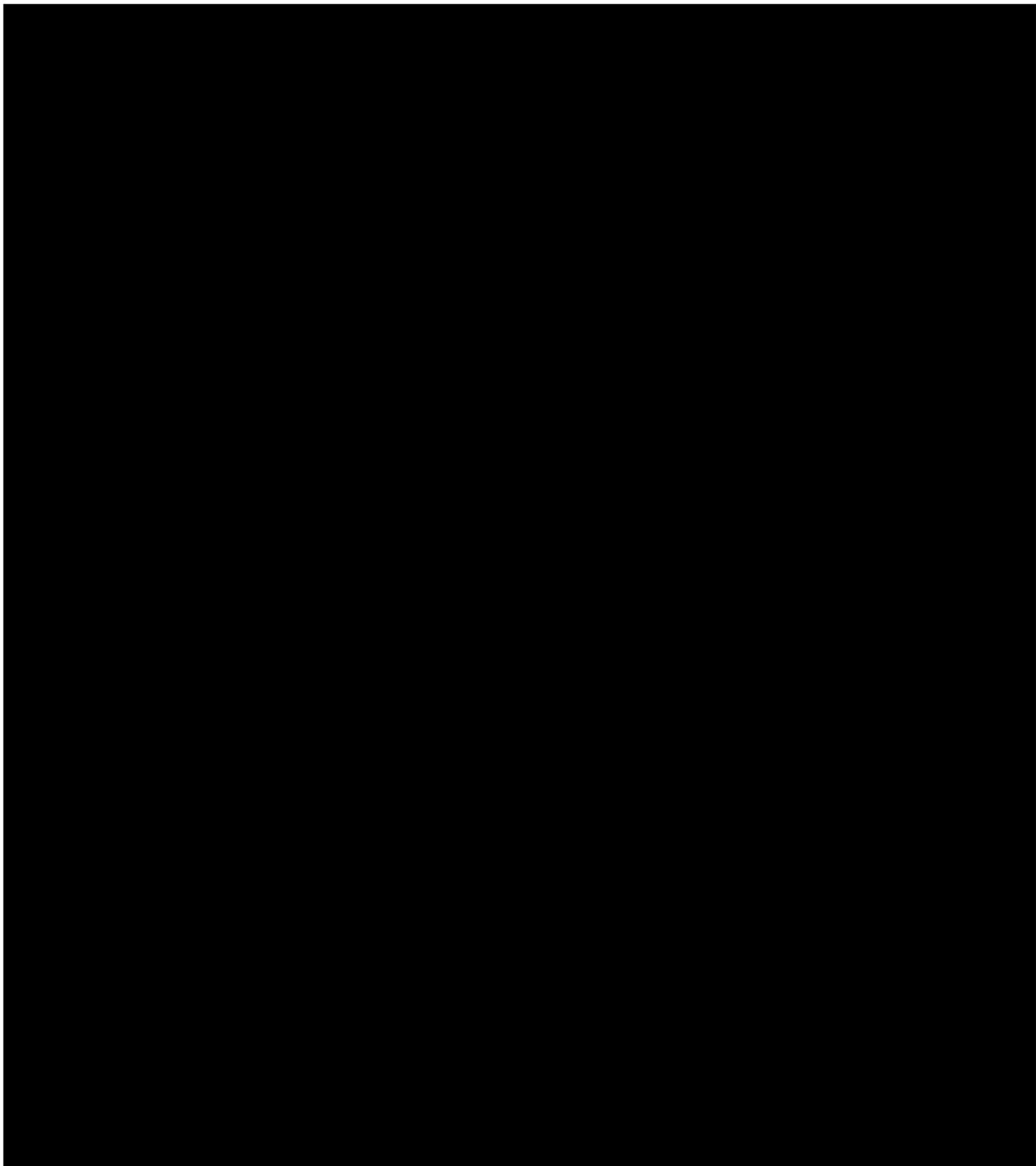


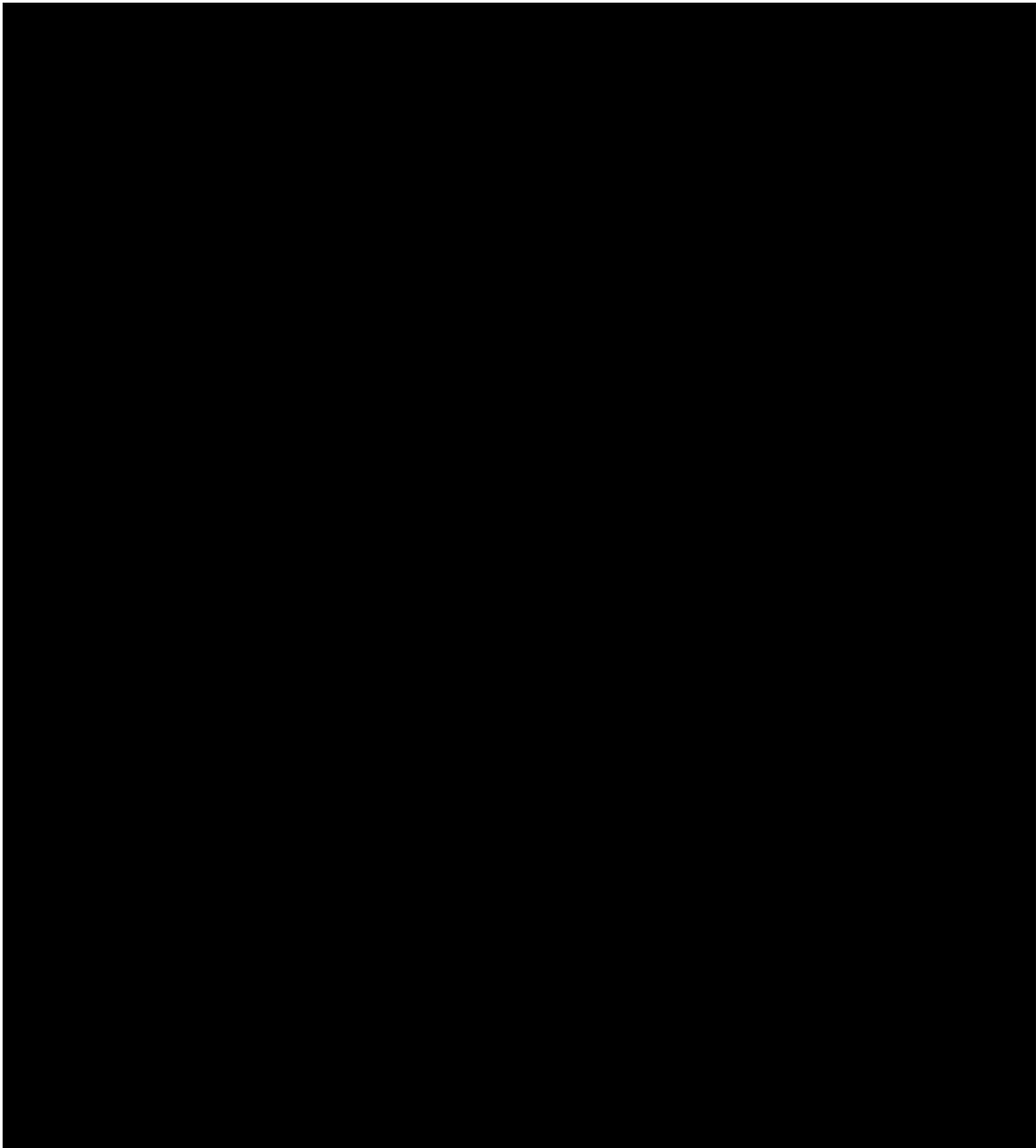
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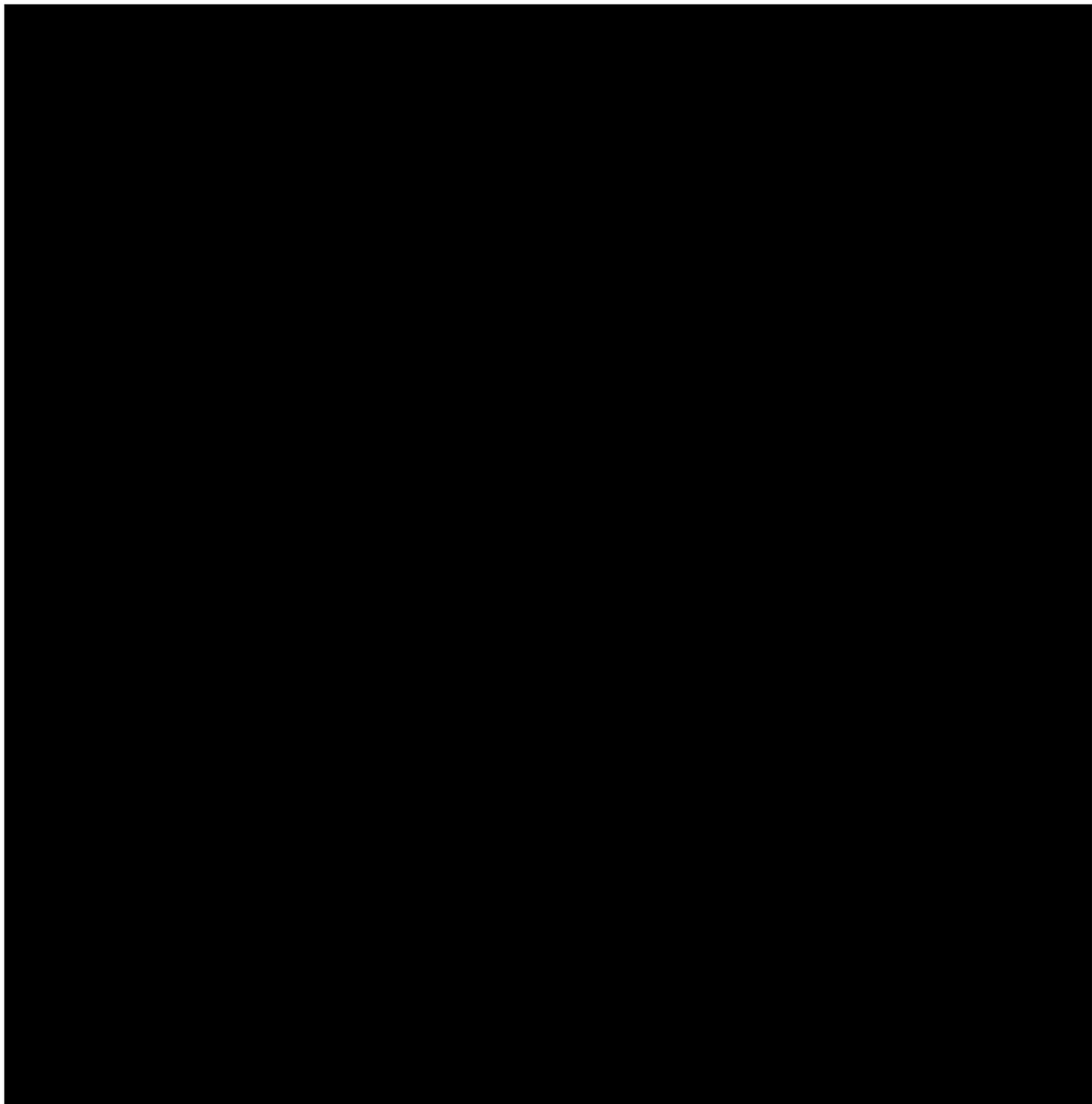
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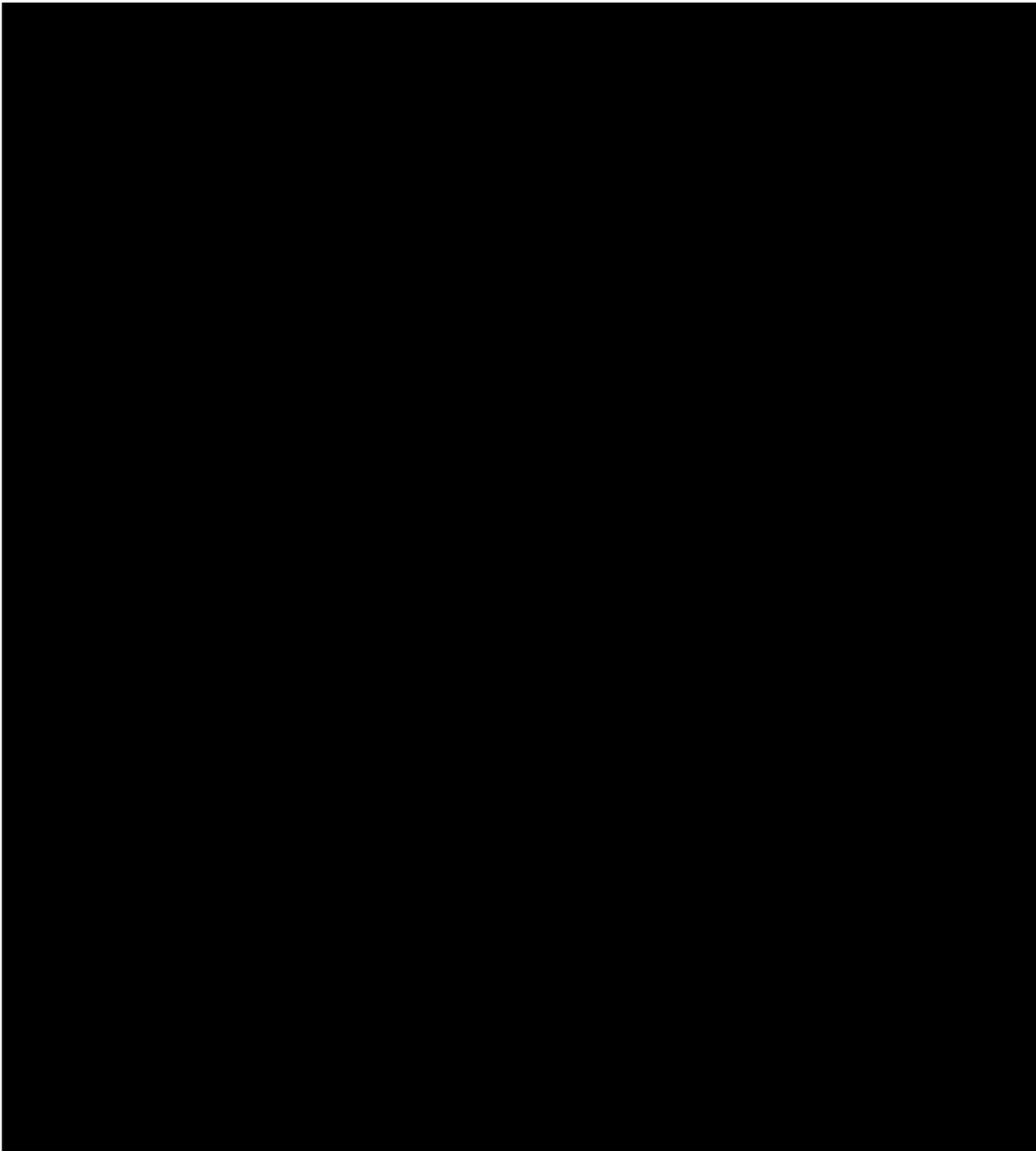


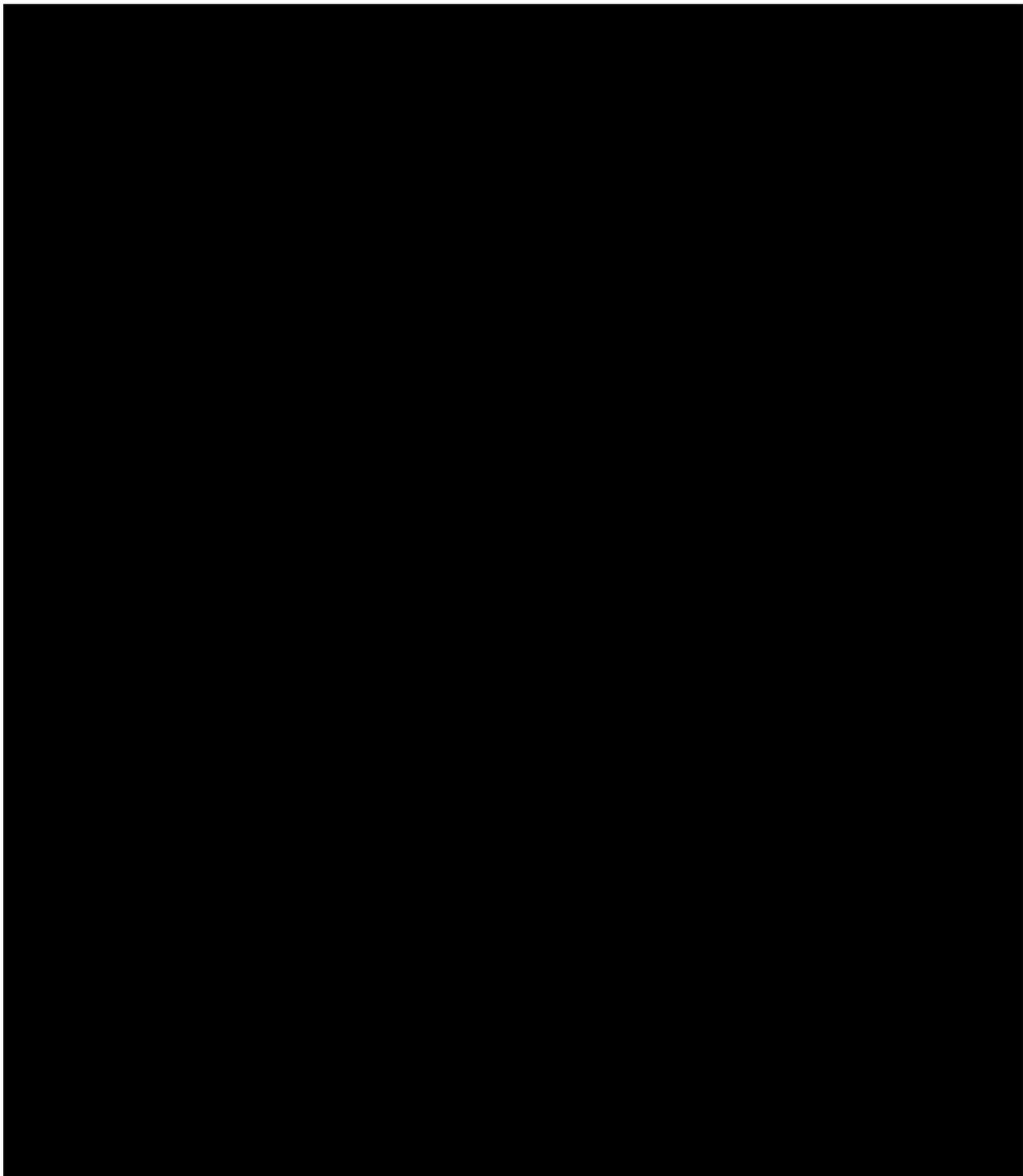


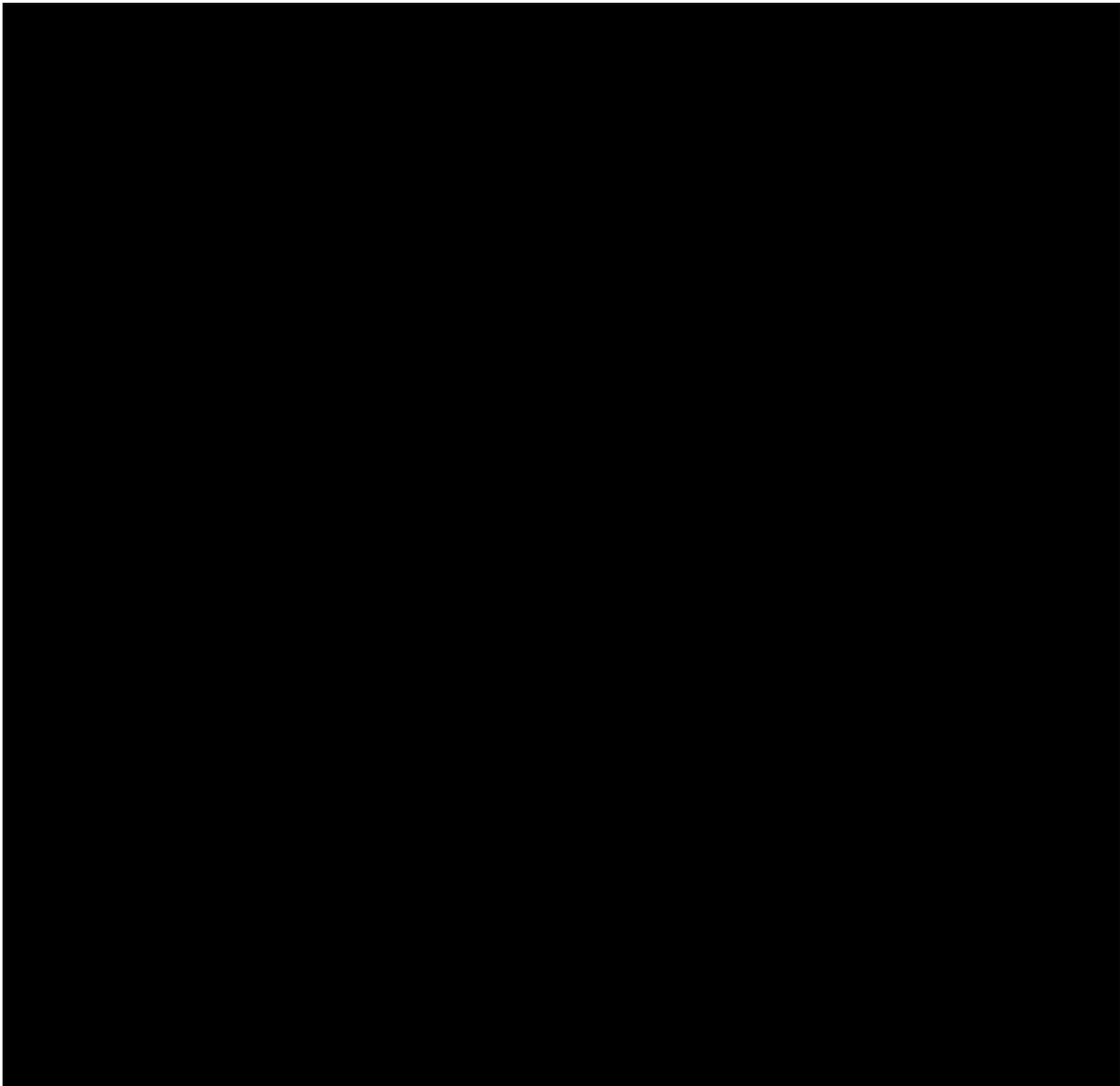








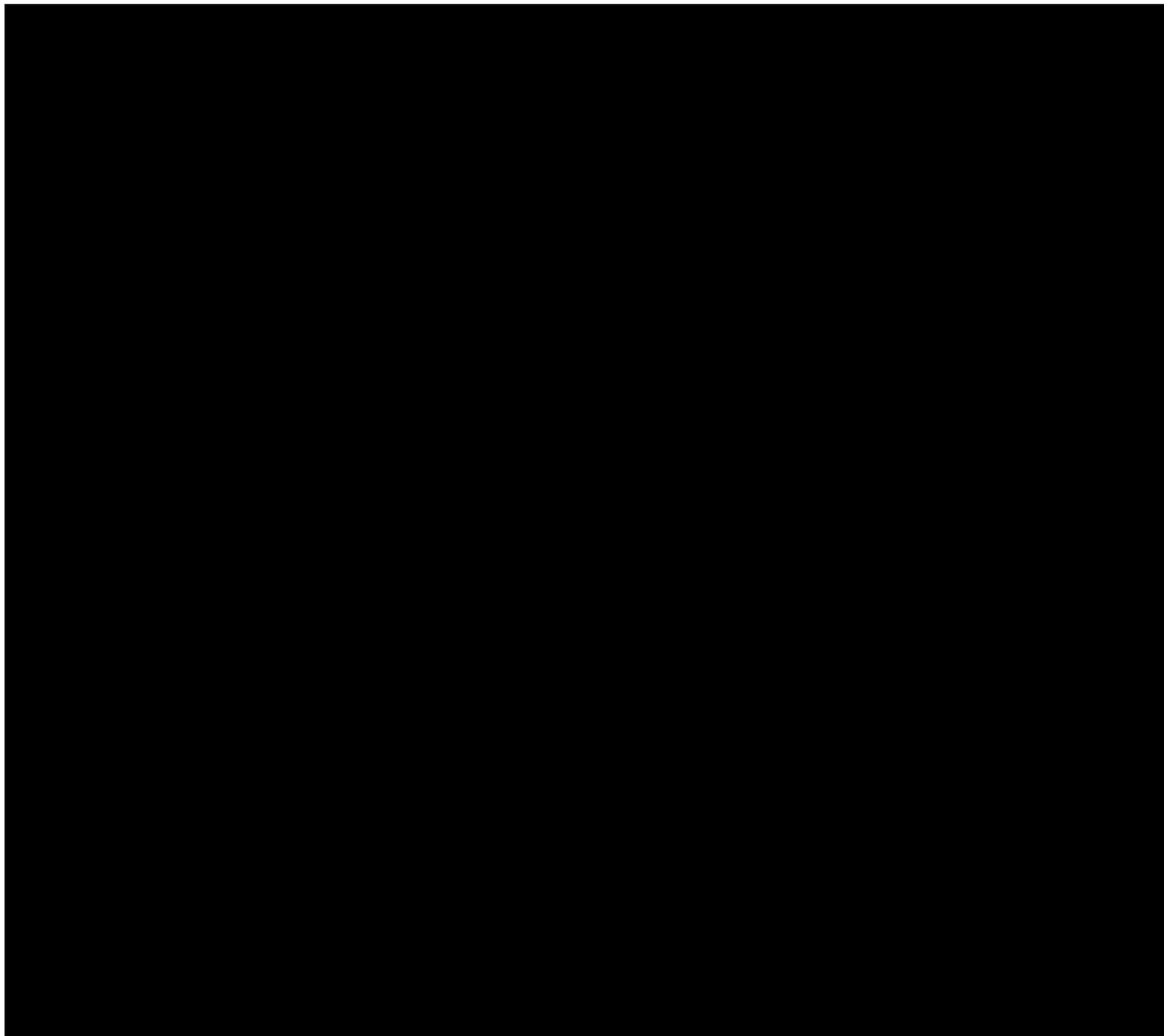


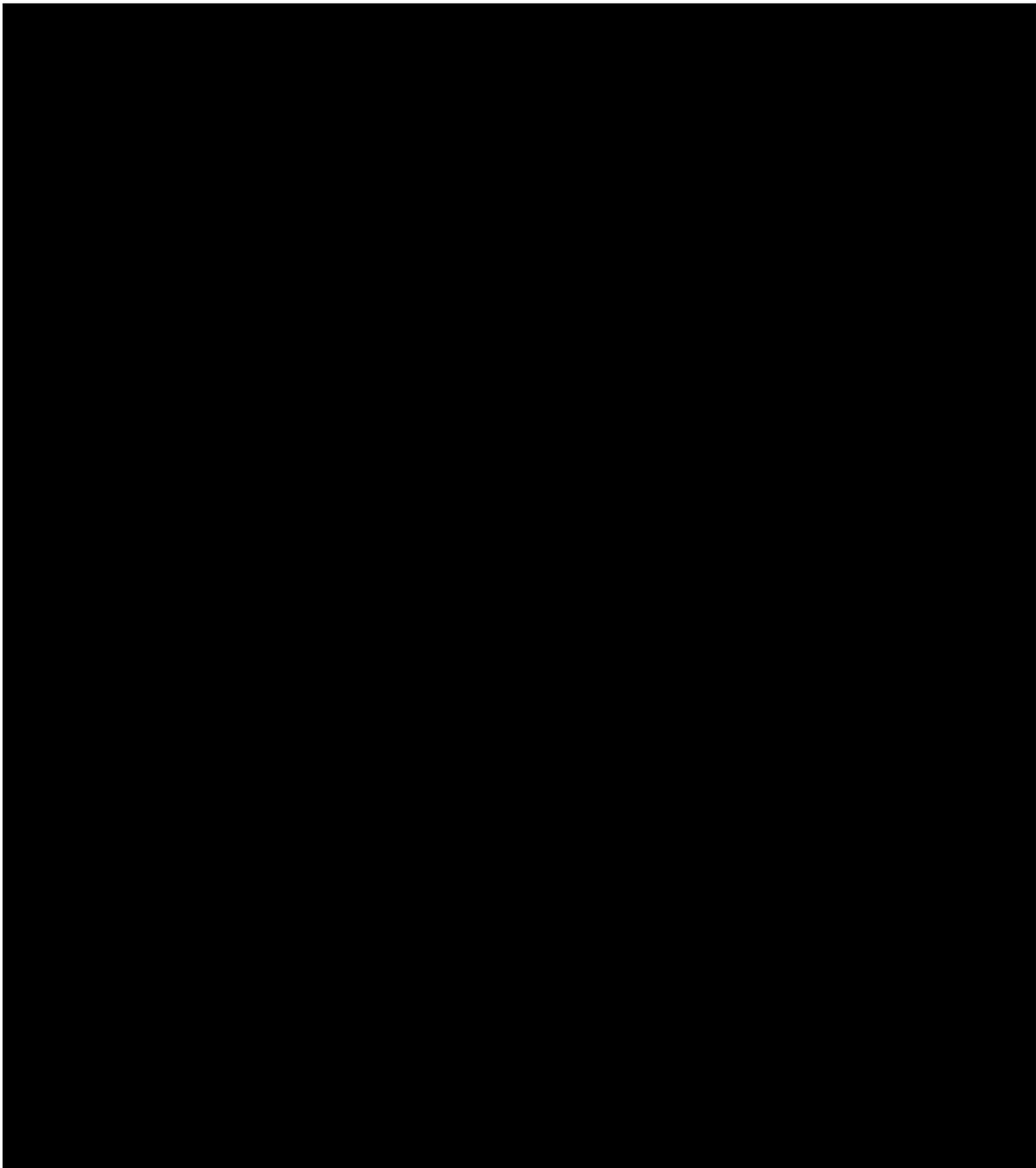


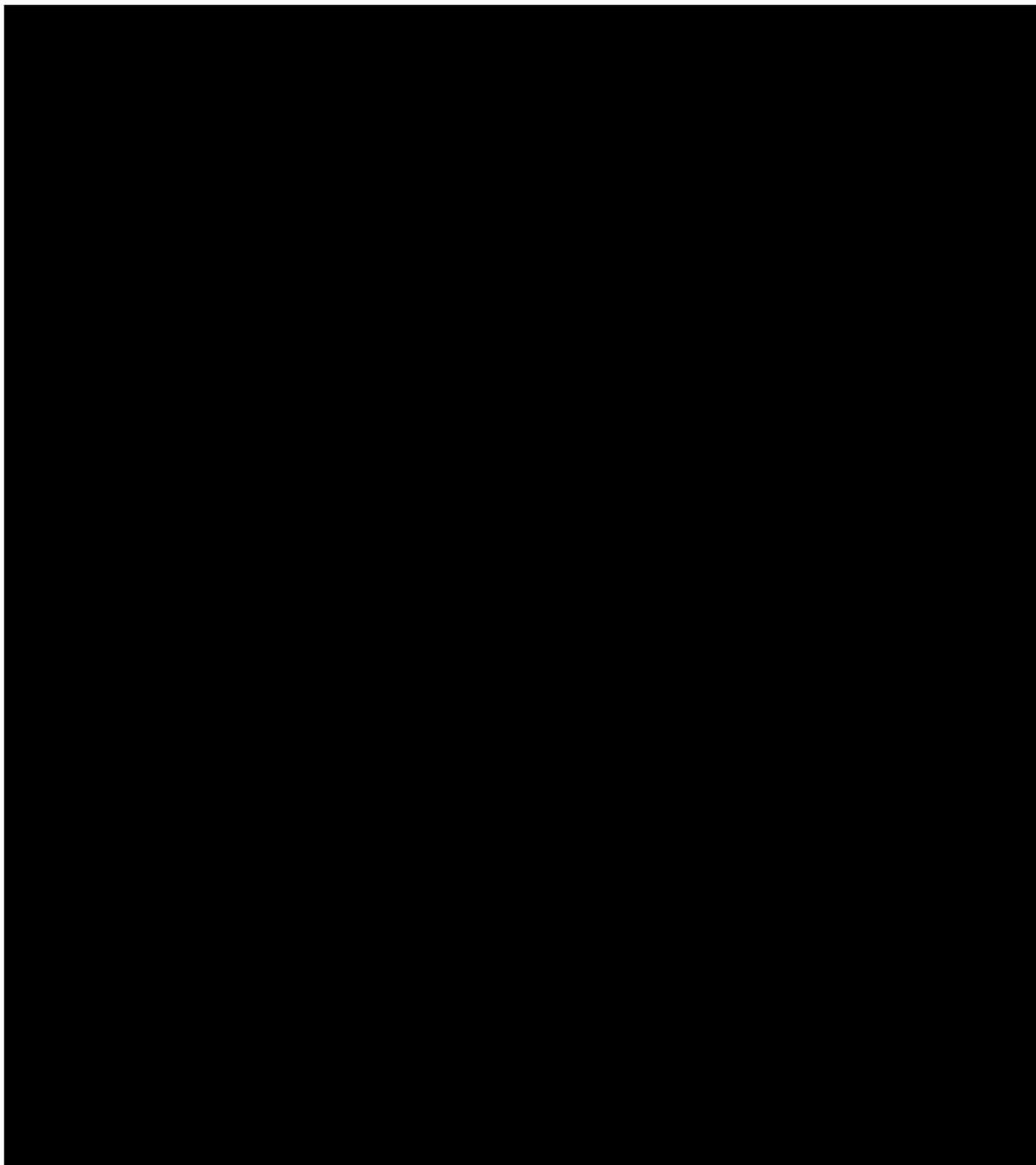


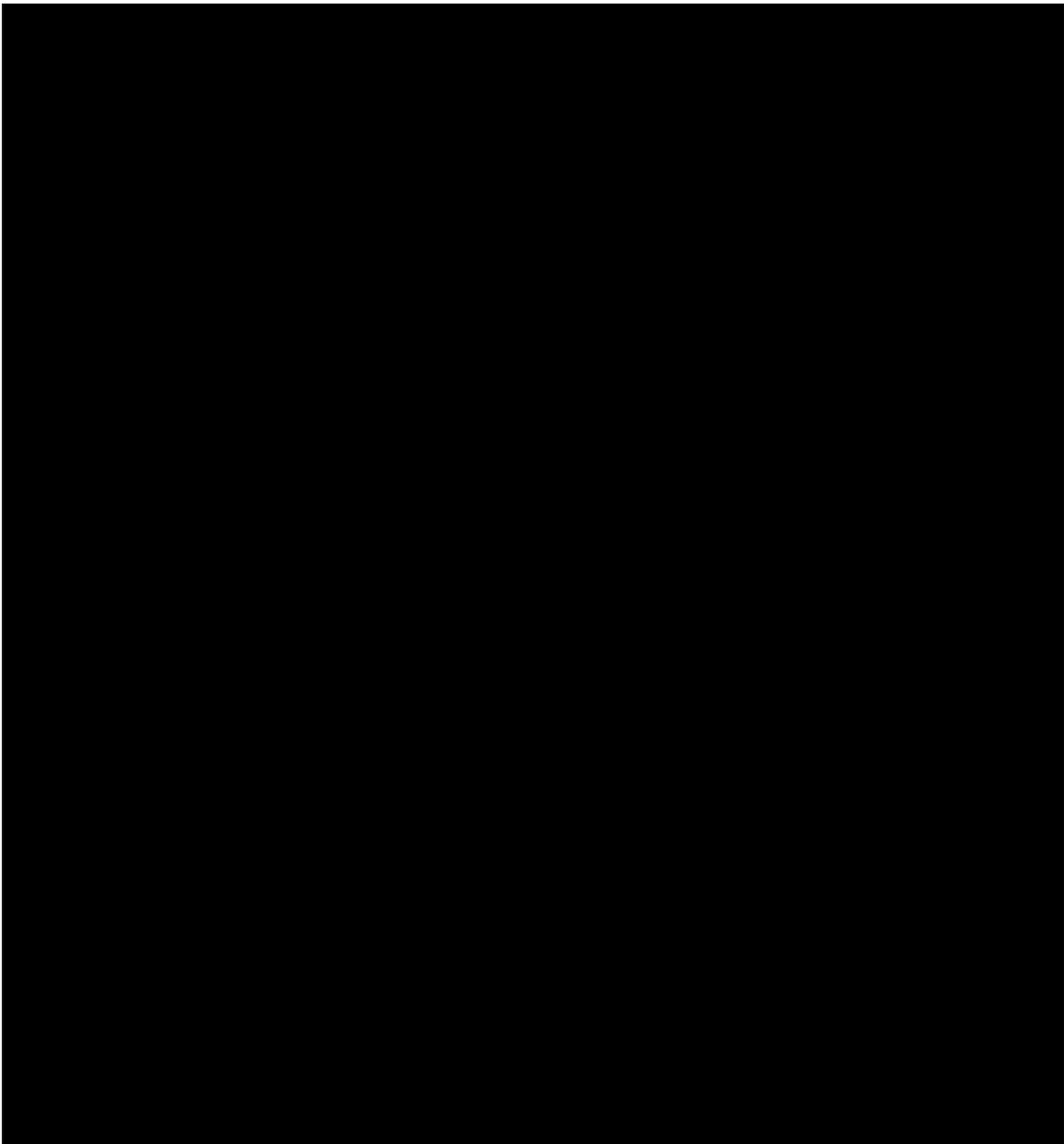
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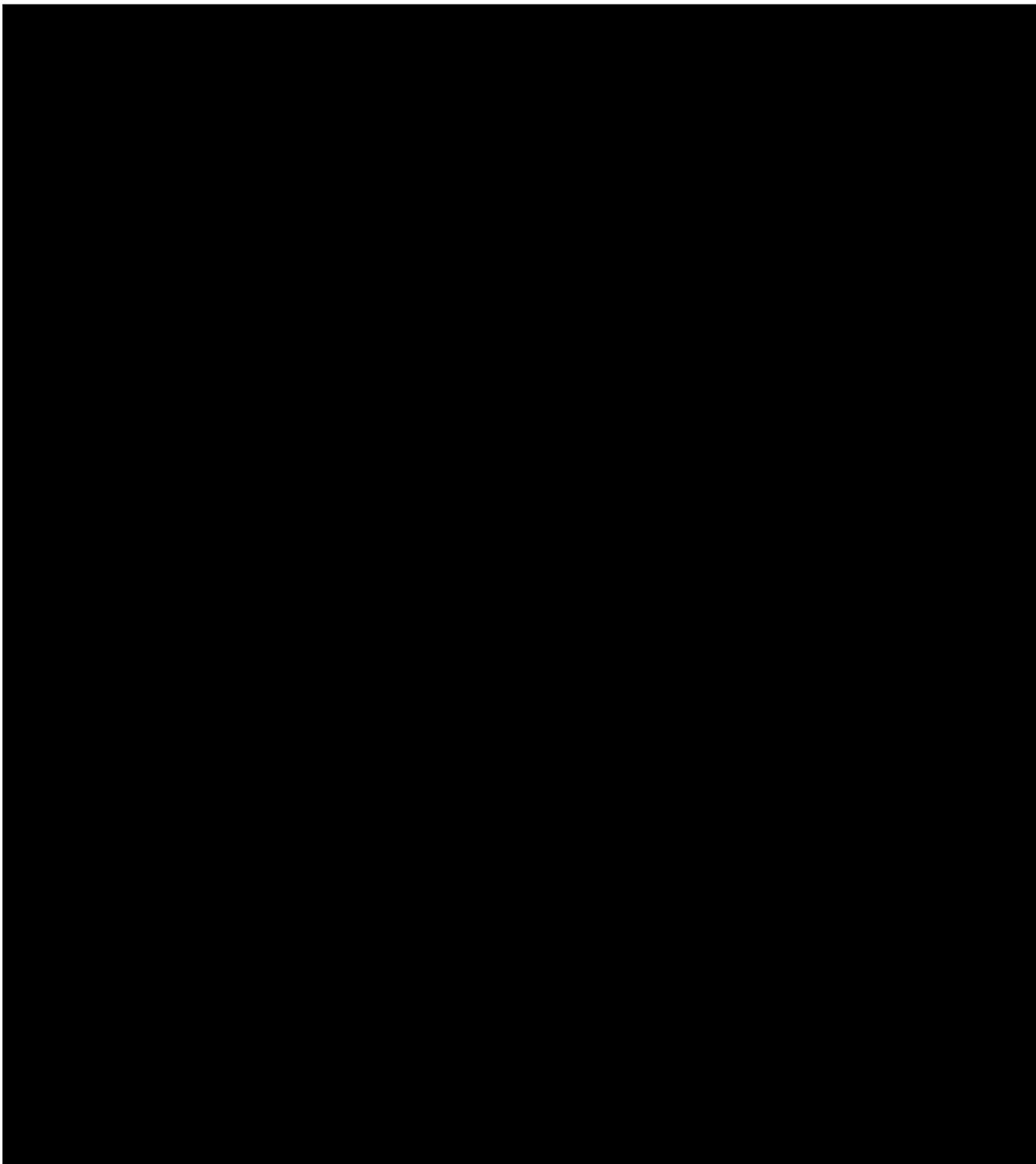
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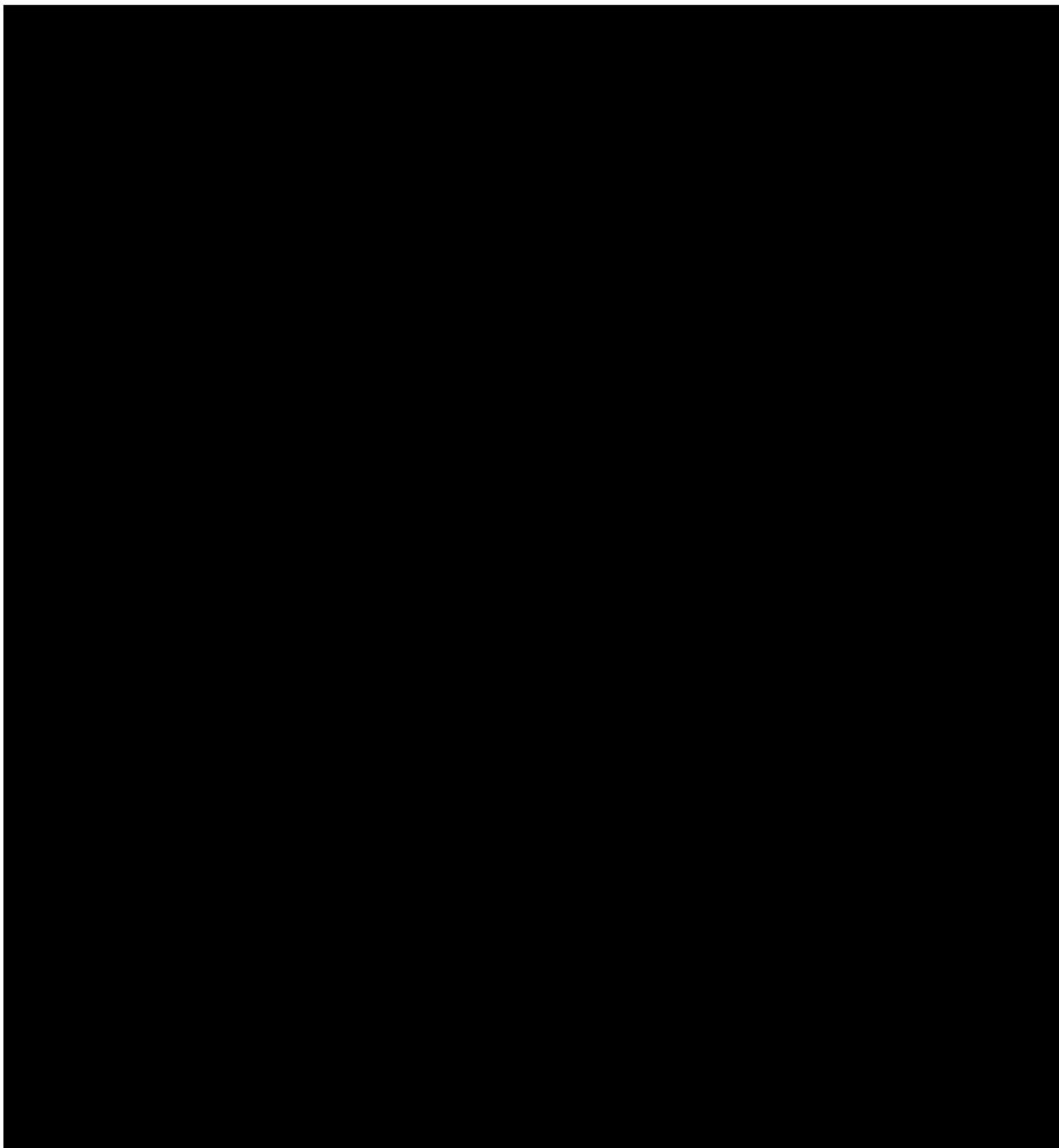


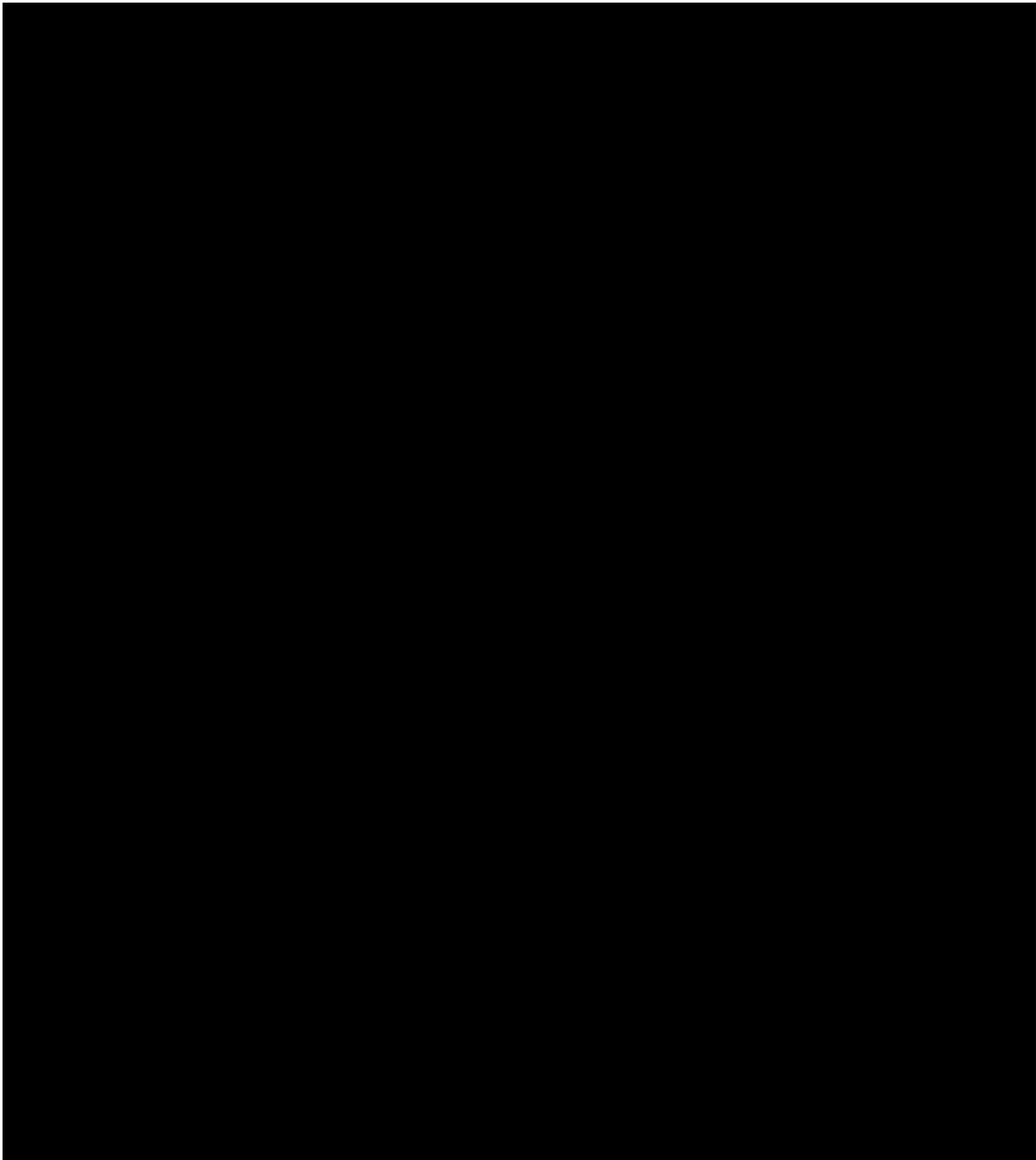


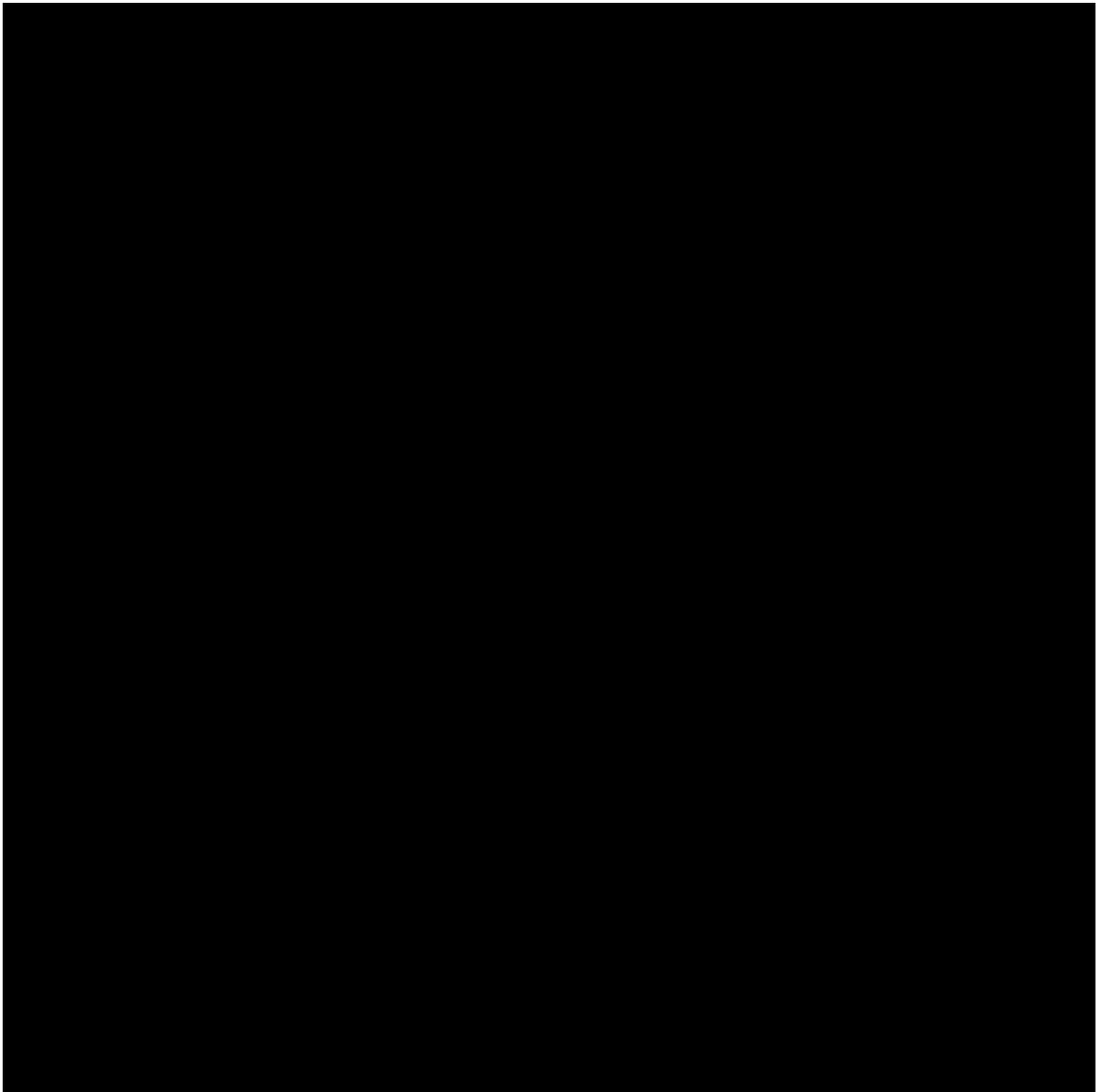


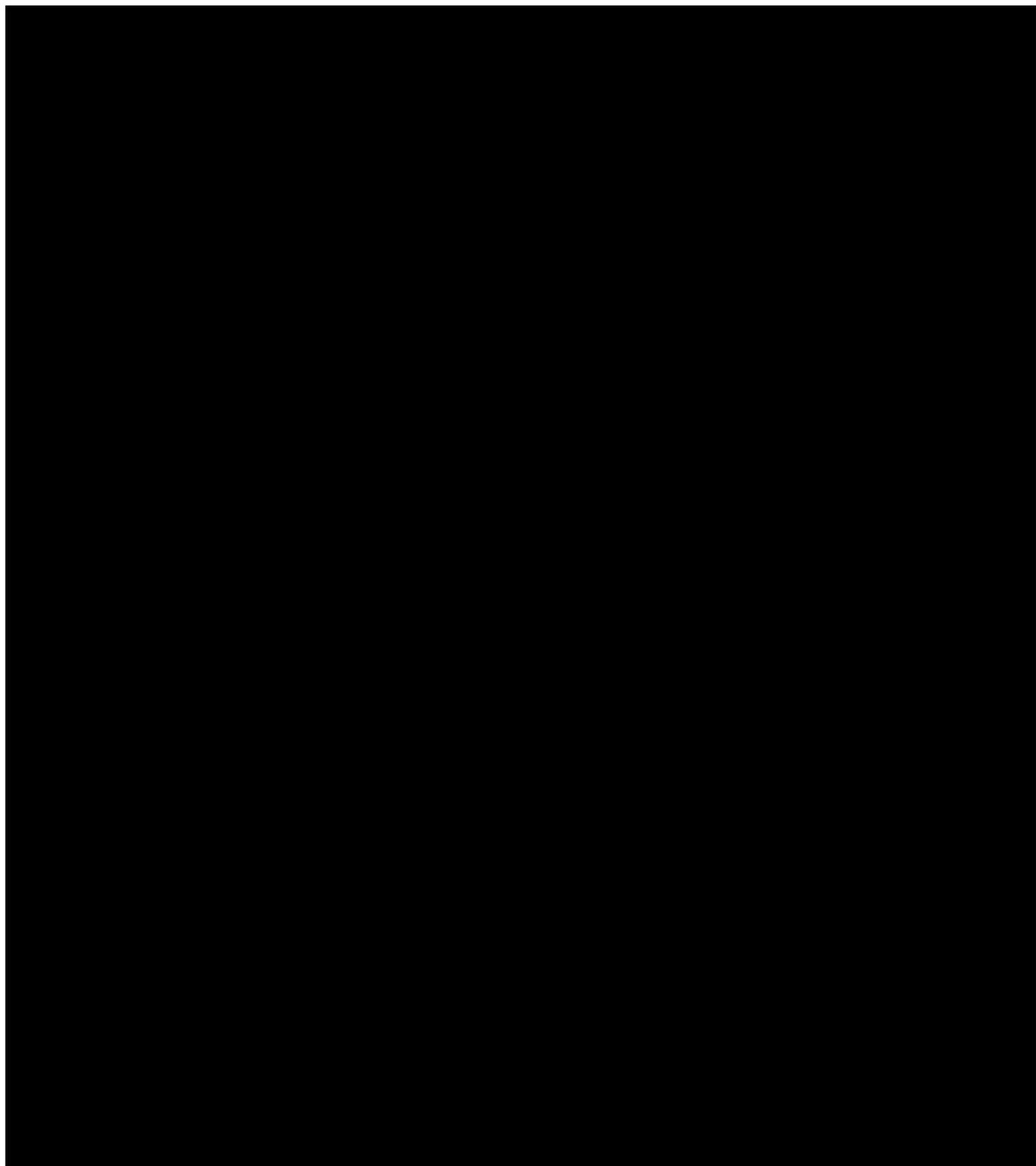












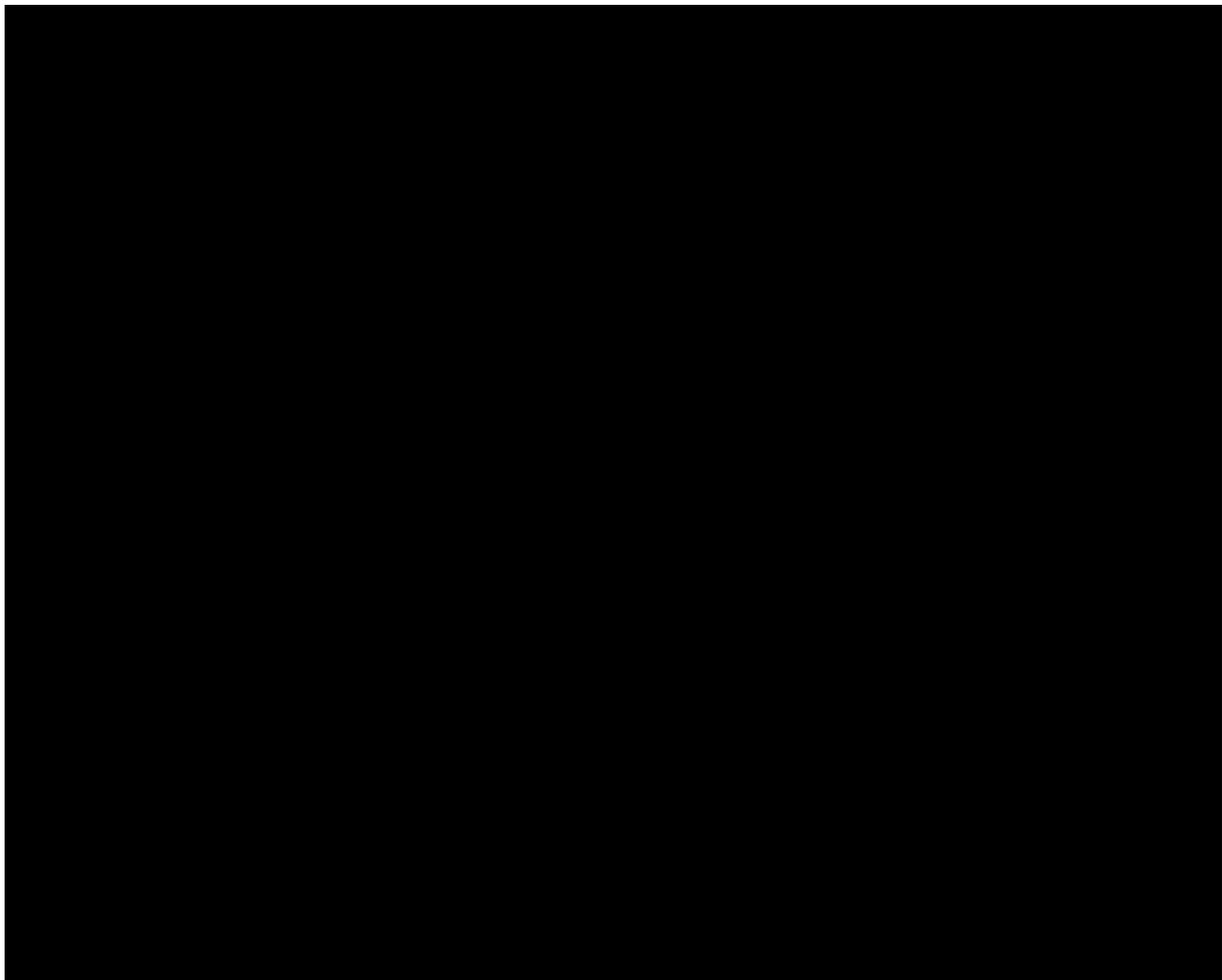




EXHIBIT G

Security Exhibit

The requirements of this Exhibit G are applicable if and to the extent that OptumRx creates, has access to, or receives from or on behalf of State any State Information (as defined below).

1. Definitions. The following terms shall have the meanings as set forth below:

1.1 "State Information" means any information of State provided, collected or created by OptumRx in course of providing products or services under the Agreement that includes or is comprised of any of the following:

- (a) Protected health information as defined in 45 C.F.R. § 160.103, and is limited to the Protected Health Information received from, or received, created, maintained or transmitted on behalf of, State.
- (b) Non-public personal information (i.e., any information that would be termed "non-public personal information" under the Federal Gramm-Leach-Bliley Act, any related state statutes, and any related federal or state regulations);
- (c) Personal data (i.e., any information relating to an identified or identifiable natural person, as further defined under the European Union Directive 95/46/EC and each EU member state's implementing laws, including any regulations and codes of conduct issued under such laws);
- (d) Cardholder data, as that term is defined in the most current version of Payment Card Industry (PCI) Data Security Standard; or
- (e) Other personal information (i.e., other personally identifiable information about individuals, or information that can be used to identify individuals, the disclosure and/or use of which is restricted by applicable federal or state law, including social security numbers).

1.2 "State Information Systems" means information systems resources supplied or operated by State or its contractors, that OptumRx is authorized to access under the Agreement.

1.3 "Device" means equipment or electronic media on which State Information is accessed, stored or processed, including storage drives or tapes, removable drives or media, desktop and laptop computers, tablets, and mobile devices.

1.4 "OptumRx Information Systems" means information systems resources supplied or operated by OptumRx, including network infrastructure, computer systems, workstations, laptops, hardware, software, databases, storage media, printers, proprietary applications, Internet connectivity and printers which are used, either directly or indirectly, by OptumRx in providing products or services under the Agreement.

1.5 "OptumRx Personnel" will mean employees, contractors or agents of Vendor, or of its subcontractors, who provide products or services (or any component thereof) to State.

1.6 "Security Incident" means the unauthorized access, use, disclosure, modification, or destruction of State Information or access to or interference with the operations of any State Information Systems.

2. General Requirements.

2.1 Security Program. OptumRx shall maintain a comprehensive security program under which OptumRx documents, implements and maintains the physical, administrative, and technical safeguards



necessary to: (a) comply with applicable law; and (b) protect the confidentiality, integrity, availability, and security of OptumRx Information Systems and State Information. OptumRx's security program shall be consistent with the requirements of this Exhibit and shall be designed to ensure compliance with the provisions of applicable law, including without limitation the Health Information Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), the Payment Card Industry Data Security Standards (PCI DSS), and Sarbanes-Oxley (SOX).

2.2 Policies and Procedures. OptumRx shall maintain written security management policies and procedures to identify, prevent, detect, contain, and correct violations of measures taken to protect the confidentiality, integrity, availability, or security of OptumRx Information Systems and/or State Information. Such policies and procedures shall (a) assign specific data security responsibilities and accountabilities to specific individual(s); (b) include a formal risk management program which includes periodic risk assessments; and (c) provide an adequate framework of controls that safeguard OptumRx Information Systems and State Information.

2.3 Infrastructure Protection. OptumRx shall maintain healthcare industry standard procedures to protect OptumRx Information Systems, including, at a minimum:

- (a) Formal security programs (e.g., policies, standards, processes);
- (b) Content aware solution (i.e., data loss prevention) to discover, monitor, and protect data during transit across network, storage, and endpoint systems;
- (c) Processes for becoming aware of and maintaining security patches and fixes;
- (d) Router filters, firewalls, and other mechanisms to restrict access to the OptumRx Information Systems, including all local site networks that may be accessed via the Internet (whether or not such sites transmit information);
- (e) Resources used for mobile access to State Information Systems shall be protected against attack and penetration through the use of firewalls, malware detection/prevention, and encryption; and
- (f) Processes to prevent, detect, and eradicate malicious code (e.g., viruses).

2.4 IT Change and Configuration Management. OptumRx shall employ reasonable processes, consistent with healthcare industry practices, for change management, code inspection, repeatable builds, separation of development and production environments, and testing plans. Code inspections must include a comprehensive process to identify vulnerabilities and malicious code, logic-bombs, sniffers, and backdoors. In addition, OptumRx shall ensure that processes are documented and implemented for vulnerability management, patching, and verification of system security controls prior to their connection to production networks.

3. Risk Management

3.1 General Requirements. OptumRx shall maintain appropriate safeguards and controls and exercise due diligence to protect State Information against unauthorized access, use, and/or disclosure, considering all of the factors and/or requirements listed below.

- (a) Federal and state legal and regulatory requirements;
- (b) Information technology and healthcare industry best practices;
- (c) Sensitivity of the data;



- (d) Relative level and severity of risk of harm should the integrity, confidentiality, and availability of the data be compromised, as determined by OptumRx as part of an overall risk management program; and
- (e) OptumRx's data security requirements, as set forth in this Exhibits, its due diligence process and/or the Agreement.

3.2 Security Evaluations. OptumRx shall periodically (no less than annually) evaluate its processes and systems to ensure continued compliance with obligations imposed by law or regulation with respect to the confidentiality, integrity, and availability of State Information and OptumRx Information Systems. OptumRx shall document the results of these evaluations and any remediation activities taken in response to such evaluations.

3.3 Internal Records. OptumRx shall maintain mechanisms to capture, record, and examine information relevant to Security Incidents and other security-related events. In response to such events, OptumRx shall take appropriate action to address and remediate identified vulnerabilities to State Information and OptumRx Information Systems.

3.4 Vulnerability Assessment and Patch Management. OptumRx shall, at least once a year, perform penetration tests of applicable OptumRx environments, including perimeter vulnerability testing, internal infrastructure vulnerability testing, and application testing. OptumRx shall also ensure that appropriate patches and security updates are applied in accordance with healthcare industry standards.

4. Personnel Security

4.1 Access to State Information. OptumRx shall require that OptumRx Personnel who have access to State Information or OptumRx Information Systems to comply with the provisions of the Agreement, including this Exhibit and any confidentiality agreement(s) or Business Associate Agreement(s) binding upon OptumRx. OptumRx will remain responsible for any breach of this Exhibit by OptumRx Personnel.

4.2 Security Awareness. OptumRx shall ensure that OptumRx Personnel remain aware of healthcare industry standard security practices, and their responsibilities for protecting the State Information which includes::

- (a) Protection against malicious software (such as viruses);
- (b) Appropriate password protection and password management practices; and
- (c) Appropriate use of work stations and computer system accounts.

4.3 Sanction Policy. OptumRx shall maintain a sanction policy to address violations of OptumRx's internal security requirements or security requirements which are imposed on OptumRx by law, regulation, or contract.

4.4 Supervision of Workforce. OptumRx shall maintain processes for authorizing and supervising its employees, temporary employees, and independent contractors and for monitoring access to Information and OptumRx Information Systems.

4.5 Background Checks. OptumRx shall maintain processes to determine whether a prospective member of OptumRx's workforce is sufficiently trustworthy to work in an environment which contains State Information.

5. **Physical Security.** OptumRx shall maintain appropriate physical security controls (including facility and environmental controls) to prevent unauthorized physical access to OptumRx Information



Systems and areas in which State Information is stored or processed. Where practicable, this obligation shall include controls to physically protect hardware (e.g., lockdown devices). OptumRx shall adopt and implement a written facility security plan which documents such controls and the policies and procedures through which such controls will be maintained. OptumRx shall maintain appropriate records of maintenance performed on OptumRx Information Systems and on the physical control mechanisms used to secure OptumRx Information Systems.

6. Security Monitoring and Response

6.1 Incident Response. OptumRx shall maintain formal processes to detect, identify, report, respond to, and resolve Security Incidents in a timely manner.

6.2 Incident Notification. OptumRx shall notify State of any Security Incidents as required under the Agreement (including the Business Associate Agreement). Upon request, OptumRx shall provide State with a written remediation plan for any Security Incident.

7. Communications Security

7.1 Exchange of State Information. OptumRx shall utilize a method of transmitting State Information electronically that prevents the unauthorized access to and/or modification of such information.

7.2 Encryption. OptumRx shall maintain encryption, in accordance with healthcare industry standards, for all transmissions by OptumRx of State Information via public networks (i.e., the Internet). Such transmissions include:

- (a) Sessions between web browsers and web servers;
- (b) Email containing State Information (including emails containing passwords);
- (c) Transfer of files via the Internet (e.g., FTP);

Additionally, OptumRx shall maintain encryption of data maintained on the following devices or media:

- (a) Laptop / desktop;
- (b) Mobile Device; and
- (c) Removable storage media (e.g., thumb drive, external hard drives, writable CD drives, backup tapes).

7.3 Protection of Systems, Devices and Storage Media. OptumRx shall ensure all reasonable, healthcare industry standard measures are taken to physically secure Devices containing State Information to prevent any unauthorized disclosure while in transit and while at rest. OptumRx shall ensure that all Devices on which State Information was stored or processed are properly sanitized before such Devices are used for any other purpose. All media on which State Information is stored shall be protected against unauthorized access or modification. OptumRx shall maintain reasonable and appropriate processes and mechanisms to maintain accountability and tracking of the receipt, removal and transfer of Devices used by OptumRx in providing products or services under the Agreement or on which State Information is stored.

8. Access Control

8.1 Identification and Authentication. All access to any State Information or any OptumRx Information Systems shall be Identified and Authenticated as defined in this Section. "Identification" (or "Identify," as the context requires) refers to processes which establish the identity of the person or entity requesting access to State Information and/or OptumRx Information Systems. "Authentication" (or "Authenticate," as the context requires) refers to processes which validate the purported identity of the requestor. For access



to State Information or OptumRx Information Systems, OptumRx shall require Authentication by the use of an individual, unique user ID and an individual password or other appropriate Authentication technique per OptumRx's standard policies and procedures. OptumRx shall maintain procedures to ensure the protection, integrity, and soundness of all passwords created by OptumRx and/or used by OptumRx in connection with the Agreement.

8.2 Account Administration. OptumRx shall maintain appropriate processes for requesting, approving, and administering accounts and access privileges for OptumRx Information Systems and State Information. These processes shall include procedures for granting and revoking emergency access to OptumRx Information Systems and State Information. All access by OptumRx Personnel to State Information Systems shall be subject to prior approval by State and shall follow State standard policies and procedures.

8.3 Access Control. OptumRx shall maintain appropriate access control mechanisms to prevent all access to State Information and/or OptumRx Information Systems, except by (a) specified users expressly authorized by OptumRx and (b) OptumRx Personnel who have a "need to access" to perform a particular function in support of OptumRx's provision of products or services to State under the Agreement. The access and privileges granted shall be limited to the minimum necessary to perform the assigned functions. OptumRx shall maintain processes to ensure that OptumRx Personnel access to State Information is revoked upon termination. OptumRx shall maintain appropriate mechanisms and processes for detecting, recording, analyzing, and resolving unauthorized attempts to access State Information or OptumRx Information Systems.

8.4 Personal Devices and Removable Media. OptumRx shall restrict access to, and the use of removable media, such as USB drives, writable optical media, portable hard drives, and other removable media. OptumRx may not (and shall cause OptumRx Personnel to not) use any such removable media to store or transfer State Information, except as directed by State.

9. Network Security

9.1 Access to State Information Systems. OptumRx shall only have access to State Information Systems authorized by State under the Agreement. OptumRx shall not attempt to access any applications, systems or data which State has not authorized OptumRx to access or which OptumRx does not need to access in order to provide products or services for State. OptumRx further agrees to access such applications, data and systems solely to the extent minimally necessary to provide products or services to State.

9.2 Remote Access Security Controls. Any remote access by OptumRx Employees to OptumRx Information Systems shall be subject to the following security controls:

- (a) Only OptumRx-owned and maintained PC devices (e.g., laptops and desktop PCs) may be used for remote access into OptumRx Information Systems, other personally-owned Mobile Devices may be used in accordance with OptumRx policies and this Agreement;
- (b) Mobile devices shall be registered with the OptumRx security guard or the OptumRx manager, as required.
- (c) OptumRx shall restrict administrative rights to PC device.
- (d) OptumRx shall configure the PC device according to OptumRx's connectivity requirements, including approved VPN software.
- (e) OptumRx will maintain PC device password and screen lock safeguards.
- (f) OptumRx shall use current, commercially supported operating systems on the PC device.
- (g) OptumRx shall use current and up to date patches, hot fixes, and service.



- (h) OptumRx remote access users shall adhere to OptumRx standard authentication protocols including, but not limited to, network and application login accounts, and/or two factor authentication tokens.

9. Business Continuity Management. OptumRx will, at its sole expense, establish and maintain (i) written business continuity plans for the Services and supporting facilities and (ii) written disaster recovery plans for critical technology and systems infrastructure and (iii) proper risk controls (collectively, the “Contingency Plans”) to enable continued performance under this Agreement in the event of a disaster or other unexpected break in Services. OptumRx will update and test the operability of any applicable Contingency Plan at least annually, and will maintain each such plan upon the occurrence of a disaster event. As used herein, a disaster is defined as an unanticipated incident or event, including, without limitation, force majeure events, technological accidents, or human-caused events, that may causes a material service or critical application to be unavailable without any reasonable prediction for resumption, or that causes data loss, property damage or other business interruption without any reasonable prediction for recovery, within a commercially reasonable time period.

10. Back-up Plans. OptumRx shall store all backup and archival media containing Information used to provide the Services in secure, environmentally-controlled storage areas owned, operated, or contracted for by OptumRx.



PRIORITY CLARIFICATION ITEMS

Customer Service

1. Confirm the PBM's dedicated team of customer service representatives (for commercial and EGWP) are available from 7AM to 10PM Alaska time for the state's members, with designated representatives available outside of these hours.

As agreed to with the State, we will provide the State of Alaska with a highly designated team, who are prepared to offer your members our highest level of service. We expect the Salem, Oregon location to handle 85-90% of the member calls. For purposes of redundancy, the highly designated team has back up staff in other site(s) to ensure business continuity. All team members supporting the State of Alaska will receive client specific training, including geographical and culture training. The team will be focused on providing high touch service with emphasis on taking the member out of the middle and achieving First Call Resolution.

2. Please explain if commercial and EGWP member calls will be handled through the same dedicated team of customer service representatives.

Confirmed.

3. Provide an explanation of how you define "after-hours." How are calls "after-hours" of operation handled?

Outside of the 7AM to 10PM Alaska time hours, calls will be handled by our overnight team. The overnight team will be fully trained on the State of Alaska account. There will be supervisory support available during the overnight time frame as well.

4. Do members reach a live representative or an interactive voice response unit (IVR) when calling customer service?

Members calling one of our toll-free numbers are greeted by the IVR system. The IVR system helps to authenticate the caller which ensures they route to the correct team. This is especially important should the member happen to call a general OptumRx toll free number, instead of a State of Alaska dedicated number. Our sophisticated IVR system features detailed menus and instructions that help callers perform routine functions and submit inquiries. Members can also choose to speak with a customer service advocate (CSA), and if needed, one of our clinical pharmacists. It is also an option for a member to skip the IVR and go straight to a CSA.

5. List how many customer service representatives will be dedicated to the State's plans.

Under a highly designated model, we will have 23 Health Care Advisors, as well as redundancy from Health Care Advisors in two other locations. All staff will receive the same training regarding the State of Alaska benefits, requirements, culture. This includes annual enrollment and annual changes to CMS coverage changes for Medicare Part D/EGWP plans.

6. What are call volume metrics for determining appropriate staffing for the dedicated call center?

In the highly designated call center, a customer service advocate takes 17 calls per day, with the calls ranging from 8 to 12 minutes per call. Based on call volume provided by the State, in



addition to factoring PTO, one on one's, training events, etc. [REDACTED] and will adjust as volumes stabilize.

7. What is the current ratio of customer service representatives to supervisors and managers.

Team Leads: CSAs – 1:18

Supervisors: CSAs - 1:18

Managers: CSAs - 1:108

8. Do customer service representatives handle both member calls and provider calls?

Most physician calls are related to prior authorization, so they are connected directly with the prior authorization team. Pharmacies and members are serviced by two separate customer service teams. Both the pharmacy and member customer service teams will receive training on State of Alaska, including the details of COB.

9. Can customer service representatives access claims status on-line in real-time?

Confirmed.

10. Do customer service representatives have access to member eligibility, claims history, benefit descriptions, records of prior contacts including status of question/complaint, precertification requests, mail order or specialty delivery status, medication price estimators, ID card orders, and disease specific educational information?

Confirmed.

11. Describe your training program for customer service employees.

New hire training includes 6 weeks of instructor led classroom training. During this time, they learn our systems, policies and procedures, PBM terminology, specifics on the clients they will be servicing and call handling expectations, including demonstrating empathy and de-escalation techniques. While in the classroom, they are given hands-on opportunities to practice what they have learned.

Following the classroom training, the class will move to the call center floor and spend 3 to 4 weeks working with a supervisor who is dedicated to supporting the new hires. In addition, a group of tenured staff will be assigned to work with them as they take calls.

Existing employees receive refresher training and new client training via a classroom setting or on-line courses depending on the complexity.

Specific to State of Alaska, training will be in a class room environment. In addition to basic training on things such as benefits, we will also cover geographical and cultural training.

We are happy to partner with the State of Alaska on identifying key training that should be conducted on an annual basis. Throughout the year, we make test calls, provide pop quizzes and listen to call recordings to monitor our performance. If an opportunity is identified through these activities we are quick to take action on those opportunities. Actions taken may include



reviewing the situation with an individual CSA; sending out an email bulletin; supervisor huddles; class room training.

We are consumer obsessed and act with a high level of accountability and integrity with the goal to get the member out of the middle. We are prepared to step in and resolve issues for the State of Alaska membership. In some cases, we will make an outbound call to resolve any outstanding issues to ensure first call resolution was achieved. As needed the situation will be referred to our Research and Resolution team for handling. Once there is resolution, the Research and Resolution Specialist would then follow-up with the member to let them know the outcome.

Specific examples given by the State:

Member lives 40 miles from the pharmacy with an issue, can we save them the drive by making sure everything will be okay with the Rx once they arrive at the pharmacy. It was confirmed that our Lead team would step in and take the member out of the middle, then follow-up with the member once resolved.

Drug requires PA which is denied for one reason or another; outreach would be made to the provider. Once the issue is resolved and can verify a successful trial claim a call would be made to the member.

12. Describe the training you provide to client's staff and other health vendors who could take calls from Medicare retired members

We will empower the State's staff or other health vendors with training on our claims adjudication system, RxClaim, so that they are able to access member eligibility and demographics, claims history, and prior authorizations. We will also provide EGWP specific training which includes an overview of the EGWP program, CMS waivers, differences between RDS and EGWP, OptumRx PBM services for EGWP, Part D benefit design, and CMS subsidies.

13. Confirm the PBM will provide geography training on the state of Alaska to customer service representatives.

Confirmed.

14. Explain any incentive programs you employ to retain competent customer service employees.

We compensate CSAs through hourly wages and quarterly performance-based initiatives. Performance is measured against company and department goals. Compensation is determined by a balanced performance scorecard. For that reason, CSAs are encouraged to continuously improve their performance scorecards. CSAs receive cash payouts based on their performance for the quarter. Incentive programs are heavily based on quality and member experience. Member experience is determined from member satisfaction surveys.

PERFORMANCE-BASED INCENTIVES

We also offer the following performance-based initiatives to reward top performers:

- **Work-From-Home Program:** Rewards top performers with full-time telecommuting privileges. Participants of the work-from-home program are evaluated for a full year before



they are selected. [REDACTED]

- Pharmacy Technician Certification Exam Preparation Course: CSAs are eligible to participate in the Pharmacy Technician Certification Exam Course. This course is designed to help the CSA review for and successfully pass the Pharmacy Technician Certification Exam to become a nationally-certified pharmacy technician by the Pharmacy Technician Board. We reward CSAs who have completed this course and have successfully passed the exam by paying for their certification fees.
- Leadership Development Course: Eligible CSAs can participate in our Leadership Development course and be mentored by senior managers. Through the course, mentors help CSAs chart a clear development path through our call center operations. In addition to these programs, we view areas of advancement within the department as another performance-based initiative. Within the call center alone, we provide seven different areas for advancement across four to five career levels.

15. What is the average years of experience for your customer service staff?

This information is not available, as we do not track an employees' prior employment history.

16. What is the average length of employment for your customer service staff?

CSAs have an average tenure of 2.6 years; customer service managers have an average of tenure of 5.9 years; professional administrative staff have an average tenure of 14.9 years.

Specific to the Salem location, we have 26 CSAs who have been here 3 or more years, with 5 of the 26 being here 10 or more years.

17. Provide the turnover rate of your call center representatives for the past three calendar years.

[REDACTED]

18. How many dedicated toll free phone lines for the hearing impaired will be made available to answer member and provider inquiries?

We work with a 3rd party vendor to support hearing impaired or hearing disabled calls.

19. What other methods of contacting customer service representatives, besides telephone, are available for members to use?

Members can contact customer service through our website, IVR, our mobile app, secure messaging email or by chat.

We confirmed emails can be worked by the highly designated phone team based on the State's preference.

**20. Describe your process for written inquiries.**

Our member service correspondence team manages email, fax and U.S. mail. The email

The Mail Service Correspondence team receives the same training as our CSAs handling telephone inquiries and have access to the same resources, including an Assist Line/Chat, and our Research and Resolution team.

The team uses templates for frequently asked questions as a framework to craft a custom response for the members unique inquiry. Often, a phone call or email contact may be noted as the preferred contact method on the members record. In instances where a phone call can better serve the needs of the member, a call is initiated.

Action is taken as a result of the written correspondence is documented and tracked on the members record in our customer relationship management application.

Emails can be worked by the highly designated phone team based on the State's preference.

21. Do you send a letter of acknowledgment for written inquiries prior to the issue resolution?

Members who initiate an email via our secure messaging, or mail a written inquiry via the U.S. postal service or other carriers will receive an acknowledgement email response or letter via U.S. postal service.

22. In the past calendar year, what was your average turnaround time for responding to written inquiries?

We define written inquiries as those received by email, mail and fax.

23. For a member to receive or access to the PBM's video consultation platform services offered by the PBM, what technological requirements are necessary?

To use BrivoLive, members connect through a third party HIPAA-compliant platform and only need an Internet connection and a laptop, desktop or tablet.

Our mobile app is supported on Apple and Android devices. Members using Blackberry devices can access these features from our mobile website, m.optumrx.com.

24. Describe when and how a caller's recurring or unresolved issue is elevated to a supervisor/manager for resolution. Explain how you measure the success of this process over time.

We have various escalation protocols in place for providing expedited support to the State's members who contact our call center. Members may call us or write a letter regarding any unresolved inquiry or issue. We send inquiries related to our business practices, including plan design, to the assigned client manager for resolution.



The appropriate departments document, review and attempt to resolve inquiries to the member’s satisfaction.

COMMERCIAL MEMBERSHIP ESCALATION PROTOCOLS

If the State escalates a member issue to OptumRx, the following process is followed:

CLIENT ESCALATION

1. The State or a benefit administration representative escalates a member issue to the State’s client management team.
2. The client management team refers the member issue to our client advocate team. The client advocate team within our customer service department works closely with the State’s client management team to provide member service support and guidance for the overall delivery of prescription benefits. This team performs research and root cause analysis to identify operational, process, system and knowledge gaps. They perform member outreach to advise resolution. Client advocates participate in regular service meetings with account managers and the State, including performance reviews and remediation planning that may be required.

3. [REDACTED]

[REDACTED]

If a member escalates an issue to the CSA, and the CSA is not able to resolve the inquiry, the following process is followed:

CSA ESCALATION

1. CSA escalates to the Customer Service Assist Line.
2. The assist line team consists of customer service team leads and supervisors who handle escalated member inquiries. Supervisor support is available 24/7. The majority of inquiries are resolved during the same day the call is placed. However, if resolution is not met, the issue is escalated to the client management team assigned to the State. We confirmed we will provide data around how many State of Alaska calls come through to a supervisor.
3. The client management team resolves the member issue.
4. The client advocate performs member follow-up.

If a member escalates an issue to the CSA, and the CSA is not able to resolve the inquiry during the call and the inquiry requires further action or research, the issue is triaged to the research and resolution team. The escalation protocol for this team is as follows:

RESEARCH AND RESOLUTION ESCALATION

1. CSA refers the inquiry to the research and resolution team.
2. The research and resolution team identifies a root cause.



3. The research and resolution team resolves the issue no later than seven days from the date of receipt.
4. The research and resolution team performs member follow-up.

MEDICARE MEMBERSHIP ESCALATION PROTOCOLS

The Medicare escalation protocol follows the same action plan as provided in the Commercial description above. However, we involve an extra step in the process for member grievances.

If a CSA is not able to resolve the grievance during the initial call, the following process is followed:

1. CSA refers the inquiry to the Medicare Part D grievance team.
2. The Medicare Part D grievance team identifies a root cause.
3. The Medicare Part D grievance team resolves the issue within seven to 30 days within Medicare Guidelines.
4. The Medicare Part D grievance team performs member follow-up.

25. How many pharmacists are available to answer member questions?

Our current staffing includes 91 Consulting Pharmacists.

26. If pharmacists are not available 24 hours per day, 7 days per week, 365 days per year, to answer member questions, what are the hours of operation for the pharmacy customer service unit?

Not applicable. Pharmacists are available 24/7 365 days per year.

27. If you have a separate pharmacy customer service unit dedicated to answering questions specific to Specialty Medications and the Specialty Pharmacy, how many pharmacist customer service representatives are dedicated to answering questions specific to Specialty Medications and the Specialty Pharmacy?

Our specialty customer service unit includes 115 pharmacists and over 950 specialty staff.

28. How many customer service representatives are dedicated to answering questions specific to Specialty Medications / Pharmacy?

Our specialty customer service unit includes 115 pharmacists and over 950 specialty staff.

29. What is the composition of staffing in your Specialty organization? Include the clinical support available for patients through your Specialty organization, including the number of nurses and pharmacists on staff at the proposed pharmacy(-ies).

Our specialty customer service unit includes 115 pharmacists and over 950 specialty staff.



30. Confirm all member service call recordings and notes between the PBM and the state's members will be the state's property. Confirm the PBM can share files of recorded member calls, call notes or call logs within two business days.

Recorded calls and member record notes will remain property of OptumRx due to HIPAA, PCI Compliance and other regulations. However, OptumRx will make available recorded calls and or member transcripts to the State within two business days of the request, including regularly scheduled reviews of recorded calls.

31. Explain your process of providing a secure electronic portal for members and providers to contact you via e-mail for customer service inquiries

Members are presented with a "Register Now" option from the home page on our OptumRx.com Web Portal. When selected, the member begins by entering their personal information, setting up their user name and password, selecting their security questions and response. Once submitted, members can generate email inquiries via Secure Messaging on our Portal.

Members can also contact our customer service center through our website. Our online member support services include pages featuring:

- A logon assistance page
- A "click-to-call" option that immediately connects to an available CSA or Pharmacist for a phone call over the secure internet service.

32. Describe your company's use of current system technologies to notify customers of issues that relate to them.

The assigned client management team keeps the State informed of any issues related the State's plan by phone or email. The client service manager (CSM) is responsible for resolving day-to-day issues, and provides timely client updates and resolution to potentially impacted members. OptumRx also sends out regular communications via email to our clients. These communications include clinical newsletters (new drugs, recalls, new indications for drugs, etc.) as well as Medicare Part D notifications (CMS call notes, regulatory updates and program changes).

Additionally, from our client portal, the State's plan administrators can access information and resources that allow them to manage the State's benefit plan. Plan administrators commonly use the client portal to perform the following functions:

- Manage eligibility and view benefit information
- Make real-time updates to the claim system
- Submit manual claims
- Access member-specific features such as claim history, prior authorization history, provider information and member call history and related details
- Request member ID cards
- Submit overrides on member profiles
- Compare pharmacy transmissions



- Access information on formulary and rebate management, clinical services and specialty pharmacy
- Manage plan data and create custom reports using the online reporting tool
- Review our newsletter, RxNews, which contains relevant industry topics that may impact the State's business or benefit plan

33. Describe any on-line comparative cost estimator tools you make available to assist members.

OptumRx provides cost estimator tools through our online member portal and mobile app. Our Price and Save™ tool enables members to manage their prescription budget and provides the following features:

- Search for the lowest-priced pharmacy for your prescription plan with advanced price comparison technology
- Find low-cost generic programs
- Check prices among multiple retail pharmacies and your home delivery pharmacy
- See savings between brand name and generic medications

34. Confirm order refills and renew retail prescriptions are member services available on your website?

Renewing retail prescriptions must be done through the retail pharmacy utilized by the member. The member would not be able to do this through the website.

35. Confirm order refills and renew mail order prescriptions are member services available on your website?

Confirmed.

36. Confirm order refills and renew specialty pharmacy prescriptions are member services available on your website?

Confirmed.

37. Confirm order new prescriptions (when allowed by law) is a member service available on your website?

Confirmed.

38. Confirm prescription refill reminders is a member service available on your website?

Confirmed.

39. Confirm order status for a mail order prescription is a member service available on your website?

Confirmed.

40. Confirm order status for a specialty prescription is a member service available on your website?

Confirmed.

**41. Confirm claims history is a member service available on your website?**

Confirmed.

42. Confirm a review of financial out-of-pocket information is a member service available on your website?

Confirmed.

43. Confirm look-up medication information is a member service available on your website?

Confirmed.

44. Confirm locate network pharmacy is a member service available on your website?

Confirmed.

45. Confirm reviewing eligibility is a member service available on your website?

Confirmed.

46. Confirm reviewing benefit information is a member service available on your website?

Confirmed.

47. Confirm state-specific/member specific prescription cost estimates are a member service available on your website?

Confirmed.

48. Confirm member- and state-specific cost and calculated savings information about lower-cost generic alternatives for multi-source brands (i.e., generic equivalents and generic or preferred brand therapeutic alternatives) available for consideration will be available on your website?

Confirmed.

49. Confirm member- and state -specific cost and calculated savings information about lower-cost alternatives for single-source brands (i.e., generic or preferred brand therapeutic alternatives) available for consideration will be available on your website?

Confirmed.

50. Confirm member specific potential gaps in (or omissions of) care (e.g., diabetic without a claim for a medication that is recommended in treatment guidelines, like an Angiotensin Converting Enzyme Inhibitor) will be available on your website?

At this time there are programs that identify potential gaps such as med adherence however they are not currently integrated with the website.

51. Confirm member specific medication non-adherence alert (alert when a gap in therapy/day supplies according to claims history is identified) will be available on your website?



The portal identifies medications available for refill or renewal to ensure no gaps medication adherence.

The portal does currently have the capability to notify a user of upcoming refills dependent of the last refill date, consumption rate and day's supply.

Also we have feature available to users of the site called My Medication Reminders.

This feature allows the user to add a mobile number on file to receive text alerts to a specific event such as:

- When it's time to take your medication (user may select the if they wish to be notified daily, weekly or monthly and at what time they would like to receive the text alert during the day.)
- When it's time to refill a medication
- When you're out of refills and need a prescription renewal
- When your order has recently shipped

52. Confirm state specific applicable drug exclusion list will be available on your website?

Confirmed.

53. Confirm state specific prior authorization list will be available on your website?

Confirmed.

54. Confirm notation during medication lookup about coverage limitations (e.g. excluded, requires prior approval, subject to step therapy or quantity limitations) is a member service available on your website.

Confirmed.

55. Confirm if members will be able to chat with a customer service representative through your website.

Confirmed.

56. Confirm member will be able to order replacement ID cards through your website?

Confirmed.

57. Confirm member will be able to order paper claim forms through your website?

Confirmed.

58. Confirm members will be provided instructions for requesting reimbursement for paper claims through your website?

Confirmed.

59. Confirm members will be provided instructions about how to get started/use the mail order pharmacy through your website?

Confirmed.



60. Confirm members will be provided instructions about how to get started/use the specialty pharmacy through your website?

Confirmed.

61. Confirm members will be provided instructions for how to file an appeal through your website?

Confirmed.

62. Will you notify the State's members when you delete pharmacies from your Retail network? If so, please explain how and when members will be notified.

The OptumRx national pharmacy network remains very stable and rarely do we encounter situations where utilized pharmacies are removed from the network for reasons other than fraudulence. However, should a pharmacy be removed from the network and cause utilizing members to be disrupted, OptumRx can create custom mailings or perform telephonic outreach alerting members to this and provide alternative network pharmacy locations for members to switch to. Your account management team can set up regularly scheduled network disruption reports to scan for situations of member disruption due to removal of a network pharmacy and work with the State to craft a strategy for member notification.

63. Please provide a list of languages that are available through your Mail Order (for Rx labels and patient information), in addition to English.

We have materials available in Spanish. In addition, we offer translation through a phone call with a CSA and a translation vendor.

64. Do you provide the following cost information to recipients on mail order prescriptions: member cost, employer cost, total cost, YTD out-of-pocket (towards deductible and annual maximums), and YTD payments. Is this customizable (e.g. suppress YTD out-of-pocket for retirees)?

A mail order prescription receipt will include the member cost, employer cost, total cost, amounts applied towards deductible and annual maximums. YTD information is not included on mail order prescription receipts. Yes we can provide the following cost information via the web portal (optumrx.com) for mail order prescriptions:

- Member cost: Yes - on claims history page and Claims detail
- Employer cost: Yes - on the Claims detail page
- Total cost: Yes- on the claims details page for single claim, multiple claims and benefit info page shows additional accumulators
- YTD out-of-pocket (towards deductible and annual max): Yes on benefit information
- YTD payments: Yes to mail order under my profile > Payment Due > Balance activity
- Is this customizable (e.g. suppress YTD out-of-pocket for retirees)? No - unfortunately not customizable aside from filtering dates, but is broken down for Med-D or EGWP into categories (Initial, gap, catastrophic phase, etc.).

65. Do you offer expedited delivery of mail order prescriptions?



Confirmed.

66. Does your mail order system require the member to enter a credit card number? Can this be suppressed?

No. While we do not require the member to provide a credit card number, payment for Home Delivery Pharmacy prescriptions is due at the time of submission. Members can pay for new and refill prescriptions by check, credit card, debit card, or money order by mail, phone, or Internet. We accept Visa, MasterCard, Discover, and American Express credit and debit cards. Our credit card payment processing is fully PCI compliant and includes quality controls such as masking credit card information when a member chooses to add a credit card to their record.

67. What is the average number of work days from placing an order to time of mail order delivery to the patient, including delivery time?

[REDACTED]

[REDACTED]

A member who mails a prescription should allow 15 calendar days for dispensing and return delivery of the medication.

68. What is your organization's standard maximum delinquent amount in outstanding balances before a member is denied further mail pharmacy prescriptions?

We will process the prescription if it falls under our recommended \$100 threshold (or agreed upon threshold) and collect payment thereafter. For amounts greater than the established threshold, we contact the member to resolve payment prior to shipment.

69. How are members notified when a mail order prescription is delayed due to the following circumstances?

- a. A prescription requiring clarification from the physician or physician's agent (e.g., missing quantity, illegible drug name)?**
- b. A clean prescription where the delay is due to the Offeror's operational, capacity or drug supply issues?**
- c. A clean prescription where the delay is a result of the Offeror's therapeutic switch/ intervention?**

Any delays in processing Home Delivery Pharmacy prescriptions can be communicated to members with different options depending on the campaign/reason for the delay: text, email, telephone (dialer/outreach), and mail.

Home Delivery pharmacists can outreach to member (if applicable) or physician to clarify an order. If the member is not able to be reached this triggers a physician outreach call to prevent order delay. In an instance where both member or physician outreach was not successful, the



documentation is notated on patients profile. The provider would be able to call OptumRx via (TFN) number and provide reference order information to pharmacists/technicians. The member would contact Optum Rx and speak with a CSA who would be able to assist member and/or reach a pharmacist internally.

The emails are not available for members to see through their on-line account (portal).

While the email itself is not retained, information regarding the email is available on our system for the Customer Service Advocate to reference. This information includes the type of notification that was emailed and the date it was sent.

70. Explain the process for providing members with a short-term retail prescription supply in the case of delayed delivery of their mail order prescription.

In extenuating circumstances such as a manufacturer shortage, we may authorize a short-term fill for a Home Delivery Pharmacy prescription at retail. The criteria we examine to authorize a short-term retail supply is dependent on each unique situation. In these situations, we work with the retail pharmacy to obtain step copayments for the short-term supply and arrange for the member to pick up the portion of their prescription at the retail pharmacy. When we are able to ship the member the remainder of the prescription, the remaining copayment is applied.

71. Can you provide a system edit to facilitate physician outreach in order to avoid partial fills?

To facilitate member adherence, we do not dispense partial fills through our Home Delivery Pharmacy. In the event that we are unable to complete a prescription due to a stock shortage or any other circumstance, the prescription would be treated as an intervention and we would attempt to contact the member to notify them of the issue.

72. How far in advance may participants order a refill on a 90-day supply prescription?

We employ system-based edits and criteria to screen for early refills. We recommend a “refill too soon” edit that identifies attempts to submit the same prescription number within a 75 percent timeframe from the shipping date of the prior prescription. For example, for a 90-day supply Home Delivery Pharmacy prescription, a member must wait 67 days before refilling the prescription.

We are comfortable that the 75% timeframe allow enough time to for the medication to be delivered in Alaska. The State could choose to adjust it to 70% if that is more comfortable. If the State chooses to start at 75% and then determines more time is necessary, it is an easy change for us to make after implementation.

We may adjust this timeframe to accommodate customer-specific objectives. We work with the State during the implementation process to identify customization requirements.

We utilize an 80% refill to soon edit for opioids.

73. Describe your process of filling/ordering prescriptions, refills, and split-prescriptions. Do you have an automatic refill process with a standard refill too soon threshold? Can you offer multiple refill too soon edits by therapy class (e.g. higher percentage for narcotic pain medications) Are you able to send email reminders for refills?



During implementation, we collaborate with the State to determine the most appropriate method for administering early refill requests. Depending on the benefit design, early refill requests can result in a claim rejection or a DUR hold. We apply overrides for rejections based on customer-specified exceptions (for example, the State may wish to allow exceptions for members with travel plans). For requests that result in a DUR hold, we suspend the claim for a few days until our system indicates that the prescription is eligible for refill. The maximum holding period for a queued or held order is 14 days.

74. Who will be responsible for maintaining continuously updated network information and what will be the frequency of updates?

We maintain an online pharmacy locator within the member portal of our integrated website. This locator is updated daily and offers a map tool that helps members find and print directions to nearby pharmacy locations. Since our network is updated daily, additions and deletions are not communicated unless they have an acute impact on the customer.

75. Understanding AlaskaCare has a high volume of internal coordination, including multiple benefits being reported under the same unique identifier, please explain your plan for coordinating benefits beginning 1/1/19?

We provide coordination of benefits (COB) electronically at the point of service. Understanding the State's unique internal COB requirements, we collaborate with the State to confirm that the correct COB information is provided in the eligibility file. OptumRx plans to also work with the state on a unique business structure to assist in accommodating the requirements. These claims may be paid as normal, flagged, or reported as COB claims covered by another insurance carrier. They may also include messaging instructing the submitting pharmacy to use the alternative insurance (in which case the member can cover the product at 100 percent). Alternatively, the messaging may tell the pharmacy to adjudicate the claim and submit it to the State for filing with the alternate carrier.

If the member submits a claim to a primary insurance carrier and then sends the carrier's explanation of benefits (EOB) to us, we process the claim as a direct member reimbursement. We then reimburse the member in full or in part for the remaining amount less the applicable copayment.

76. Explain the edits used in your system to identify potential external COB cases on a continual basis.

Our claims adjudication system supports COB for electronic and manual claims. We offer the State three options for COB processing:

- Deny claim at the point of service
- Pay claim as normal point of service
- Pay claim as a direct member reimbursement (DMR) paper claim when a member submits a claim to his or her primary insurance carrier, and sends an explanation of benefits (EOB) statement from the primary insurance carrier to us.

77. Explain whether or not you have an electronic system currently in place to allow Medicare Part B claims filed with the Medicare carrier to automatically coordinate



(crossover) with the retiree plans so that retirees are not required to submit secondary Part B claims to this plan.

We have the ability to use claim messaging to prompt the Part B billing on the part of the pharmacy when the appropriate scenarios are invoked. While we won't be able to monitor actual claim submissions given that the Part B claims will need to go outside of our system for payment, we can work with our network oversight team to ensure they evaluate this in on-site reviews. We can also use claim messaging to instruct pharmacies to then submit any costs not covered under Part B through the EGWP Part B Wrap benefit.

78. Describe how you will obtain coordination of benefits information to determine when case management might not be appropriate, such as when the plan is secondary to Medicare or other plans.

In the event that a member has other primary coverage and the State indicates this on the eligibility file, our adjudication system will send a message back in real time to the pharmacist using a standard NCPDP rejection code indicating COB is required.

Plan participants with secondary coverage would be marked in the system as secondary coverage, and only secondary coverage claims would be allowed to process for that member. We can establish a unique BIN/PCN for the members who have primary Medicare Part D coverage with other insurance carriers. This allows the national switches to route the secondary claim response information to the True out-of-pocket (TrOOP) Facilitator and ultimately to the Medicare PDP, as required by CMS.

For plan participants with dual coverage, we index and store employees and their dependents are based on:

- Member ID
- Group ID
- Account ID
- Carrier ID

As such, members may be in the system multiple times, allowing for dual coverage and the separation or accumulation of benefits. The internal COB application's last step is to auto-generate an N1 transaction to send the results of the secondary payment back to the primary Medicare Part D plan on the system. This will allow the results of the secondary payment to be considered in the member's TrOOP accumulation and reporting on the CMS Prescription Drug Event (PDE), per CMS rule.

79. Please confirm that all calls will be recorded

Confirmed.

80. Will the state's vendor manager be able to review recorded calls?

Confirmed.

81. Will transcripts of recorded calls be made available for appeals?

Confirmed.



82. Attach an example of your proposed member satisfaction survey tool and label it “Member Satisfaction Survey”

Please see attached Exhibit 1 Member Satisfaction Survey.

83. Detail your member satisfaction survey methodology, including: member selection, details on minimum number of respondents to achieve statistical significance, mode of communication (telephonic or mail) and calculations used to determine the final satisfaction score.

Our overall approach includes several instruments for capturing member feedback including post call member satisfaction survey, member Verbatim, Social Media Monitoring, mail survey of customer membership assesses retail benefits, home delivery pharmacy, specialty pharmacy and customer service satisfaction, and Client Advocate Member Outreach.

We assess member satisfaction through an optional, automated post-call survey through which members provide feedback through voice or touch-tone commands. This survey gathers real-time feedback immediately following interaction with a CSA, which enables our customer service team to adjust and personalize our support to achieve expectations.

84. Indicate your willingness to modify the existing survey tool to meet the needs and requests of the State.

Confirmed.

85. Describe the process for notifying members of prescriptions not on the formulary.

Our primary goal when transitioning the State to our formulary is to maximize continuity of care. We work closely with the State to encourage utilization of cost-effective medications by examining member utilization data. We identify potential disruption and put strategies in place that leverage effective benefit design criteria, system edits and targeted communications to promote optimal use of our formulary.

Member communications are sent 30 days prior to the plan’s Effective Date. During implementation, we work with the State to establish transition communication timeframes. In order for us to send materials, we need to have current eligibility and the plan design approved by the State before we mail any communications.

As needed after implementation, we create and distribute additional tailored notifications throughout the year. Examples include changes to the member's pharmacy benefit plan, formulary or network. These are distributed on an ad hoc basis or on a predetermined schedule, depending on the type of communication and the State’s preference. Extra costs may be involved, depending on the complexity of the request.

86. Describe the mail order process for notifying members of the expiration date of their prescription.

The State’s members can quickly and easily identify the expiration date of medications that we ship. The expiration date is printed on the prescription label and is also included on the Home Delivery Pharmacy statement and reorder form that accompanies each filled prescription. The statement lists the number of refills remaining and the last date on which a prescription can be



refilled. The prescription label also states the number of remaining refills. Members can also determine expiration status by contacting our customer service center or at our member website. A prescription expires one year from the date it was written.

We do not currently conduct proactive expiration alerts. However, CSAs can proactively alert members when a prescription is about to expire during contact. Should a member call customer service with an inquiry, member-specific information automatically pre-populates on the CSA's screen. After the CSA has authenticated the call, the CSA can deliver important information regarding pending expiration, refills and other prescription information.

87. Describe the mail order process for notifying members of their next refill date and the number of refills remaining.

We offer various means of reminding members about order refills to achieve this goal. We include prescription refill information on the prescription label and the reorder form that accompanies each shipped order. This form lists the number of refills remaining and the last date on which a prescription can be refilled.

In addition, the prescription label states the number of remaining refills. Members may also contact our customer service center or access our website to get information regarding specific refill dates and number of refills remaining on a prescription.

We also support monthly refill reminders for members taking maintenance medications in these formats:

- Email
- Auto-dialed, recorded phone calls
- Text messaging to mobile devices

Our refill reminder program also includes a unique feature - members may enjoy an optional feature wherein the first three letters of their medication names will appear in their ongoing reminder emails.

Members can request text message reminders for their medications, including general notifications (refill reminders or shipping information) or customized medication reminders (dosage amount or time of day to take a particular medication). Depending on the type of account access, members may also set up reminders for other household members or caregivers.

88. What percentage of mail order prescriptions receives a patient-information supplement?

All Home Delivery Pharmacy orders include educational materials that describe the appropriate use of the medication. The materials answer specific questions about possible side effects, how to store the medicine and what to do if a dose is missed.

89. Describe your system of providing patient-advisory information with mail order prescriptions filled.

The source of the information for the educational materials included in Home Delivery Pharmacy orders is Medi-Span's Customer Advisory Program. Information typically includes:



- Name of the medication
- Administration information
- Medical conditions the medication is commonly prescribed to treat
- Contraindications to taking the medication
- Possible side effects or adverse reactions
- Possible drug interactions
- General customer information

If the FDA has mandated a Risk Evaluation Mitigation Strategy (REMS) program for a medication that requires a Medication Guide be provided to the member, we can print and provide the guide as required.

90. How do you provide notification of a product recall (such as Vioxx) to the State and members?

The State's client management team works directly with the State to address drug recall activity. Our communications may include reasons for the recall, reports identifying members who may be using the recalled drug and recommendations for coordinating efforts to notify members of the recall promptly.

After we learn of a member-level safety-related drug recall that may significantly disrupt member therapy, we notify the State's members by mail to explain the reason for the recall and advise on next steps.

- Letters encourage members to call their physicians for further instructions.
- Our CSAs call members if we have dispensed the recalled medication from our Home Delivery Pharmacy. CSAs advise the member on how to proceed in handling the recalled drug or getting a new prescription.
- Specialty pharmacy CSAs call members if we dispensed a specialty drug affected by a recall. If we shipped the medication to the member's physician, we call the physician. Where appropriate, our CSAs or pharmacists contact the physician to arrange for a replacement product.

Outreach to members is performed as quickly as possible, which often involves a posting on our website within one to two business days. We send letters within 20 to 30 calendar days as each of the following steps must be followed or approved prior to mailing:

- Development
- Approval from medical director and legal department
- Data analysis by analytics team
- Approval from client management and affected customers
- Coordination with mailing fulfillment vendor and approval of mailing proofs

As critical communication on recalled medication is sent by letter to members, we reach 100 percent of affected members.



91. What edits occur prospectively at point of sale (POS)? Concurrently? Retroactively?

Concurrently - Standard concurrent drug utilization review (CDUR) edits are employed companywide which include edits such as drug-drug interactions, drug-age caution screening, drug-sex caution screening, duplication of therapy screening, therapeutic dose limits screening, and morphine equivalent dose limit screening among others. These edits set to reject at point of sale in order to alert the pharmacist of safety concerns and to facilitate action by the pharmacy and prescriber to ensure safe medication use.

Retroactively - We also offer a retrospective drug utilization review program include Gaps in Care, Safety Management, and Opioid Management/Abused Medications. These are buy-up programs that look back in claims data to identify safety issues, gaps in care, opioid-specific safety issues to engage with the provider in ensuring safe/appropriate use of medications.

92. Do you have edits or programs in place designed to detect and address potential drug fraud and/or abuse? If yes, explain and include a listing of the specific drugs targeted by this program. If yes, please describe the enrollee outreach after fraud or abuse is identified. If yes, please detail the controls put into place after fraud or abuse is identified.

We have a standard Fraud, Waste, and Abuse Program and an Advanced Pharmacy Audit Services (APAS) Program. The standard offering includes real-time, desktop, targeted, on-site, and investigative audits. In addition to the standard functionality, the advanced program includes a designated audit staff, quarterly business reviews, client-specific audits, and client-specific reporting.

93. Do you have publically available medical necessity/clinical standards?

No. Detailed clinical program criteria are confidential and proprietary. However, we can provide the necessary information upon request.

When determining medical necessity of a drug, our Pharmacy & Therapeutics Committee considers clinically significant advantages compared to therapeutic alternatives used to treat the same or similar conditions. Placement on a lower tier may be clinically warranted if the drug satisfies a significant unmet need. Some examples include:

- Very limited member population
- Limited drug options for one or more member populations
- Marked member-to-member variability in response to medication for one or more member populations

We also may develop prior authorization criteria to support off-label use of drugs. Off-label use may be deemed medically necessary if supported by clinical literature or standard drug compendia. Investigational or experimental use includes those not supported by medical literature or compendia.

For higher tiered, or excluded, drugs that meet our standards, coverage may be considered if lower-tiered drugs for treatment of the same disease have been tried and failed or would not be as effective as the higher-tiered drug. Coverage also requires that the member has met our standard criteria or State-specific criteria, if applicable.



94. Can members submit claims electronically if unable to be adjudicated at point of sale?

Members can utilize our direct member reimbursement (DMR) process to submit a claim if it was not able to be adjudicated at point of sale. Currently DMR claims can be submitted via U.S. Postal Service, email or fax.

95. Can members submit claims via fax if unable to be adjudicated at point of sale?

Confirmed.

96. Can you accommodate vacation overrides to allow up to a 6-month fill?

Confirmed.

97. Does OptumRx have member training videos available (e.g. account set-up, auto renews, email notifications, etc.)

We have confirmed we will be able to offer member training videos.

98. Does OptumRx survey its network pharmacies for customer satisfaction?

Confirmed. OptumRx conducts annual satisfaction surveys of our contracted network pharmacies. All participating pharmacies are included in the survey.

EGWP

1. Confirm the PBM is able to assist in helping the State to provide a global attestation for an EGWP and help with individual attestations through post enrollment Late Enrollment Penalty (LEP) letters. Confirm the PBM is able to mail creditable coverage determinations or mailings for EGWP members.

Confirmed.

2. Are you able to administer a Medicare B vs. D program at point of sale?

Confirmed.

3. Describe the PBM's process for routing Part B drugs to CMS for Part B coverage?

Since OptumRx is not a pharmacy, we cannot submit claims directly to Medicare Part B on behalf of members. Our Employer Group Waiver Plan (EGWP) customers have two options for Medicare Part B drug coverage/processing:

1. Reject all Medicare Part B drugs at the point of sale, directing the pharmacy to submit the claim directly to Medicare.
2. Cover all or some of the Medicare Part B products under the EGWP enhanced benefit.

4. Confirm the PBM is able to mail creditable coverage determinations or mailings for EGWP members.

Confirmed.



5. Confirm that the state will have the ability to customize member communications at no additional charge when permitted by CMS.

Confirmed.

6. Confirm that production costs, plus postage, shipping, and handling are passed through for custom communications but capped at \$1.00 per mailing.

Confirmed.

7. Confirm/describe the PBM's offering of a four-tier closed formulary for EGWP.

Confirmed. The EGWP formulary will be completely customizable

8. Please describe to what extent the PBM can mirror the EGWP formulary to the commercial formulary.

Confirmed. The EGWP formulary will be completely customizable

9. Please provide additional information on the 8.6% formulary disruption in the commercial and EGWP plans between preferred and non-preferred brand name medications.

This disruption was based upon our base Silver formulary. As outlined above, the State's EGWP formulary can be completely customizable. As a result, we expect EGWP formulary disruption to be minimal.

10. How will the PBM proactively assist in collection of MBI numbers from current RDS members?

The State can execute a Voluntary Data Sharing Agreement (VDSA) with CMS directly, which will provide them with the ability to obtain MBI's for their Medicare eligible members. We can assist the State with this process.

11. Describe the PBM's proposed process for education and communication with members utilizing Veterans Administration (VA) pharmacies.

VA pharmacies cannot process Part D claims. For the commercial population, we can ensure these pharmacies are identified and solicited for participation in the network.

12. Have efforts been made by the PBM to contract with VA pharmacies as well as any other pharmacies identified as out of network in the PBM's network analysis?

Efforts are underway and ongoing to identify all currently utilized pharmacies for solicitation and participation in the State's network. We will continue to share results of these efforts throughout the implementation process.

13. The state's retiree membership is particularly sensitive to change and clinical/utilization management programs. We anticipate a substantial number of retirees will be required to seek a PA or a pre-certification. How does the PBM propose handling/educating members who will need a new PA/pre-certification approval in the EGWP?



OptumRx supports the transition fill process detailed below.

We determine member and claim eligibility for temporary transition fills at the point of service for new and existing members.

Temporary transition fills to a new member within the initial standard 90 day period include the following elements:

- Considers break-in coverage and contract/PBP changes within a multi-contract plan sponsor
- Includes 30 days' supply in retail setting
- Includes 98 days' supply in LTC setting
- Temporary transition fills to an existing member include the following elements:
 - Formulary Change Across Contract Year fill
 - Emergency fill up to 31 days' supply outside the standard 90 day period in LTC setting
 - Level of Care change within and outside the standard 90 day period

Our transition process is able to override the following Utilization Management restrictions for CMS Medicare Part D covered drugs at the point of service:

- Non-formulary
- Prior Authorization
- Step Therapy
- Generic first
- Age restrictions
- Quantity Limit

The following Utilization Management restrictions are not subject to transition overrides:

- Medicare Part B versus Medicare Part D Prior Authorization
- Refill-too-soon
- Duplicate Therapy
- FDA Safety Quantity Limit
- ESRD drugs for members on dialysis for ESRD
- Hospice drugs for members in Hospice care
- Non-Medicare Part D ingredients in compound claims

The following procedure applies once the claim is adjudicated using transition functionality at point of sale:

- The claim is stamped with unique five character transition override
- The claim is captured within transition claim repository
- The claim is processed within RxInterACT (intervention application) for:
- Establishment of delay to encounter reversal by pharmacy within certain time period



- Letter suppression for invalid transition override stamp (for example, Level of Care Change, Generic First) or specific GPI (for example, protected drug class)
- Flagged ready to send to print fulfillment vendor in transition print file

TRANSITION FILL LETTER FULFILLMENT

If the beneficiary receives a temporary transition fill and the State has delegated responsibility for transition notice fulfillment to us, the following fulfillment procedure applies.

We run a daily data sweep twice in 24 hours (at midnight and at 10 a.m.) to create a transition print file. The file creation process is through a systematic ROBOT job to include eligible transition fill paid claims for notification. We send the transition print file to our print fulfillment vendor through Secure-FTP in a customer-specific predetermined naming convention. The print fulfillment vendor performs the following steps:

- Retrieves the customer specific print file from Secure-FTP
- Performs automated quality checks such as file format, data validation, naming convention prior to processing the print file
- Performs presorting, CASS & NCOA checking, and generating an exception report for “bad address”
- Generates the member and provider transition notification by applying the pre-established customer specific publishing rules
- Member letters are created within the customer specific CMS Approved Model letter template including Drug Information, Date of Service, Reason for Notification, Plan Exception and Appeal address
- Prints and mails the letter within the CMS-required three business day delivery requirement
- Creates digital images and posts them on vendor portal for OptumRx and customer future access. Customers can view the date and time the Transition letters left our print vendor for mailing in our vendor portal.
- Creates the transition response file for each dataset (including the letter mail date) and returns it to us for reconciliation through Secure-FTP

The response file confirms the claim count received, processed, and lettered by the print vendor in each dataset.

14. Please provide information on how prescriptions filled at an out-of-network pharmacy will be processed.

It will be OptumRx’s goal to provide maximum network participation, however, emergencies and other out of network situations do come up. In these instances, our Direct Member Reimbursement process would apply. The member would need to provide a completed DMR form and evidence of payment and we would reimburse the member directly. Part D DMR’s are processed accordingly to CMS timeliness guidelines, which is within 14 Calendar days. Claims are adjudicated according to the plan set up.

15. In addition to EGWP can you provide assistance with RDS for those not covered by the EGWP program?

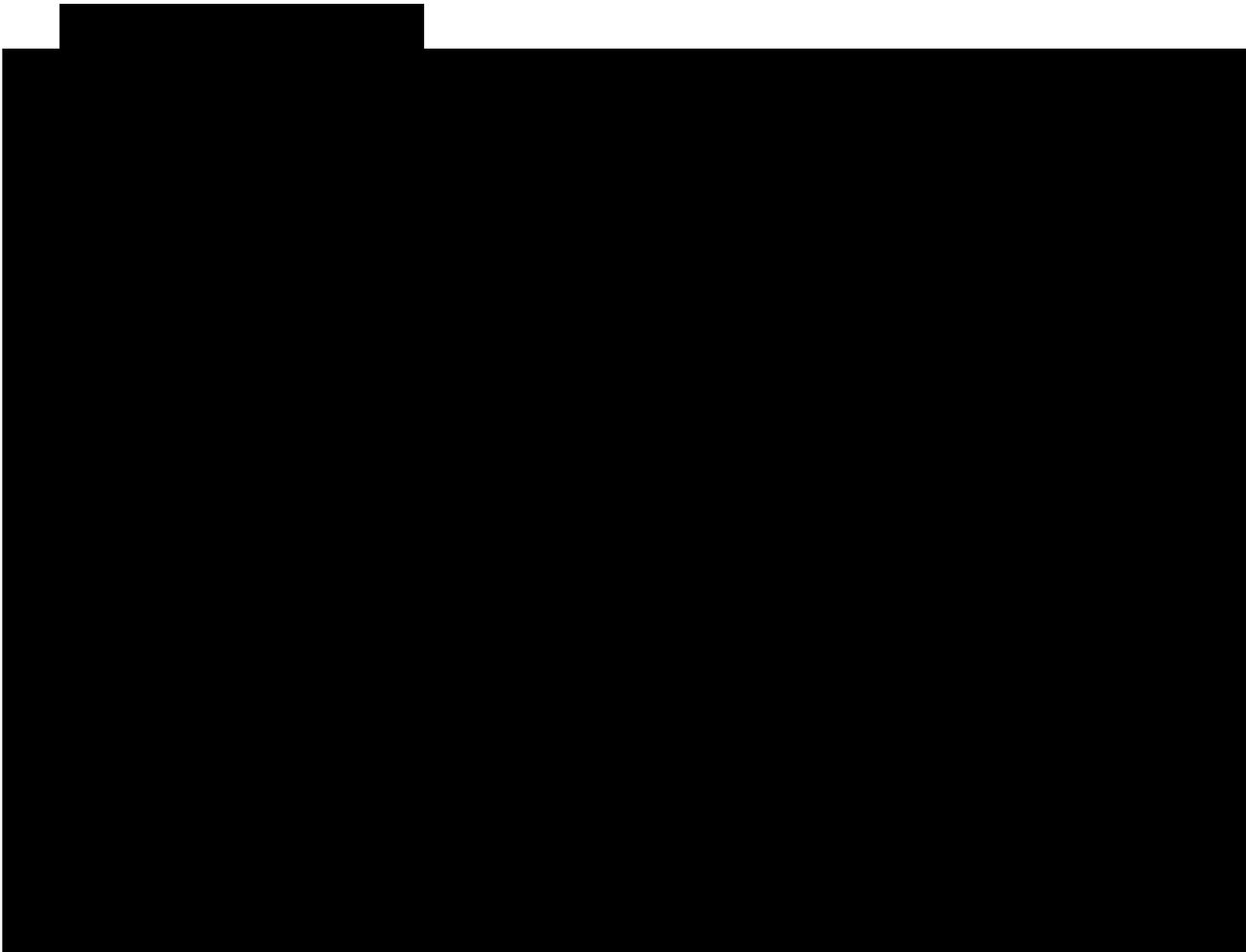


Confirmed. Will review potential fees for RDS assistance.

16. Describe how you handle retroactive claim adjustments when a member reaches the Medicare Part-D True Out-of-Pocket (“TrOOP”) limit.

The RxClaim system reprocesses members when there are retroactive eligibility updates restacking the member’s True out-of-pocket (TrOOP) and Drug Spend. When member’s eligibility has been updated, their records are added to the reprocessing queue automatically for reprocessing. The triggers for reprocessing include updates to a member’s LIS, contract/PBP, OHI and FIR. Once reprocessing occurs, all downstream processes would be updated including EOB, PDE and member reimbursements. Reprocessing is scheduled to run for members on predefined schedule. Ad hoc reprocessing jobs can be completed at any time to confirm timely updates to members.

We follow the EGWP guidance as put forth by the Centers for Medicare & Medicaid Services (CMS) in the PDE guidance and examples for cross over claims, including the requirements for cross overs from Gap to Catastrophic. The following example is from PDE Guidance reporting examples for benefit year 2014:





remaining TrOOP. Under this scenario, the EGWP is administering one benefit package that is the combination of the Medicare Part D defined standard benefit and OHI, and reports the PDE using this information.

17. Describe how you honor repayment demands or requests for reimbursement that are made within the time period mandated by Medicare for recovery of improper payments.

Our adjustment process enables the State to restack or adjust/reprocess all claims, regardless of submission method (hard copy or point of sale). Impacted members are identified and claims are reprocessed through a batch function or by individual member. The reprocessing application re-determines costs and updates all applicable accumulations and payments based on the current member eligibility/plan set-up information without impacting pharmacy payment.

Any change in member responsibility results in reporting to generate a member reimbursement check or collect underpayment from the member. Finally, Prescription Drug Event (PDE) adjustment records and explanation of benefits (EOB) are automatically created during the next PDE and EOB job runs.

Although it is the determination of the State to set a reprocessing schedule, we recommend a bi-monthly reprocessing schedule to maintain compliance with the Chapter 13 guidance of sending out a reimbursement or collection letter 45 days after the retro-active change is communicated.

For CMS member complaints, we offer a standard, ad hoc process to remain in compliance with the 14 day turn-around timeframe on grievances, should the State deem there to have been a previous improper payment.

18. Describe your clinical programs over and above the minimum CMS requirements.

We offer the following programs that go over and beyond the Minimum CMS requirements:

CONCURRENT DUR (CDUR) PROGRAM

While CMS requires Therapeutic Dose level screening in CDUR, our CDUR program also includes the additional safety edits;

- Allergy Screening – Member is taking a medication to which he/she may be allergic.
- Drug-Drug Interaction Screening – Member is taking 2 interacting medications and/or medication classes.
- Drug-Diagnosis Caution Screening – Member has a certain diagnosis (as determined by drug proxy) and is taking a medication that may worsen the member's diagnosis.
- Drug-Inferred Health State Screening – Member has a certain diagnosis (as determined by drug proxy) and is taking a medication that may worsen the member's diagnosis.
- Dosing/Duration Screening – Member is taking a medication for longer and/or at a higher dose than recommended.
- Drug-Age Caution Screening – Member is taking a medication that is not recommended for people of certain ages (pediatric and geriatric)
- Drug-Sex Caution Screening – Member is taking a medication that is not recommended for his/her gender.



- Morphine Equivalent Dose Limit Screening- Member is taking opioids where the total cumulative daily dose exceeds the suggested morphine equivalent dose (MED)
- Exact GPI Duplication Screening- Member is taking two medications with the same ingredient
- Drug Class Duplication Screening- Member is taking 2 medications in the same drug class

RDUR SAFETY

The Safety Management program targets potentially inappropriate medication patterns across a broad range of drug classes for safety and to minimize potential adverse events.

Pharmacy and available medical claims data is analyzed for concerns including:

- Drug-Drug Interaction
- Drug-Age Interaction
- Therapeutic Duplication
- Drug-Disease Interaction
- Overutilization (Non-controlled meds)
- Dose Per Day

When a potential issue is identified, provider-focused interventions reach members to prevent serious health issues before they occur, leading to healthier members, and helping customers control their overall health care costs. Customers will receive a monthly member detail, as well as quarterly reports of activity metrics and outcomes.

RDUR GAPS IN CARE

The Gaps in Care program drives quality of care by identifying and closing gaps in medication therapy for select chronic diseases while improving compliance and lowering total health care costs.

Using evidence-based medicine, pharmacy and medical claims data is used to identify members with the following disease states and/or medication regiments:

- Asthma
- Cardiovascular
- Diabetes
- Migraine
- HIV
- Osteoporosis
- COPD
- Rheumatoid Arthritis

Providers of identified members receive a notification fax with a provider-specific listing of the identified members and the clinical rationale for clinically appropriate medication



considerations. Customers receive a monthly member detail report, and a quarterly report that includes activity metrics and intervention outcomes.

The program also incorporates quality measures supported by the Centers for Medicare and Medicaid Services (CMS), Healthcare Effectiveness Data and Information Set (HEDIS), and Pharmacy Quality Alliance (PQA).

MEDICATION ADHERENCE

The OptumRx® Medication Adherence program uses a data-driven approach to identify members who need help taking medications as prescribed across multiple drug classes — including those to treat diabetes, hypertension, high cholesterol, HIV/AIDS, mental health, as well as respiratory and cardiovascular conditions. By identifying non-adherent members, engaging early and staying connected — we can help individuals stay on track with their health and medications. In turn, this can lead to better outcomes and lower overall health care costs. OptumRx uses claims data and advanced analytics to identify members taking medications at crucial points in their therapy. Outreach Includes:

- New to Therapy Letter: Educating members on new prescriptions and their disease, including the importance of medication adherence.
- Primary Medication Non-Adherence: Faxes/mailings are sent to providers alerting them if their member did not start their new therapy
- Early Refill Reminder: Interactive IVR reminding members to refill their medications, typically 3 days prior to refill date. Members have option to be transferred to their last dispensing pharmacy to refill.
- Late to Refill: Interactive IVR calls include barrier survey and tips to address barriers that members may be facing. Members have option to be transferred to their last dispensing pharmacy to refill.
- Low Adherence
 - Educational letter to the member about the importance of adherence with tips on how to remember to take their medication
 - Fax/ mailing to their provider alerting them of the non-adherence
 - Interactive IVR with barrier survey and tips to address barriers. Also offers members the option to connect with a live OptumRx pharmacist for telephonic consultation. The IVR collects barrier information which will be reported back to the client
- Mobile app refill reminder available for members



PATTERNS OF CARE

The OptumRx Patterns of Care program allows our customers to understand their primary care providers' prescribing patterns and their patients' utilization behavior. The objectives are to reduce costs and improve quality by leveraging the physicians within customer's community. The program increases patient medication adherence through insights and targeted provider engagement, improves compliance to clinical guidelines, and reduces volume of branded prescriptions when safe and effective generic options are available.

The program uses proprietary methodology to individually measure each PCP relative to average values and top performers across all metrics. By looking at each physician's pattern of care individually, customers can begin to clearly see opportunities for targeted messaging and action. For an individual PCP, we provide detailed quarterly reporting including:

- Cost Efficiency: A look at the Generic Dispensing Rate (GDR) across five therapeutic classes
- Optimal Adherence: View of the percentage of members who are adherent for each PCP, as well as the distribution of the various Percentage of Days Covered (PDC) scores for these patients
- Guideline Compliance: Looking at how well this PCP's members followed key clinical guidelines where complex regimens exist. Special focuses are on asthma and diabetes because of their prevalence across populations.
- Member Panel Details: All of the individual patients that comprise the aggregate metrics seen on the previous reports. Each measure is separately detailed so the PCP or perhaps a practice administrator can help prioritize individual members to bring back for a repeat visit or require a phone call

TREND FORECAST ANALYSIS

Trend Forecast Analysis is a proprietary tool that provides a customized three-year projection to help customers budget more accurately, and take action to control future pharmacy costs.

The forecast is based on evaluation of customer-specific:

- Population and projected shifts
- Prescription drug utilization
- Drug trends and spend
- Clinical management
- Plan design



- Quantified impact of upcoming major market events

Detailed analytics and insights are used to create a tailored customer picture detailing how planned programs or strategies could impact future costs. This information is built into a model to accurately forecast the trend for a specific population - at both an aggregate and detailed level.

The Trend Forecast Analysis report includes a reporting package of total pharmacy costs forecasted over a 3-year timeframe.

Included in the report are the following:

- Drug class summaries for top traditional drug classes
- Drug class summaries for top specialty drug classes
- Forecasted spend by class
- Cost drivers

TARGETED CLINICAL ANALYTICS

Targeted Clinical Analytics is a solution that offers flexibility in how we deliver clinical insights and value. Providing individualized data and analytics expertise, we empower customers to manage their own clinical outreach programs. Proprietary algorithms and rules engines are leveraged to identify and prioritize intervention opportunities to reach members who need it most, delivering targeted member insights for intervention to meet customer needs, impact quality ratings and improve key population metrics. This solution is available for the following clinical products:

- Retrospective DUR Safety Management
- Retrospective DUR Gaps in Care
- Medication Adherence

Identification frequency can be tailored to meet customer needs with Daily, Weekly, Monthly and Quarterly identification currently offered. The program does have a cost of either PMPM (Per Member Per Month) or Per Rx Per Month, depending on what the State is interested in purchasing.

19. Will you allow the State to elect to cover non-formulary drugs via a prior authorization exceptions process?

Confirmed.

20. Are you able to manage a commercial wrap-around plan using one identification card?

Confirmed.

21. Verify that your P&T Committee meets CMS' requirements for objectivity and validity.

Confirmed.



22. Describe the transition process you will utilize for members who are currently using non-formulary prescription drugs, drugs requiring prior authorization, step therapy, and quantity level limits.

If a member has been on a medication subject to prior authorization, step therapy, or is not covered under OptumRx's formulary, they are allowed a one-time transition fill at the point of sale. Immediately following this transition fill, they will receive a letter from OptumRx informing them of the prior authorization or step therapy requirement or formulary alternative. The transition fill allows the member to continue therapy while providing time to work with their prescriber to obtain prior authorization or consider formulary alternatives. OptumRx is able to grandfather existing prior authorizations for members but this is not recommended due to change in formulary and utilization management programs.

23. Describe the enrollment/disenrollment process and include detail regarding the timing of when enrollment/disenrollment changes go into effect. The State allows for the retroactive termination of enrollment even though CMS only permits prospective termination. Note: The State does not normally cancel/terminate Medicare retirees prospectively. How do you handle the CMS required "opt hold" period such that there is the least amount of benefit disruption to the member if the State notifies you retroactively within 30 days of Medicare enrollment?

On a daily or weekly scheduled basis (as per customer's need), the State can send an electronic file to us with requests for new EGWP enrollments, disenrollments, and changes. We process customer files daily. New enrollment applications received by file are loaded as "pending" in our system.

We create a daily file for submission to CMS. The first file submitted to CMS is a BEQ for all new applications. The BEQ is required to confirm that the member is on file at CMS (by comparing HICN, name, DOB and gender code). At the same time that the BEQ is being processed, we order Opt-out Letters and Summary of Benefits to be produced/mailed to new members. Responses to the BEQ are received daily. When a member is BEQ-approved, their enrollment request is then submitted to CMS. All enrollment requests (as well as disenrollment requests and changes) are sent to CMS daily. CMS processes these files and sends a response file back to us. These response files inform us which new members enrollments, disenrollments and changes have been approved, rejected, or updated by CMS. This can include requests sent by OptumRx as well as CMS-generated changes (for example, to a member's LIS level). We process CMS-response files daily and load into our adjudication system. Members on the response files have their status changes accordingly (from pending to enrolled, to disenrolled, or to rejected). All applicable responses are communicated to customers through weekly reporting so that they may update their systems as needed. Customers are required to review these reports and provide update information to prevent access to care issues or mitigate delayed terminations from the plan.

Upon CMS acceptance of enrollment, all CMS-required member correspondence (including ID cards, EOCs, formularies, CMS model letter exhibits, etc.) are triggered to be produced/mailed to members so they receive these communications within 10 calendar days of CMS confirmation of enrollment.



24. Describe the member termination process under the EGWP, including the timing of termination after termination date is received from the State.

Members are terminated from the EGWP in a number of ways but for reference, members can only be termed as of the end of a calendar month, per CMS. Certain terminations require advance notice before they can be termed which will determine the effective date of the disenrollment. Members can be terminated through several mechanisms including: (1) A request by the State via their eligibility file, (2) if they no longer qualify for Part D, (3) they have moved out of the plan's service area, (4) have been incarcerated, (5) are not lawfully present, or (6) have voluntarily joined another plan, (7) failed to pay the required Part D IRMAA, etc. Each of these termination reasons all result in notification to the member in advance. During the implementation process, the entire process is reviewed in depth including all member communications. In addition, while CMS only requires members to be entitled to Medicare Part A and/or Part B, the State can require members to have both Part A and Part B to be eligible for the EGWP in addition to any other eligibility rules established by the State.

25. OptumRx to confirm Silver rebates apply to full open EGWP formulary as customized by the State.

Confirmed.

Operations

1. Confirm the PBM is able to administer HIPAA creditable coverage notices.

Confirmed.

2. Confirm the state or its designee will have the right to audit at least 12 pharmaceutical manufacturer contracts during an on-site rebate audit as long as the auditor is mutually agreed upon between the parties.

Confirmed.

3. Confirm that with the exception of FDA recalls or other safety issues, the PBM's client management team will communicate updates within 120 days of negative up-tier changes. Communication includes a summary of customer-specific member disruption.

Updates will be communicated to the State within 90 days or as soon as administratively possible.

4. Confirm the PBM agrees not to make any up-tier drug changes without notification and prior approval from the state, no less than 90 days from the suggested effective date of the change.

90 days or as soon as administratively possible. State has the ability to not implement tier changes and move to a custom formulary, however this may impact standard formulary rebate guarantees. OptumRx will provide updated formulary documents and/or the link to new formulary location



5. Confirm members with a negative tier change will be notified within 60 days of the effective date.

Confirmed. Members will be identified and mailed formulary change letters within 60 days of the effective date

6. Confirm members with a negative tier change will be notified within 60 days of the effective date. Confirm up-tiers are limited to twice a year, January 1 and July 1, unless due to new generic availability.

Confirmed. State can suppress July 1 formulary changes to January 1 if necessary.

7. Confirm that with the exception of FDA recalls or other safety issues, the PBM's client management team will communicate updates within 120 days of formulary exclusions, if any.

Updates will be communicated to the State within 90 days or as soon as administratively possible.

8. Communication includes a summary of customer-specific member disruption. Confirm the PBM agrees not to remove any additional drug products, brand or generic, from the state's formulary or preferred drug listing without notification and prior approval from the state, no less than 90 days from the suggested effective date of the change.

90 days or as soon as administratively possible. State has the ability to not implement tier changes and move to a custom formulary, however this may impact standard formulary rebate guarantees. OptumRx will provide updated formulary documents and/or the link to new formulary location.

9. Confirm members with a formulary excluded drug will be notified within 60 days of the effective date.

Confirmed.

10. Confirm the PBM's client management team will notify the State of estimated percentage of participants disrupted by formulary deletions and no greater than two percent (2%) of participants will be disrupted by any formulary deletions or all deletions in total, on an annual basis.

Confirmed.

11. Confirm that any formulary exclusions will be limited to once a year.

Confirmed.

12. Confirm the PBM will agree to defend claims litigation based on the PBM's decision to deny coverage for clinical reasons, for all coverage decisions.

Confirmed.

13. Confirm the PBM agrees that the state reserves the right to review, edit, or customize appeal templates from the PBM to state's membership to ensure compliance with state law and due process requirements.



Confirmed.

14. Confirm the PBM will allow the state to customize appeal letters for EGWP members as allowed by law.

Confirmed.

15. Confirm the PBM agrees to notify impacted members at least 90 days prior to a deletion of a drug from the specialty drug list.

Members are not notified of a down-tier change. Members will be notified within 90 days prior to any specialty drug exclusion.

16. Please provide additional information on your care management program for members taking specialty medication.

See Exhibit 2 attached for an overview of our Clinical Management Programs.

17. Confirm the PBM agrees to obtain the state's approval for all member communication materials (commercial and EGWP) before distribution to members.

Confirmed.

18. Confirm the PBM will not automatically enroll the state in any programs that involve any type of communications with members or alterations of members' medications, without express written consent from the state.

Confirmed.

19. Confirm the state reserves the right to make the AlaskaCare logo as the prominent feature in communications to commercial and EGWP members.

Confirmed.

20. Confirm all member service call recordings and notes between the PBM and the state's members will be the state's property.

Duplicate. See Pricing section.

21. Confirm the PBM can share files of recorded member calls, call notes or call logs after the PBM has reviewed and removed PHI and other confidential data discussed with members during business hours.

Duplicate. See Pricing section.

22. Confirm the PBM can provide redacted materials within two business days.

Duplicate. See Pricing section.

23. Confirm the PBM will allow the state to choose the dedicated Account Executive.

Confirmed. The State will be able to interview and approve the dedicated Account Executive.

24. List the level of detail that can be provided by the PBM for MAC pricing inquiries and appeals.



We will support the level of detail the State requires in regards to MAC pricing inquiries and appeals. The detail of these inquiries can be extensive, so we would just need to work with the State to identify the needed detail and information on the specific appeal(s).

25. Where are the PBM's mail order facilities located? Do you utilize the same or separate facilities to fill orders for commercial and EGWP prescriptions?

We own and operate four Home Delivery Pharmacy dispensing facilities based in Carlsbad, California; Overland Park, Kansas; Las Vegas, Nevada and Jeffersonville, Indiana. These facilities feature state-of-the-art automated fulfillment equipment, climate and access controlled production environments, and in-house pharmacists that provide hands-on verification of every order.

Our facilities operate on a completely integrated platform, which enables us to balance workloads and monitor inventories across our facilities. Integration also allows us to provide commercial and EGWP members with consistent, efficient, and timely fulfillment of their Home Delivery Pharmacy prescriptions in the event of product shortages, periods of high volume, or other disruptions.

26. Where is the PBM's specialty pharmacy located? Please list the primary locations as well as any additional facilities. Do you utilize the same or a separate specialty pharmacy to fill orders for commercial and EGWP prescriptions?

Our national specialty pharmacy facilities are located in Jeffersonville, Indiana and Las Vegas, Nevada. Additionally, 13 regional locations support our national pharmacies, as needed. Our specialty facilities dispense prescriptions for both commercial and EGWP members.

27. 2 Confirm that you will set up the state's account structure based upon their requirements. The state requires that the PBM's system accommodate the account structure necessary to report and invoice by the various groups, trusts and divisions that exist in the program.

Confirmed. See Transition #3 section of the clarification document.

28. How will the PBM prevent retirees with an existing PA or members who have taken a medication for years, from having to repeat the process?

See Transition #3 section of the clarification document. For all non-EGWP lives, OptumRx will request an open Prior Authorization file from the State's incumbent to ensure all existing PA's move over with the members. For EGWP, if a member has been on a medication subject to prior authorization, step therapy or is not covered under OptumRx's formulary, they are allowed a one-time transition fill at point of sale. Immediately following this transition fill, they will receive a letter from OptumRx informing them of the prior authorization or step therapy requirement or formulary alternative. The transition fill allows the member to continue therapy while providing time to work with their prescriber to obtain prior authorization or consider formulary alternatives. OptumRx is able to grandfather existing prior authorizations for members but this is not recommended due to change in formulary and utilization management programs.



29. Confirm you able to accept electronic feeds of data or referrals from other vendor partners at no additional cost.

Confirmed.

30. Confirm you able to provide electronic feeds of participating data to an outside data aggregator or vendor partners at no additional cost.

Confirmed.

31. Confirm you are willing to provide monthly interface with the data integration vendor or other vendors for claims and utilization of data at no additional cost.

Confirmed.

32. Please describe how you will coordinate with other Contractors, if any, to manage functions such as data sharing, eligibility, coordination of benefits and payment of medical, pharmacy and healthcare claims.

During the implementation process, we work with the State and its vendors to establish mutually acceptable parameters for data capture, delivery and exchange to manage the State care management programs and financial services, such as consumer-driven health plans (CDHPs).

33. Confirm you are capable of designing exports to the FSA vendor to process FSA claims based off medical claim data that is stored within your system?

Confirmed.

34. Confirm you will coordinate clinical management with the medical administrator, wellness and disease management vendor, and any other vendor or administrator the State contracts with to provide services for its member's health administration and management services.

Confirmed.

35. Provide an overview of your documentation, storage, retrieval and recovery of electronic files.

We store the following data elements in the member eligibility table in our transaction system:

- Member name
- Date of birth
- Gender
- Address
- Care facility
- Primary care physician
- Relationship code
- Date coverage range

At the State's request, we can also store select care-level data, such as diagnosis and allergy information as part of a submitted eligibility file.



RETENTION

We maintain two rolling years of commercial eligibility data and four years of Medicare Part D eligibility data in our system. We retain historical eligibility data including member information to support retroactive claim processing or adjustments that may be required. Eligibility data retention is subject to change based on new regulations and storage requirements.

36. Explain your Computer Disaster Recovery plan. Provide the most recent outside assessment of its readiness.

Please see Exhibit 3 OptumRx Disaster Recovery Plan attached.

37. Do you provide unlimited on-line eligibility entry and update functionality to authorized State staff?

Confirmed.

38. Confirm you conduct manual eligibility updates at no charge to the State.

Ad hoc eligibility updates are provided at no cost. Large scale manual eligibility updates/adds can be discussed further and the scope of the project and any additional fees mutually agreed upon

39. Confirm your understanding that the State's data is their data, and will not be shared, except at the State's request, or sold to any entity without full knowledge and express written consent of the State.

Confirmed.

40. Does the online system allow the State to assign different levels of access internally?

Confirmed.

41. Confirm you will provide all necessary data for the State to comply with or participate in programs (whether optional or mandated) implemented as part of any local, state or federal government health care reform legislation at no additional cost to the State.

Confirmed.

42. Upon determination and identification of system problems, programming problems, or transfer problems, confirm you will notify the State immediately upon identification of issue. The Confirm you shall also make every effort necessary to correct such problem immediately or as soon as possible, including but not limited to: working nights; weekends; and holidays, to minimize any negative impact to employees, retirees, or dependents and to maintain continual operations of the program.

Confirmed.

43. Describe your system access security process with members, providers and the State.

During implementation, we define appropriate access permissions for the State's data. This practice helps us meet the highest level of HIPAA and Sarbanes-Oxley (SOX) regulations. For instance, we can provide a secure electronic library for all claims information for the State, when



appropriate. We manage this library internally by creating logical views for the State over the main physical database library. Consequently, the State may only reference the specific library identified in its user profile, securing data from any unauthorized access.

Moreover, we have implemented a system to protect the State data in a testing environment. This system eliminates production data in non-production environment, or removes identifying the State data from our Online Reporting Tool. As a result, we better protect personal health information while still allowing customers to run the reports they need.

Additionally, we employ various hardware and software tools to guard system and network access. We also apply a multitude of physical security controls so that we only grant appropriate access.

44. How often will the account management team meet with the State and will the meetings be in person on a quarterly basis in Alaska or other locations to be specified by the State?

Confirmed. The account management team will meet telephonically with the State as frequently as needed. The account management team will meet in person with the State at least quarterly.

45. Please confirm that you will provide run-out administration, including communications and data support for transition to new Contractor, for a period of 12 months following contract termination.

Confirmed.

46. Confirm your organization is in compliance with and will administer the proposed benefit plan (s) in accordance with all applicable legal requirements, including HIPAA, COBRA, DOL, ERISA, and state and local mandates.

Confirmed.

47. Describe how you maintain confidentiality of patient and plan data.

We take the protection of customer information assets very seriously:

- All personnel are required to be familiar with all of our corporate security, compliance and HIPAA policies and procedures. It is a corporate requirement that each staff member participates in training and proves proficiency in each of these areas in order to retain the job at OptumRx.
- Data retention polices specific to the customer are determined by the contract. However we retain an archival record of all pharmacy claim adjudication transaction for up to ten years from the date of the transaction.
- All databases are operated within the United States. No production data is allowed to be housed from locations outside the United States.
- We protect customer data assets from external destruction, damage, and disclosure. This commitment results in industry standard policies over access to the systems. All OptumRx data processing assets are protected by appropriate firewall, virus/malware protection, software inventory monitoring, spam filtering, standard secure email and like security and



protection measures or solutions. Our policy also limits access to our network from non-OptumRx equipment and devices to only:

- Trusted sources
 - Through defined addresses and ports in our firewalls scheme
 - From identified addresses and domains (example: access control management)
 - With appropriate, strong, and date-sensitive passwords
 - Applications that are approved for outside and vendor access
 - Over secured communication links.
- In general, foreign computers are not allowed onto the network. Only desktop sharing (through Citrix-like devices) is allowed for network access for non-OptumRx assets and desktops.
 - File exchanges are only allowed with specific exchange servers, driven by our Multi-Enterprise Service Architecture (MESA) to promote standardization, reliability, authentication, and security.

48. Are your eligibility and claim systems compliant with HIPAA regulations?

Confirmed.

49. Confirm you are currently receiving eligibility files in the HIPAA 834 format.

Confirmed.

50. How soon after the contract award will you provide the HIPAA companion guide for creating eligibility files that load to your system?

Confirmed. OptumRx can provide its eligibility companion guides immediately upon request from the State

51. Please confirm all communications/educational materials will be submitted to the Project Director, or his designee, for review and approval before dissemination to members.

Confirmed.

52. Confirm you will create, customize, produce and distribute: Employee ID cards, replacement cards, claim forms, summary annual reports, and general letters and correspondence sent to members. Please explain if any these items are not included in your cost proposal.

Confirmed. OptumRx would like to request an example of the summary annual report from the State to review.

53. Will you generate some form of an Explanation of Benefits (EOB) for commercial claims?

OptumRx provides an EOB with all Direct Member Reimbursement (DMR) requests from non-EGWP participants. The pharmacy receipt will serve as proof of coverage for non-EGWP point of sale claims. Members can also view and print their pharmacy claims history from our



member portal. For EGWP participants, they will receive monthly EOBs from OptumRx. Additionally, an EGWP member can request a historical EOB going back 3 years.

54. Please confirm you contract with and manage directly the retail pharmacy and EGWP networks that you are proposing for the state.

Confirmed.

55. Please describe what steps, if any, the PBM plans to take in regards non-network pharmacies in Yukon Kuskokwim-Bethel, Ketchikan, Kakanak and Dillingham?

Immediately upon implementation activities, OptumRx will conduct an updated review of potential network disruption within the state of Alaska, focusing on rural access. If a currently utilized pharmacy is not contracted with OptumRx, we will reach out the pharmacy and solicit them for a contract to participate in our network.

Based on our initial analysis, there are only 11 currently utilized pharmacies across both commercial and EGWP lines of business that are currently not in network. We would begin our efforts here and coordinate with the State on any others they are aware of.

56. The retail network analysis indicated there were 2,957 impacted members in Elmendorf AFB (568), Yukon Kuskokim Delta Regional-Bethel (449), and Petersburg Rexall Drug - Petersburg (250), but the corresponding numbers did not add up. Similarly the out-of-state analysis showed 1,073 members impacted for University of WA Medical Center (98), Harborview Medical Center (43) and Portland VAMC (38). Please explain these discrepancies.

Please see attached Exhibit 4.a and Exhibit 4.b for updated network disruption reports for the Commercial and EGWP lines of business.

57. The GeoAccess Analysis showed 628 members without access in the commercial plan, and 7,371 members without access in the EGWP plan. However, the detailed list did not equal these numbers. Please describe the discrepancy and actions that will be taken to mitigate the impact?

Please see attached Exhibit 5.a and Exhibit 5.b updated GeoAccess reports for the Commercial and EGWP lines of business.

58. Does the PBM track edits performed on retail prescriptions (e.g. change in dose, therapy)?

Confirmed.

59. Do you have contracts with retail pharmacies that allow you to deliver prescriptions filled by your mail-order pharmacy to their pharmacy for customer pick-up? If "yes," please provide list of pharmacies available to receive mail pharmacy deliveries.

This service is not currently part of any of our retail pharmacy contracts. However, we can explore this option further with select retail pharmacy partners if the State feels it is of value to their membership.



60. Should there be a decrease in the number or composition of one of your pharmacy network for which the State participates, will you agree to (1) provide an analysis of the impact of the change in the network - to help the State understand the impact to (a) participants, (b) the Guaranteed Ingredient Cost Discounts, and (c) Guaranteed Dispensing Fee; (2) allow the State to perform its own analysis; and (3) if the State disagrees with (a) the Offeror analysis, (b) the proposed change in the Guaranteed Ingredient Cost Discounts and Guaranteed Dispensing Fee, or (c) that the change to the network is unacceptable, the State may terminate the contract without financial consequence (e.g., no loss of rebates earned but not yet paid) upon sixty (60) days' notice.

Confirmed.

61. Are you willing and able to customize your networks based on the State's specifications and needs?

Confirmed.

62. Confirm your contractual agreements with pharmacies/pharmacists will not prohibit the pharmacy/pharmacist from educating the member on lower cost alternatives, including if the member can purchase the medication directly for less than the plan copay.

Confirmed.

63. Confirm your contractual agreements with pharmacies/pharmacists will not prohibit the pharmacy/pharmacist from mailing a prescription to the member upon request of the member.

Confirmed.

64. Specify the pricing source(s) used for each of your retail networks.

OptumRx utilizes Medispan as its sole pricing source.

65. Specify the pricing source(s) used to determine pricing (e.g., Average Wholesale Price, or "AWP") guarantees with your clients.

OptumRx utilizes Medispan as its sole pricing source.

66. How often do you update the pricing file used in contracts with your retail networks and with the State?

Our network pharmacy contracts are multi-year agreements that are evergreen with pricing improvement in subsequent contract years. We periodically contract with new network pharmacies that may change pharmacy rates. Any pricing improvements are factored into all quotes for new business. The State may work with us to pursue more-aggressive contract terms with network pharmacies.

67. For each mail order facility currently in operation that you propose for the primary and/or secondary mail order fulfillment for the State, please provide: Name of facility, city and state located, year opened, number of pharmacy technicians/pharmacists, max number of prescriptions processed per 24-hour period (using last quarter data), current operating



volume or prescription per 24-hour period (using last quarter data) and dispensing accuracy during the last 12-month period.

The Carlsbad and Las Vegas facilities will be the primary and secondary facilities for the State.

Facility/Location: Carlsbad, California

Year Open: 2000

of Pharmacy Technicians: 104

of Pharmacists: 91



Facility/Location: Las Vegas, Nevada

Year Open: 2015

of Pharmacy Technicians: 65

of Pharmacists: 19



68. Are all packages shipped from the mail pharmacy tracked from your pharmacies to the point of delivery? If yes, is the mail package tracking available regardless of whether a package is destined for a mailbox, P.O. Box, or mail slot?

Confirmed.

69. What percent of all inbound prescriptions and order forms are electronically imaged? If less than 100%, please explain why they are not all imaged.

Confirmed. 100% of all inbound prescriptions and order forms are electronically imaged.

70. Does your organization track mail order errors reported by members? Is the tracking client specific?

Confirmed. We track mail order errors reported by members. The tracking is client specific.

71. Does your organization track edits performed on mail order prescriptions (e.g., change in dose, therapy)? Is the tracking client specific?

Yes, edits on mail order prescriptions are tracked and are client specific.

72. Do you track errors on: date of Rx fill, patient name, physician name, name of drug, dosage-strength of drug, quantity, directions, drug interaction labels, drug warning labels,



patient address? How do you report these errors? Are those errors identified by members tracked separately from those found in-house?

We capture pharmacy errors chiefly through our Real Time Audit System, which proactively examines every claim we adjudicate. Claims that do not meet specific guidelines are flagged for expedited review. These claims are reviewed for possible fraud or unintentional errors to prevent further processing.

The top five reasons for audit corrections are:

- Prescription not found
- Overbilled quantity – exceeds prescribed quantity or exceeds plan guidelines
- Use as directed directions
- Unauthorized/undocumented refills
- Wrong member billed

Our Real Time Audit System allows us to prevent over-billing by correcting a problem with the pharmacy before the claim is paid. We leverage audit and educational opportunities to reduce the possibility of future errors and save the State money.

73. What was your average annual turnaround time for dispensing mail order drugs without intervention?

[REDACTED]

74. Do you fund emergency supplies of medication if/when the delivery from your mail-order pharmacy is delayed, creating the need for an emergency supply?

Confirmed. Short term supplies can be accessed from a retail pharmacy.

75. Confirm all mail order claims will be adjudicated at the lowest of: (a) the contracted discount plus dispensing fee; or (b) MAC plus dispensing fee.

Confirmed.

76. Confirm all mail order claims will be adjudicated according to the “lowest of” logic such that members always pay the lowest of the applicable copayment or the discounted price. Confirm you will not adjudicate based on a minimum copayment amount through mail order.

Confirmed.

77. Confirm you will offer consistent pricing for all standard mail order prescriptions regardless of the days’ supply (i.e., will not apply retail pricing to any mail order claims).

Confirmed.

78. Confirm the MAC list you use for the State at mail pharmacies will include the same medications or more and will use the same prices or lower prices as the most aggressive retail pharmacy MAC list.



Confirmed.

79. How many calendar days advanced notice must a member provide in order to guarantee that their supply is received before existing supply is depleted?

Refill thresholds can be set to the State's requirements during the implementation process. Typically we advise that members provide at least 2 weeks prior to their existing supply being depleted.

80. What is the standard turnaround time for a mail order supply?

[REDACTED]

81. Explain how prescriptions are shipped. Differentiating between specialty and standard prescriptions, describe your protocol for shipping temperature sensitive products, and your quality control processes.

HOME DELIVERY PHARMACY SHIPPING

Our system automatically determines the most appropriate shipping method based on weight, ZIP code and any specific delivery instructions. Our Home Delivery Pharmacy facilities use first class mail through the United States Postal Service for the majority of orders; remaining orders are shipped using United States Postal Service Priority Mail or an overnight carrier, such as United States Postal Service Express Mail, FedEx or UPS. Signature-required and expedited shipments are available as necessary for specialty medications, controlled substances, expensive orders, or urgently needed medications.

Medications requiring cold storage are shipped in recyclable, biodegradable and eco-friendly Styrofoam alternative that is able to maintain standard refrigerated temperature of (2° - 8°C) for up to 50 hours.

WarmMark temperature indicators are included with select refrigerated packages, based on the allowable temperature range of the medication. The indicator changes color if the contents of the cooler exceed the acceptable temperature range. Members are directed to contact the number on their prescription label for help if the indicator has changed color.

SPECIALTY PHARMACY DELIVERY PROCESS

In keeping with our “right medication at the right time” model, PCCs schedule a convenient delivery time with the member. UPS is our primary carrier for overnight delivery. The proximity of our Jeffersonville, Indiana location to UPS World Headquarters provides direct access to logistics and delivery services, including next day delivery and fulfillment until midnight. Additionally, Sunday morning fulfillment from our Jeffersonville, Indiana facility is available for Monday delivery of refrigerated medications.

Specialty medications requiring cold storage are shipped in biodegradable packaging that is able to maintain standard refrigerated temperature of (2° - 8°C) for 36 hours.



TransTracker temperature indicators are included with select refrigerated packages, based on the allowable temperature range of the medication. The indicator changes color if the contents of the cooler exceed the acceptable temperature range. Members are directed to contact our specialty pharmacy if the indicator has changed color.

Orders may also ship with FedEx or United States Postal Service (USPS) Express Mail. The shipping department analyzes the member’s geographical destination and selects the carrier believed to perform most efficiently and reliably within that region. We ship orders in nondescript packaging to obscure contents.

82. For each specialty pharmacy currently in operation that you propose for the primary and/or secondary mail order fulfillment for the State, please provide: Name of facility, city and state located, year opened, number of pharmacy technicians/pharmacists, max number of prescriptions processed per 24-hour period (using last quarter data), current operating volume or prescription per 24-hour period (using last quarter data) and dispensing accuracy during the last 12-month period.

Our Las Vegas and Jeffersonville specialty facilities will be the primary and secondary facilities for the State until our new Seattle location is operational. Once online, the Seattle facility will become the primary specialty pharmacy for the State, with Las Vegas serving as the secondary site. This new specialty pharmacy is strategically located to provide the logistical flexibility to further help meet the specific geographic needs and provide the highest level of service for the State's valued members. Current timeline for our Seattle location is 3Q 2019.

Facility/Location: Las Vegas, Nevada

Year Open: 2015

of Pharmacy Technicians: 65

of Pharmacists: 19

[Redacted]

Facility/Location: Jeffersonville, Indiana

Year Open: 2013

of Pharmacy Technicians: 38

of Pharmacists: 15

[Redacted]



83. Which price source (e.g. Medispan, Micromedex, etc.) does your company use to determine the gross cost of medications which are dispensed at the specialty pharmacy?

Medispan.

84. Do you have a dedicated P&T (Pharmacy and Therapeutics) committee for your specialty drug program? If you have a dedicated specialty P&T Committee for specialty, what is the composition of your specialty P&T Committee, and their credentials.

One, single OptumRx Pharmacy & Therapeutics (P&T) Committee provides objective evaluation, review, guidance and clinical recommendations regarding:

- Formularies
- Clinical guidelines/criteria and procedures
- Medication policies, quality initiatives and other clinical pharmacy interventions
- Utilization management tools

Our goal is to promote clinically appropriate, safe and cost-effective drug therapy that reflects community and national standards of practice. P&T Committee members exercise professional judgment to make determinations, based on clinical and scientific evidence, national/international best practice guidelines and drug utilization analyses. P&T Committee clinical recommendations are reviewed by our internal Business Implementation Committee, which makes the final determination of medication inclusion on OptumRx formularies.

The P&T Committee chairperson is an external committee member. The P&T Committee is comprised of members that are selected to provide diversity of specialty, expertise and geography.

The P&T Committee consists of an appropriate number of voting members that represents needs of the State members and various specialties to make sound clinical recommendations and comply with regulatory requirements. In addition to the P&T Committee's specialties, consultants in various areas of specialty—such as, infectious disease, neurology, psychiatry, and pulmonology—are also available to the P&T Committee for consultation. There are no members that are employed by our organization. Voting members may not be employed by OptumRx or any of its affiliates.

85. List the Specialty drugs to which your organization does not have access (i.e., limited distribution products).

We dispense approximately 98 percent of specialty medications through Briova. We also utilize a narrow network of specialty pharmacies to provide access to all drugs, including specific limited distribution drugs, and as back up in the rare case of a potential shortage.

We provide access to 100 percent of limited distribution drugs through our network of pharmacies.

86. What are your procedures to address out-of-stock drugs?

At any given time, our inventory team places between five and 40 NDCs on a long-term out-of-stock list out of the approximately 5,000 that we stock. These drugs represent those that are



unavailable due to manufacturing issues and are not expected to be restocked within 24 hours. All other out-of-stock medications are generally supplied by a wholesaler or the manufacturer within 24 hours of depleting stock.

87. What was your out-of-stock rate for each of the past 2 years?

We do not currently track significant out-of-stock rate due to our ability to maintain regularly available stock.

88. What procedures do you have in place to minimize drug wastage, including ensuring precise dosing of self-injectables?

Briova complies with Centers for Medicare & Medicaid Services fraud, waste and abuse (FWA) rules and regulations, local regulations and plan requirements. Additionally, we offer other features to combat FWA:

- Comprehensive support: Through therapy initiation, physician coordination, pharmacist counseling and medication delivery, we closely monitor member needs and physician requirements.
- Refill dates: Medication deliveries are based on each member's need-by date, which is carefully calculated, to confirm the member receives medication on time and not in excess.
- Advanced software and systems: We track and document inventory levels, member care activities and dispensing. Additionally, pharmacists conduct extensive drug utilization reviews to confirm appropriate dispensing.
- Comprehensive reporting: We track outcomes for key therapeutic categories that require a higher level of member care and for which medications costs demand close attention to utilization. Our reporting is being expanded to provide a more robust solution that supports clinical care and closely monitors utilization and dispensing.
- Split Fill Program: We accommodate customized days' supply for specific specialty medications. Short fills, such as 15 days' supplies, are appropriate for certain oral oncology medications until members are stable on therapy.

In addition, we leverage technology through our BriovaLive application to conduct a live unboxing session with every new Briova patient via Skype or FaceTime. A Briova pharmacist will go through the unboxing process and ensure the member is comfortable with their medications and dosing of self-injectables.

89. Does your Specialty pharmacy titrate and pre-mix self-injectables so that syringes are ready for patient use upon delivery?

Confirmed.

90. Does your Specialty Pharmacy charge as a compound drug when they have to dilute or pre-mix a medication for patient use upon delivery? If so please provide the pricing formula.

During the State's implementation, we determine how compound prescription drugs are to be paid and set up within our system.



[Redacted]

91. Confirm the MAC list you use for the State at specialty pharmacies will include the same medications or more and will use the same prices or lower prices as the most aggressive retail pharmacy MAC list.

[Redacted]

92. Confirm specialty pharmacy claims will be adjudicated at the lowest of: (a) the contracted discount plus dispensing fee; or (b) MAC plus dispensing fee. Confirm you will not assess a "minimum charge" through specialty pharmacy.

Confirmed.

93. Provide a listing of the prior authorizations, step therapy and other clinical programs available for Specialty drugs dispensed at Retail and Specialty pharmacies. Label attachment "Specialty Drug Management Programs."

Please see the attached Exhibit 6 for our specialty utilization management programs.

94. Confirm you will price all claims processed by the specialty pharmacy for medications that are not on your specialty drug list at the mail-order pharmacy rates.

Confirmed.

95. Confirm if you classify a drug as specialty, but the drug is designated by the FDA as generic, you will price drug at the generic guaranteed rates.

All specialty claims will be part of the overall specialty guarantee.

Confirm specialty pharmacy medications delivered through mail can have mail copays applied?

Confirmed.

96. What was your average annual turnaround time for dispensing Specialty drugs without intervention?

[Redacted]

97. What was your average annual turnaround time for dispensing Specialty drugs with intervention?

[Redacted]

98. Will your organization split quantities to meet client benefit parameters if requested?

Confirmed.



99. You agree that the MAC lists used to price claims will be updated no less frequently than 4 times throughout each contract year term of the contract to remain competitive; however, you will proactively communicate, identify and explain, to the client any deletions and any unit price increases over 10% per month.

Confirmed

100. Confirm the AWP used to price the claim must be from only one nationally recognized source (e.g., MediSpan).

Confirmed. OptumRx utilizes MediSpan as its sole pricing source.

101. Confirm the AWP used to price retail, mail order and specialty pharmacy claims will be the actual National Drug Code (NDC)-11 submitted by the pharmacy as the one the pharmacy used to fill the prescription.

Confirmed.

102. Confirm all inputs for AWP will apply to the AWP applicable on the date that the claim is processed.

Confirmed.

103. Does your organization, or your associated facilities, repackage drug products for use in filling mail order prescriptions? If yes, does the AWP for repackaged drugs match the AWP of the same package size of the source labeler? If not, describe how you establish the AWP for your repackaged NDCs.

No, OptumRx does not repackage drugs.

104. Confirm you will maintain a list of single-source generics and will provide the list upon the State's request. Additionally, you will provide effective dates and term dates for drugs that have dropped from or been added to the list.

Confirmed.

105. Confirm all retail claims will be adjudicated at the lowest of: (a) the contracted discount plus dispensing fee; (b) MAC plus dispensing fee; or (c) the recognized charge (RC) price (including the pharmacy's sales price, if any).

Confirmed.

106. Confirm claims priced at recognized charge will NOT be assessed a separate dispensing fee.

Confirmed.

107. Confirm that the State will be provided at least 90 days' notice in advance of new medications being added to your "specialty drug list" whenever feasible; confirm the state has the right to exclude the medication from coverage if the medication is in a category that is currently excluded (e.g., growth hormones).

Confirmed.



108. Confirm you can accommodate an account code structure in the eligibility file that will allow the State to identify trends in rebates and claim activity information broken down by different organizational units.

Confirmed.

109. Describe if you will provide on-line access to the State to view eligibility files. If yes, describe this arrangement, and whether or not this access includes the ability for the State to update member data on an ad hoc basis.

Confirmed.

110. How often is eligibility electronically updated? Confirm that you will accept a daily eligibility file.

Confirmed. Eligibility files are loaded within hours but within 1 business day. Confirmed we can accept a weekly eligibility file.

111. How often is eligibility electronically updated by any subcontractors or joint ventures?

Eligibility is updated as often as needed with receipt of electronic file or manual update (commercial only).

112. Will a secure FTP site need to be established and what information from the State is needed to set that up?

OptumRx will establish a secure FTP site for the State and provide credentials for the State to access the site.

113. Do you require static IP addresses for file transfers to the FTP site?

No.

114. Can you accept eligibility via paper, as well as by electronic feed?

Yes. Manual eligibility can be provided for the commercial population (actives and U-65). EGWP must follow electronic group enrollment process.

115. Indicate how dependent eligibility information is stored. Is it part of the member record, or a separate record?

Member records are unique, but linked through Family ID (Subscriber ID #)

116. What is the standard turnaround time for an eligibility file upload?

Eligibility files are loaded within 1 business day, however most require only hours to process.

117. How will you confirm eligibility with members who are Direct Bill or COBRA, currently through Payflex?

OptumRx can accept eligibility from multiple vendors for a specific client. We can accommodate standard as well as custom eligibility files from our clients and their vendors. OptumRx can accept a 2000 bit eligibility file format and currently does so for other existing clients.

**118. How do you audit your eligibility system to find data anomalies or reporting errors?**

OptumRx has a standard reconciliation process to identify inconsistencies and erroneous errors between eligibility data sources and what has been loaded into our system. We work with our clients and their partners to compare data, identify root cause for errors and take corrective measures to ensure data accuracy. We will review the eligibility reconciliation process with the State during implementation and determine the resources, inputs/outputs and frequency for the eligibility reconciliation.

119. Will you be providing any eligibility error reports for the State to review?

All eligibility files go through QA process before loading with error reports provided via the FTP site.

120. Is there a limited time (days/months/years) to correct an eligibility period retroactively?

No limit.

121. What is the expected method for communicating eligibility ad hocs (email, phone, online portal...)?

All methods listed can be used for communicating ad hoc eligibility requests. The State will have access to make these updates as well.

122. What is the expected turnaround time for eligibility updates via ad hocs?

Ad hoc eligibility updates will be done within 1 business day, however most updates can be done within hours. All changes are updated in our system in real-time.

123. Do you require a specific form to report eligibility ad hocs, and what are the key data elements that will need to be included in the request?

No specific form. Member ID or SSN (if OptumRx is assigning ID's), member name, DOB, dates of eligibility and benefit plan.

124. How will payment for claims be invoiced to the State?

OptumRx's standard billing cycle is bi-monthly on the 1st and 16th. Billing can be as frequent as weekly if desired. Separate Clarification call on AP/AR/billing.

125. Will transcripts of recorded calls be made available for appeals?

Confirmed.

126. Will you provide medical director/pharmacist support for appeals advance to the Office of Administrative Hearings or superior court?

Confirmed.

127. Are all claims processed on a single claims system?

Confirmed.

128. How are changes to the claims system implemented?



OptumRx upgrades and enhances its system regularly. In addition to minor monthly enhancements, we implement comprehensive upgrades to the system on a quarterly basis. Beyond these efforts, we regularly schedule maintenance activities throughout the year for our business critical systems to maintain optimal system performance and security. Maintenance activities include system enhancements, upgrades and break fixes.

129. Are system changes planned in the next two years? If there are system changes planned, please indicate the nature of the changes.

We do not anticipate any major system-wide changes or migrations to new platforms in the near future.

130. Confirm that you are able to pay claims in accordance with provider contracts held by the State and not your network.

OptumRx confirms the ability to support provider contracts held between the State and independent retail pharmacies within the State of Alaska, excluding direct contracting with a Specialty Pharmacy. Direct contract claims will adjudicate at the pharmacy’s submitted price and will be excluded from the discount/dispensing fee guarantee reconciliation. Direct contract claims will be charged an administrative fee of \$0.95 PNPC. Rates may be changed if greater than 10 percent of utilization is filled and processed by an independent pharmacy directly contracted with the State. OptumRx

131. Please describe your methodology for calculating DUR Savings. If different methodologies are used for Prospective compared to Concurrent and Retrospective DURs, please describe each separately.

[Redacted content]

132. Does your company automatically notify participants about savings opportunities? If yes, can this be suppressed by group or on an individual basis?

OptumRx Home Delivery does offer mail order campaigns that promote lower cost alternative medications. The State can opt in or out of these campaigns. The State can also suppress these campaigns at the group level.

133. Does your company currently have the ability to run all pharmacy claims of a given client against a RDUR program to identify potential safety issues (e.g., drug-drug interactions) for which physicians would be alerted?



Confirmed.

134. Does your company currently have the ability to run medical claims against a pharmacy RDUR program to identify potential safety issues (e.g., drug-medical condition interactions) for which physicians would be alerted?

Confirmed.

135. Can you receive and use data from the medical vendor to identify and outreach to members obtaining specialty medications through a provider?

Confirmed.

136. Does your company currently have the ability to run claims against a RDUR program to identify gaps or omissions in care (e.g., no ARB for a patient with Diabetes), or patient adherence for which physicians would be alerted?

Confirmed.

137. Are savings reported for DUR programs auditable to the individual claims transactions?

Confirmed.

138. How often are your formularies reviewed?

See Operations section # 84.

139. Describe the committee(s)/team(s) involved in developing and managing your formularies?

The OptumRx P&T Committee is a broad-based, nationally represented body of practicing physicians and pharmacists — all with specialized clinical expertise — chaired by an independent practicing physician. Members may not be employed by OptumRx or its affiliates. The P&T Committee complies with Centers for Medicare & Medicaid Services (CMS) requirements regarding member composition, inclusion of specialists and independence from manufacturers. This allows for an unbiased review of new products by clinical experts representing a wide range of medical specialties. Committee members submit annual disclosure forms and recuse themselves from voting if a conflict of interest arises. They are asked to reaffirm changes to conflict of interest at each meeting. OptumRx also conducts routine monitoring of sanctions and public reporting sites. The P&T Committee complies with national quality standards including those provided by CMS, the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC®). Deliberations are based on clinical evidence, national consensus guidelines and best practices— with oversight from the OptumRx Clinical Quality Management team.

140. Describe the Pharmacy & Therapeutics (“P & T”) Committee's formulary drug review and decision-making process. Please include criteria for evaluating an existing drug's formulary status and criteria for adding a drug to your formulary.

The P&T Committee appraises new and existing drugs and drug classes, reviews utilization management programs and oversees clinical programs. Drugs are evaluated based on clinical



evidence. From these assessments, the P&T Committee determines whether a drug has unique therapeutic benefit, comparable safety and efficacy, or whether risk of harm outweighs the benefits. The P&T Committee process consists of unbiased, clinically based review of new and existing drugs and their appropriate place in therapy.

1. The P&T Committee evaluates drugs based on scientific evidence, including peer-reviewed medical literature and well-established clinical guidelines. Our Medicare Part D formularies adhere to CMS requirements and guidelines.
2. Once clinical deliberations are complete, the P&T Committee recommends a drug designation and approves utilization management criteria.
3. A separate Formulary Management Committee incorporates P&T Committee recommendations as well as financial effect, member and physician disruption and generic availability to set final formulary tiering.

141. Are multi-source brand drugs moved to the non-preferred tier when a generic becomes available?

If the OptumRx Select formulary is utilized then brand drugs will move to a higher tier when the generic becomes available. If the OptumRx Premium formulary is utilized then brand drugs will be excluded when the generic becomes available.

142. How are new medications added to the formulary?

The OptumRx Clinical team is continually monitoring the drug pipeline and plans ahead for new to market medications. We typically begin putting together proposed utilization management strategies in advance on new drugs coming to market. However when a new drug is released in the market, the drug will remain excluded from our formularies until our P&T Committee reviews for formulary placement and utilization management. We are expeditious in evaluating new drugs when they come to market and typically formulary placement is determined within 3 months of the drug release. We also offer an elective interim prior authorization process that allows for medical necessity review of new to market drugs should the State want to allow its participants to have access to drugs prior to their formulary placement.

143. Are specialty drugs found in more than one tier? If yes, in which tiers are specialty drugs found?

OptumRx provides several options for the State to regarding specialty drug formulary placement. The State can select the option that best fits their business goals. Options include: 1. Specialty drugs can put into one separate Tier with its own specific member cost share. 2. Specialty drugs can be separated out by preferred brand and non-preferred brand if different member cost shares are needed. 3. Specialty drugs can remain in the standard formulary tiers if the plan does not require different member cost shares. Note that generic specialty drugs will always adjudicate at the Tier 1 member cost share.

144. Please confirm that all generics are included in the proposed formulary; if not, detail all generics that are not included.



Confirmed. All generics are included in OptumRx's standard formularies unless the State elects to exclude certain therapeutic categories. For example, the State could chose not to cover weight loss medications so then phentermine would not be covered under the pharmacy benefit plan.

145. Do you communicate formulary changes to clients at least 60 days prior to the change?

Confirmed.

146. Do you communicate formulary deletions to members impacted by the change? How far in advance?

Confirmed. 60 days in advance.

147. Confirm you agree to cooperate with any independent auditor retained by the State for the purpose of reviewing the administration, adjudication and/or utilization management performance of the vendor for the State's pharmacy plan.

Confirmed.

148. Confirm you agree that the State has the right to audit any data necessary to ensure the Offeror is complying with all contract terms, which includes but is not limited to 100% of pharmacy claims data, which includes at least all National Council for Prescription Drug Program (NCPDP) fields from the most current version and release; pharmaceutical manufacturer and wholesaler agreements; [retail pharmacy contracts; mail and specialty pharmacy contracts to the extent they exist with other vendor(s)]; approved and denied utilization management reviews; clinical program outcomes; appeals; information related to the reporting and measurement of performance guarantees; etc.

Confirmed.

149. Confirm the State has the right to conduct audits at any time during the contract term upon 30-days written notice.

Confirmed.

150. Confirm the State has the right to audit post termination.

Confirmed.

151. The Offeror will not limit the time period of paid claims to be audited.

Confirmed.

152. Confirm the State is not responsible for any of the PBM's expenses related to an operational or financial audit, including the provision of records.

Confirmed.

153. The State has the right to audit more than once per year if the audits are different in scope or for different services.

Confirmed.

154. The State has the right to perform additional audits during the year of similar scope if requested as a follow-up to ensure significant/material errors found in an audit have been



corrected and are not recurring or if additional information becomes available to warrant further investigation.

Confirmed.

155. Offeror shall provide reasonable cooperation with requests for information, which includes but is not limited to the timing of the audit, deliverables, data/information requests and your response time to our questions during and after the process.

Confirmed.

156. Offeror shall provide a response to all “findings” that receives within 10 days, or at a later date if mutually determined to be more reasonable based on the number and type of findings.

Confirmed.

157. Are on-site audits performed at your mail service pharmacies? Describe the frequency and types of audits performed and by whom.

Confirmed. As part of our internal auditing and quality control procedures we have adopted an internal medication error quality assurance (MEQA) program. This program applies quality control measures for identifying, reporting and addressing pharmacy errors.

Our MEQA program includes Six Sigma techniques. We rigorously track, evaluate and document our performance overall and at the prescription level. Our Home Delivery Pharmacy management team also conducts weekly quality improvement meetings. This group reviews and analyzes all reported quality issues and complaints while incorporating customer reviews and customer survey results. They use this data to continuously improve existing processes and develop new techniques to drive efficiency and satisfaction.

These weekly meetings include managers and supervisors from each functional area within the Home Delivery Pharmacy unit:

- Customer service
- Order entry
- Pharmacist verification
- Shipping
- Pharmacy interventions
- Fulfillment

These areas create a summary of the meetings’ results and then present them to the Senior Vice President of Home Delivery Pharmacy operations.

158. Offeror conducts a type II SAS70 audit at least annually at no cost to the State.

Confirmed.

159. Confirm that you will handle all mandatory reporting to CMS and states that have surcharges such as New York and Massachusetts.



OptumRx confirms that we handle all mandatory reporting to CMS.

160. The State requires the ability to audit the vendor administering its Medicare Part D drug program. Describe any audit requirements or restrictions regarding your services and confirm that the State will not be responsible for any audit expenses incurred by your organization.

Confirmed per Submittal Form G.

161. Describe your method for processing appeals for certification review, claim review and/or billing appropriateness.

We resolve appeal requests according to state and federal guidelines through a two-tiered process:

1. Our clinical pharmacists, who hold doctor of pharmacy degrees, conduct a first-level review. In many cases, they make a decision based on new information received with the appeal request.
2. If they are unable to overturn the denial based on new information or additional clinical insight, the case is forwarded to our contracted Medical Review Entity for physician medical necessity review.

We contract with three independent review organizations (IRO) for medical necessity determination of member appeals that our clinical pharmacists are unable to overturn. Each IRO holds national accreditation from URAC, an NCQA certification in Utilization Management.

IROs with URAC accreditation strive for a fair and impartial review process that benefits members and physicians with grievances. They also must meet the following criteria:

- Free from conflicts of interest
- Establish qualifications for physician reviewers
- Address medical necessity and experimental treatment issues
- Complete standard and expedited reviews within a reasonable time period

We selected our vendors using the following key factors:

- Wide, national spectrum of established specialist physician review network
- History of quality reviews as indicated by the external review organizations earning national accreditation
- Ability to satisfy strict compliance requirements, including turnaround times and physician specialty matches

162. Explain how you use staff medical professionals and/or outside consultants to review disputed claims for medical necessity and billing appropriateness.

OptumRx has a team of clinical pharmacists who review requests for prior authorization. The clinical pharmacists have a variety of specialties and utilize OptumRx's coverage policies to conduct medical necessity reviews. OptumRx also contracts with three independent review



organizations (IRO) for physician review of medical necessity and coverage determination denial appeals.

We use the following URAC-accredited Independent Review Organization (IRO) vendors in the external review level of appeal:

- Medical Evaluation Specialists (MES) Boston, Massachusetts
- Advanced Medical Review (AMR) Los Angeles, California
- Medical Review Institute of America (MRIoA) Salt Lake City, Utah
- MCMC, LLC, located in Quincy, Massachusetts

163. Describe how you will meet the State's appeal process requirements and confirm you will be able to provide copies of all claim and appeal documents to the State for appeals that reach the State's level.

Confirmed. OptumRx tailors its appeal process to be compliant for each State as well as the Federal government. We will create a standard operating procedure detailing the State of AK appeal process requirements and this will be utilized by the OptumRx Prior Authorization team and the Appeals team.

As requested by the State, we are providing a slide deck in Exhibit 7 which outlines the OptumRx standard commercial appeals process with flow charts of the internal appeal process as well as the external federal appeals process. Please note that the external federal appeals process may not be applicable to the State of Alaska and this will be determined during the discovery phase of implementation. We would also like to note that this slide deck is our standard commercial appeals process, we will tailor the appeals process for the State according to Alaska's specific requirements.

164. Confirm that you will participate, if needed, in administrative hearings resulting from denial determinations.

Confirmed.

165. Do you have a dedicated appeals staff?

Confirmed.

166. Confirm the State will have a single point of contact for appeals related inquiries.

Confirmed. The State's primary contact for appeals related inquiries will be the dedicated account management team.

167. Please provide copies of all appeal decision notices you use.

Please see the attached Exhibit 8 for copies of our appeal decision notices.

168. Please confirm these notices can be customized to account for state specific due process requirements.

Confirmed.

169. Please confirm you will establish a separate bank account on the State's behalf.



We agree to the alternative billing/banking arrangement described by the State's answer to Question 88 of Amendment #3.

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

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

170. Please confirm you will process claims and issue checks from the bank account you established on the State's behalf.

We agree to the alternative billing/banking arrangement described by the State's answer to Question 88 of Amendment #3.

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

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

171. Please confirm you will provide the State with a monthly report reconciling the account balance, claims drafts and electronic transfers.

We agree to the alternative billing/banking arrangement described by the State's answer to Question 88 of Amendment #3.

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

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

172. For self-funded plans, confirm that no imprest balance is required.

Confirmed.

173. What is the frequency for ACH transfers for claim funding?

Standard is bi-monthly but can be as frequent as weekly if required.

174. Confirm you can provide claims reimbursement on a "checks cleared basis" by fund and member, to include a unique claim identifier, the date of the claim, and an amount. The supporting detail total must agree to the claims reimbursement request. Additionally, the supporting detail will be utilized by our external auditors to



determine audit sample selections that will be provided to the vendor to provide the support claims detail. If this isn't available, please explain what you can provide

Confirmed.

175. Confirm you can work with our auditors each year to provide the selected claims detail for claims support. Selected audit claims detail support items will need to be returned to the auditors within a week of receipt. If this isn't an option, please explain your alternative process.

Confirmed.

176. Confirm you will provide a list of participating members by fiscal year (July 1 to June 30) in early August of each year to be used for audit purposes. If this isn't available, please explain what can be provided.

Confirmed.

177. Describe online integration, if any, with retail pharmacies to ensure non-duplication and to identify potential adverse interaction.

All retail network pharmacies connect directly to our proprietary RxClaim online transaction processing system to adjudicate claims. RxClaim verifies the claim at the point of service prior to submission for payment. It checks that the claim is submitted in the correct format, that the member is eligible, that the pharmacy is in the network, and the drug is in the correct tier.

Concurrent drug utilization review (DUR), applied at the point of service before a prescription is dispensed, and evaluates prescriptions based on established clinical criteria. Concurrent DUR screening includes the following edits:

- Therapeutic duplication, including duplicate prescription, duplicate therapy and refills that occur too soon
- Age or gender related contraindications
- Over- or under-utilization, including minimum or maximum daily dose, minimum or maximum quantity per prescription, period or days' supply, period or quantity
- Drug-drug interaction
- Drug-allergy contraindications
- Drug-inferred health state (pregnancy) screening
- Drug-diagnosis caution screening.

The edit categories listed may not be overridden by the pharmacist, with the exception of drug-diagnosis caution screening.

178. What are your contingency plans and procedures for providing backup service in the event of strike, natural disaster, or backlog?

Please see the attached Exhibit 3 for our business continuity and disaster recovery plan.

179. How often do you switch generic manufacturers for particular products? How are participants notified of the switch?



This can vary depending on availability of a product. If the member is dispensed a different generic manufacturer then what was dispensed last, there will be information in their order stating it is the same drug but a different manufacturer was used. There is a phone number listed if they have any questions.

180. How often are therapeutic interchanges performed at mail order, if at all? If so, please explain applicable drug products and rationale.

We do not perform therapeutic interchanges at our mail order pharmacies.

181. How do you handle mail order prescriptions where no copay was included in the envelope, or the check from the member bounced?

OptumRx provides [REDACTED] to members who have not provided payment with their request for mail order prescriptions. If the balance exceeds [REDACTED], we will contact the member to arrange payment.

182. Does mail order have a retail site facility that will offer mail order discount?

No.

183. Please indicate your mail order pharmacies' usage, if any, of DAW 5 for processing claims. Which drug products are assigned DAW 5 codes? Please describe your DAW 5 processing protocol and rationale.

OptumRx does not use DAW 5 for processing claims.

184. What criteria and methodologies are used to identify and monitor high cost claimants?

OptumRx has robust reporting capabilities which include reporting on high cost utilizers. The report criteria is customizable and can be ran as frequently as needed by the State.

185. How do you guard against the filling of separate prescriptions for the same or similar drugs at different pharmacies on the same day?

Our claim system monitors incoming claims for duplication through edits during adjudication and Real-Time Audit which occurs automatically following adjudication. Claims are identified and flagged as duplicates if there are multiple claims with the same information in the following key identifiers or fields:

- Prescription number
- Member identification number
- Drug identification number (NDC/GPI)
- Quantity day supply
- Fill date

If our claims system determines that there is duplication based on field matches, the claim is automatically rejected and a message is instantly sent back to the pharmacy indicating that the claim has already been paid.



186. Do you evaluate the appropriateness of the prescribing physician/practitioner credentials?

Yes. Our system maintains a number of provider and prescriber identification systems including the National Provider Identifier (NPI) and the Drug Enforcement Administration DEA. While it is standard (HIPAA mandated) to exclusively use the NPI in identifying a prescriber for the claims adjudication process, we allow for searching and linking functions that include searching for a physician by his/her NPI, DEA, unique physician identifier number (UPIN), or state license number.

187. What clinical programs do you offer that incentivize adherence? Do you have the system capabilities to offer lower cost shares for more adherent members? (e.g., if prescription is consistently filled when 75% to 100% of the prescription has been depleted, the copay is cut in half or a lower co-insurance is applied.)

OptumRx can offer an adherence program that incentivizes members with lower cost shares for certain therapeutic classes, such as Diabetes. These programs are customizable depending on the client's specific needs and business goals.

188. Do you have the system capabilities for a “starter dose” program where the first few weeks of therapy do not incur a member cost share?

Yes. OptumRx's system is capable of administering a program where the first few weeks of therapy does not incur a member cost share.

189. Do prescribing providers have an option to request an appointment with a clinician regarding pre-authorizations and denials for off-label use?

Confirmed. If OptumRx issues a denial of coverage due to off label usage, then the prescribing physician can request a peer-to-peer review to discuss the patient's case with the denying clinician. 190. If the State is sending Subscriber ID on eligibility file for both commercial and EGWP, can we confirm we can accept?

Confirmed.

191. Provide character length of all fields within RxClaim.

Please see attached Exhibit 9.

192. How can member eligibility records be searched?

Member ID number or Name and DOB

Pricing

1. Confirm the PBM's dedicated team of customer service representatives (for commercial and EGWP) are available from 7AM to 10PM Alaska time for the state's members, with designated representatives available outside of these hours.

See Customer Service section of Clarification Document, #1



2. Confirm the PBM will provide geography training on the state of Alaska to customer service representatives.

Confirmed.

3. For a member to receive or access to the PBM's video consultation platform services offered by the PBM, what technological requirements are necessary?

Wi-Fi or Cell service is necessary for a video consultation. Video Consultations are conducted via Skype or FaceTime.

4. Confirm all member service call recordings and notes between the PBM and the state's members will be the state's property.

Recorded calls and member record notes will remain property of OptumRx due to HIPAA, PCI Compliance and other regulations. However, OptumRx will make available recorded calls and or member transcripts to the State within two business days of the request, including regularly scheduled reviews of recorded calls.

5. Confirm the PBM can share files of recorded member calls, call notes or call logs after the PBM has reviewed and removed PHI and other confidential data discussed with members during business hours.

Confirmed.

6. Confirm the PBM can provide redacted materials within two business days.

Standard requests can be provided within 3 to 5 business days. Expedited requests for recorded calls and/or member transcripts can be provided within 2 business days.

7. Confirm the proposed pricing (administrative fees, discounts, dispensing fees, rebates, allowances) are the PBM's best and final offer.

OptumRx confirms the pricing proposal and terms as presented in the final Clarification Document is our best and final offer.

8. Confirm the PBM will pass through 100 percent of rebates, including inflation protection payments, price concessions, manufacturer administrative fees and any other direct remuneration the PBM receives for both the commercial and EGWP lines of business. The state requires agreement to the definitions as provided in the RFP, including the "Rebates" definition, indicating all rebate revenue is to be passed back to the state.

Confirmed.

9. Confirm that members will continue to be able to receive specialty drugs dispensed at retail pharmacies, and that these prescriptions will be included in the annual aggregate specialty guarantee, which will be better than the retail non-specialty brand and generic guarantees.

Confirmed. [REDACTED]



10. Confirm each distinct non-rebate pricing guarantee (e.g. discounts and dispensing fees) will be measured and reconciled on a component-basis only (e.g. retail 30 brand, retail 30 generic, retail 90 brand, retail 90 generic, mail order brand, mail order generic, specialty drugs at participating retail pharmacies, specialty drugs at the PBM’s specialty pharmacy) and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls paid to the state.

Confirmed.

11. Confirm surpluses in one component may not be utilized to offset deficits in another component.

Confirmed.

12. Confirm rebates are guaranteed on a dollar-for-dollar basis with 100% of any shortfalls paid to the state.

Confirmed.

13. Confirm rebate surpluses may not be utilized to offset deficits in another non-rebate guarantee component.

Confirmed.

14. Confirm the PBM will reconcile rebate guarantees to verify that the state is receiving the guaranteed rebates and provide rebate payments for at least the minimum rebate guarantees and reports listing detailed rebate utilization and calculations to the state quarterly, within sixty (60) days of the quarter’s close, without a request being made by the state.

Confirmed.

15. Confirm the PBM agrees to no additional charges for any retroactive claims reprocessing and member reimbursements due to retroactive plan design adjustments.

Confirmed.

16. Confirm all pricing will be effective and guaranteed for the term of the agreement and will not be modified or amended if the state implements or adds a 100% member paid plan design, such as a high deductible health plan/consumer-driven health plan option.

Confirmed.

17. Confirm the PBM will not modify or amend the financial provisions in the event of a reduction of less than 30 percent in the total number of members from the number provided to the PBM during pricing negotiations, upon which the financial provisions included in the proposal are based.

Confirmed.

18. Confirm all pricing will be effective and guaranteed for the term of the agreement and will not be modified or amended if the state adds or removes new classes of eligible



members. The state anticipates that any additional groups will be similar to the current membership (groups with employer-based coverage).

Confirmed.

19. Confirm the state will have the ability to annually renegotiate and/or “carve-out” specialty drug pricing and service terms without penalty or changes to all existing financial guarantees.

OptumRx confirms the State will have the ability to annually renegotiate specialty drug pricing, however, any “carve-out” of specialty service terms will have impact to all existing financial guarantees. OptumRx will provide a Service Level Agreement (specific SLA to be provided) around specialty service through Briova and provide dollars at risk for specialty performance.

We provide specialized expertise in delivering specialty medications to geographically isolated members. Delivery solutions use a combination of national, regional, and local carriers to facilitate on-time delivery and determine the method of delivery based on a member’s locations. Through a proprietary tracking system and access to specialized couriers, our enhanced concierge delivery service achieves on-time delivery of specialty medications using a broad range of delivery capabilities including private charter, boat, weather-adverse prepared couriers, dog sled and other methods. When an unexpected delay occurs, logistics specialists provide solutions to get the package delivered to members on the committed day and provides 24 hour a day, seven day a week customer support to keep the member informed.

20. Confirm that postage, shipping and handling are included in the pricing for mail service and BriovaRx dispensed claims and will not be increased for any increases in postage charges throughout the life of the contract.

Confirmed.

21. Confirm that postage for mailings requested by the State will be passed through but capped at \$1.00 per mailing.

Confirmed.

22. Confirm that quoted fees include postage paid mail order envelopes for member prescription submission.

Confirmed.

23. Provide the proposed fees for Dose Optimization Program, Custom Systems Overrides, Retro Termination Letters, Drug Notification Letters, Pharmacy Directories and other member materials, Overrides, Audit Recovery Fees, Compound Drug Management

All ancillary fees will be outlined in the Scope of Work Fee Schedules.

24. Confirm the PBM will pass through 100% of Pharmacy Audit Recoveries to the state.

Confirmed.



25. Confirm the proposed Select Base Rebates do not require a minimum of \$10 difference in copayment, or 10 percent difference in coinsurance between preferred and non-preferred Brand Drugs.

Confirmed the Select Base rebates do require a differential between preferred and non-preferred Brand Drugs. OptumRx confirms the Open Non-Incentivized Formulary rebates for the pre-65 retiree group will mirror the Select Base rebates but does not require the copayment differential.

26. Confirm the Mail Service/Home Delivery pricing guarantees require an average days' supply of at least 79 days in the aggregate. Confirm the Mail Service/Home Delivery pricing guarantees applies to all mail order scripts regardless of days' supply.

Confirmed.

27. Confirm the Mail Service/Home Delivery pricing guarantees applies to all mail order scripts regardless of days' supply.

Confirmed.

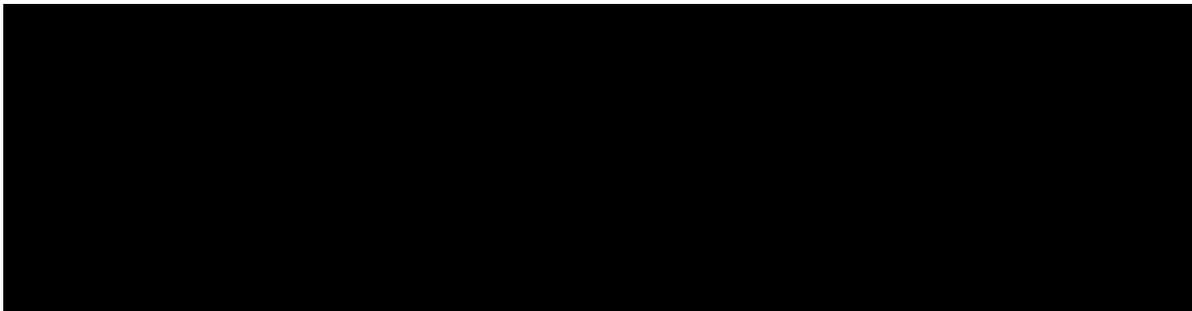
28. Confirm non-specialty claims filled at BriovaRx are reconciled under the mail order non-specialty guarantees.

Confirmed.

29. Confirm 1) Generic Drug Discount and Dispensing Fee guarantees include single source generics and generics with limited supply and 2) Brand Drug Discount and Dispensing Fee guarantees exclude all Generic Drug claims.

Confirmed, as designated by MediSpan. OptumRx will not reclassify single source generics as brands, does not participate in "House Generic" programs, and does not have "proprietary algorithms" for determining brand or generic status. MediSpan will be the sole source of drug designation.

30. Provide the proposed costs for Prior Authorization reviews and Appeals (1st and 2nd level).





31. Does the PBM monitor and provide management for unit cost spikes in drug costs? Describe your management program. Is it provided at an additional charge, if so, what is the fee?

We help customers mitigate the risk of increased drug costs by implementing a ceiling, or Maximum Allowable Price, on the majority of brand name, rebateable drugs. [REDACTED]

Our inflation cap payments or Price Protection is a guarantee by drug manufacturers that the wholesale price inflation of a drug does not exceed a certain level within a given timeframe. If a drug's inflation exceeds the threshold within this timeframe, the manufacturer refunds the difference between the actual inflation and that threshold. The value of this refund will be provided to the State in the Rebates it receives pursuant to this Agreement.

32. Confirm the PBM agrees to produce a date-sensitive comparison report showing unit costs charged to the state at a GPI-level, and reimburse the state on a dollar-for-dollar basis for all instances where mail order unit costs exceed retail unit's costs. Report and reconciliation will be provided on an annual basis, without a request being made by the state.

Confirmed.

33. Please indicate any additional charges for any required manual interventions (workarounds) due to system interface incompatibility, file format issues, plan compliance, etc. on the rate sheet.

While we don't anticipate any additional charges for most manual workarounds, all ancillary charges will be included in the pricing rate sheet.

34. PBM agrees that the State will not be responsible for any member contributions (e.g., deductible, coinsurance, copays) owed to the PBM. Collecting such fees will be the sole responsibility of the PBM.

Confirmed. [REDACTED]

35. The State will not be assessed any fees for mail order claims where member pays 100% the cost of the prescription, exclusive of administrative fees, if applicable.

Confirmed.

Reporting

1. Confirm the PBM agrees to produce a date-sensitive comparison report showing unit costs charged to the state at a GPI-level, and reimburse the state on a dollar-for-dollar basis for all instances where mail order unit costs exceed retail unit's costs. Report and reconciliation will be provided on an annual basis, without a request being made by the state.

Confirmed.



2. Confirm you will provide the state with a monthly report reconciling the account balance, claims drafts and electronic transfers.

Confirmed.

3. Confirm maximum Average Dispensing Fee guarantees will exclude all U&C claims submitted and billed by retail pharmacies including reversed/denied claims.

Confirmed.

4. Confirm effective (Average Annual) rates for Brands will include all claims for multi and single source brands.

Confirmed.

5. Confirm effective (Average Annual) rates for Brands will include all specialty brand claims dispensed at retail.

[Redacted]

6. Confirm effective (Average Annual) rates for Brands will include the impact of recognized charge claims; the ingredient cost must be equal to the submitted recognized charge price for discount guarantee reconciliation purposes.

Confirmed. Submitted recognized charge price means the pharmacy Usual and Customary price.

7. Confirm effective (Average Semi-Annual) rates for Generics will include all claims for ALL generics, including multi and single source generic drugs, MAC'd and Non-MAC'd generics, limited supply generics, patent litigated generics.

Confirmed on an annual reconciliation basis.

8. Confirm effective (Average Semi-Annual) rates for Generics will include all specialty generics claims dispensed at retail.

[Redacted]

9. Confirm effective (Average Semi-Annual) rates for Generics will include the impact of U&C claims; the ingredient cost must be equal to the submitted U&C price for discount guarantee reconciliation purposes.

Confirmed. 100% of the U&C cost will be applied to the discount guarantee reconciliation.

10. Confirm that in addition to including single source generics in the overall generic effective rate, you will also offer a standalone single source generic guarantee that must be greater than the Brand effective rate.

Confirmed. SSG's will be included in the overall generic effective rate guarantee.

11. Confirm effective (Average Annual) rates for Brands will include all claims for multi and single source brands.

Confirmed.



12. Confirm effective (Average Semi-Annual) rates for Generics will include all claims for ALL generics, including multi and single source generic drugs, MAC'd and Non-MAC'd generics, limited supply generics, patent litigated generics.

Confirmed on an annual reconciliation basis.

13. Confirm the dispensing fee per claim listed for specialty pharmacy, if any, is not an average but the maximum amount that will apply per claim.

Confirmed.

14. Confirm specialty pharmacy pricing, including guaranteed discounts, dispensing fees and rebate guarantees, apply to all specialty pharmacy claims, regardless of supply days.

Confirmed.

15. Confirm you will provide guaranteed minimum AWP discount pricing and dispensing fees per Rx for newly approved Specialty drugs similar to those already available to treat the same condition.

Confirmed.

16. Can you present quarterly data regarding appeals? Is that data specific to AlaskaCare members?

Confirmed.

17. Do you utilize a data warehouse for reporting and claim and trend analysis?

Confirmed.

18. Describe your organization's data warehousing and population health analytical service.

Timely, complete, accurate, and accessible information is needed to support our clients' benefit management goals. OptumRx's data warehousing and reporting tool, RxTrack, is powered by Cognos and allows staff and our client's zero footprint access to predefined or custom reports through a secure internet connection. The predefined or custom reporting provides high end graphical reporting with robust scheduling and distribution options.

The RxTrack Standard Report suite of management reports includes individually unique reports, each with comprehensive filtering capabilities that with a few clicks of the mouse transform any report into a custom report of the user's choosing, such as reporting by specialty drugs only, or mail order drugs, or by member age band or gender. The Standard Reporting package has been designed to provide a wide range of reporting options, from global overviews of plan performance to detailed reporting of specific data elements.

Also available within RxTrack is a tool that can be used to create ad hoc reports based on all the available data in the warehouse, which is greater than 500 fields of data. This functionality allows the user to select the data elements, report formatting, and graphics that best fit their unique business needs.



RxTrack provides a flexible scheduling feature that helps you set a report to automatically run repeatedly at specific dates and times. This is useful to automatically generate updated reports weekly, monthly, quarterly, etc. The user can chose to have reports delivered to individuals or groups of people. Additionally, report output comes in a variety of options such as Excel, PDF, Word, or in our Report Viewer.

Clients will be provided access to this reporting tool and will receive full training and support from their account management team.

19. What resources do you provide from a health data analyst perspective to support your clients?

We recognize that our State Employer clients have unique and customized reporting needs in order to manage their pharmacy benefit plans. In support of those needs, the OptumRx Government Account Management team includes data analysts who are dedicated and focused on providing the data and analysis required by our State Employer clients. We will designate a data analyst from the Government Account Management team to support State of Alaska and its custom reporting needs. Additionally, the State's dedicated Account Management team will employ the Clinical Analytics team who provides trending, forecasting and benchmarking information to support the State in managing their pharmacy benefit program.

20. Explain whether your organization will release detailed claims data to the Data Warehouse utilized by AlaskaCare (HDMS).

Confirmed.

21. Are you able to provide reporting that allows the State to see trends in claim activity information by different organization units?

Confirmed.

22. Are you are able to accommodate ad- hoc or customized reporting, and what is the normal turnaround time to fulfill such request.

Confirmed. Most reports can be provided by the account team within the same business day. More complex requests may require 1-2 business days. The State will also to have ability to run ad hoc reporting via RxTrack.

23. Will you provide performance review reports by each different group/plan at least quarterly or more frequently if requested at no additional charge?

Confirmed.

24. Will you provide clinical program management outcome reports quarterly?

Confirmed.

25. In addition to typical claims file requests for use by case and disease management vendors, please confirm that, if requested by the State and with the appropriate confidentiality agreements in place, you will provide full claims detail, which include pricing information, to State's third parties?



Confirmed based on a mutually agreed upon 3rd party.

Transition

1. Confirm the PBM agrees to provide a procurement allotment in the amount of at least \$175,000 to ensure compliance with state law and due process requirements.

Confirmed, separate from the implementation allowance and PMA

2. Confirm the Pharmacy Management Allowance (PMA) credit may also be used against claim and fee invoices and may be carried over to the following year.

Confirmed, for carry-over, cannot agree to application against claims and fee invoices.

3. Confirm that you will set up the state's account structure based upon their requirements. The state requires that the PBM's system accommodate the account structure necessary to report and invoice by the various groups, trusts and divisions that exist in the program.

Confirmed.

4. Confirm the PBM can produce a single ID card for both medical and prescription drug benefits.

Confirmed, so long as medical vendor is agreeable to provide information.

5. How often will the technical implementation team meet with the Health Operations manager and/or her designees and will these meetings be in person?

Implementation update calls are held weekly with separate break out calls to discuss eligibility, benefits, data files etc. The need for onsite meetings will be discussed further after review of the project plan.

6. Please provide a proposed timeline for technical implementation highlighting key milestones to ensure a 1/1/2019 go live date (EGWP and commercial).

Please see draft project plan in the clarification document.

7. What data elements/technical files are needed from the State?

Eligibility files. Transition files from the incumbent will be needed as well (PA History, Claim History, Open Refill Transfer Files)

8. Detail your strategy to eliminate member disruption due to changes in the pharmacy network from current.

Once the initial historical claims are received we can do an analysis to confirm what pharmacies are not currently contracted with Optum Rx. We can accommodate a member mailing, solicit necessary pharmacies to get them in network as well as accept DMRs for out of network claims.

9. In order to mirror the state's current formulary, what additional considerations must be made by the PBM (outside of the EGWP wrap)?

Additional analysis will be required by OptumRx.



10. Identify the most time sensitive areas of the implementation. Please list all of the PBM's interdependencies with the state for a successful implementation.

Please see the State deliverable Timeline in the Clarification Document.

11. Please describe the process that will be implemented to ensure that internal reference source(s) provided to your personnel are consistent with the State's documentation such as employee communication materials, open enrollment information, plan documents, etc.

OptumRx houses and stores any and all documentation from the implementation in an internal SharePoint site created specifically for the State. This site will be accessible to all OptumRx team members during and after the go live process and serves as a central repository to store all documentation and client approvals. The implementation project manager is audited on a monthly basis to ensure the appropriate documentation is stored the SharePoint site in a timely manner.

12. Please attach sample member communication materials, including a sample ID card and sample member welcome letter.

Please see Exhibit 10 Sample Member Welcome Kit and ID Card.

Please keep in mind this is a sample. The member letter will be customized based on the programs chosen by the State. This welcome kit can be used for both the Active and EGWP members.

Please see Exhibit 11 EGWP Member Communication Checklist.

The first tab includes the Open Enrollment Member Materials and indicates which items can be customized and which cannot based on CMS requirements. The State's logo can be included. The second tab includes LIS and LEP letters and the third tab includes information on our standard PA/Coverage determinations. The content of the member communication pieces included in the second and third tabs cannot be modified.

13. Describe the proprietary software that will be used in administration of this Contract, as well as any services or software purchased or licensed from outside vendors to update your system.

OptumRx's proprietary software for claim adjudication is RxClaim. This software is owned and operated by OptumRx. No software or licenses are needed from other vendors. PBMs lease the RxClaim Processing Platform to adjudicate claims.

14. Please provide an organizational chart depicting the account management structure.

Please see Organizational Chart section of the clarification document.

15. List other projects and or plans anticipated to be implemented by each member of the account management team during 2018/2019 and evaluate their impact on each member's ability to implement the scope of work set forth in the RFP relative to PBM services.

The Sr. Implementation Project Manager will be dedicated to the State throughout the implementation process. The Account Management Team and the Clinical Consultant will be dedicated during and after the implementation phase. Shared resources will be assigned to assist



with implementation activities i.e. Eligibility, Benefit documentation and coding, formulary and data files etc.

16. A work flow chart depicting how the implementation work associated with each function that will be performed and a narrative describing the processes depicted in each flow chart.

OptumRx will provide a detailed project plan on a weekly basis. The project plan will outline the workflow for each implementation function.

17. Confirm you will provide welcome kits as part of the implementation. Please identify and describe all information that will be contained in the welcome kits.

Confirmed. Welcome kits include a welcome letter, tri-fold quick start guide for members, home delivery enrollment form, ID cards. We can also include other items

18. Confirm you will perform comprehensive systems testing and quality assurance audits, with results reported to the State, prior to the contract effective date as part of the base administrative fees with no additional charge to the State.

Confirmed.

19. Please outline your procedures for loading patient payment histories from the prior carrier.

OptumRx will work closely with the incumbent to transition historical claim and PA data. We will meet with both the State and the Incumbent to determine file formats and timing of files to coordinate when eligibility will be loaded. Once production eligibility is loaded, OptumRx will start the process of loading the historical data. Reporting will be provided outlining any fall out or errors. This process will be repeated for any lag files received after the initial production files. Standard is to load one year of claim history and active PAs.

20. Please confirm that you will be able to provide ID cards without Social Security Numbers to all members prior to the effective date of the Contract.

Confirmed.

21. Confirm that you are able to customize all communication/educational materials to include the AlaskaCare logo as the prominent feature.

Confirmed.

22. Please provide a copy of your standard Administrative Services Organization contract.

Please refer to the Scope of Work provided within the clarification document.

23. Provide a brief description of how existing mail order patients would be transitioned over to your mail order facility with minimized disruption.

OptumRx will work with the State's incumbent to facilitate a mail order open refill transfer file. For a 1/1/19 go live, OptumRx would expect a test ORT file no later than 12/15/18. Production files are typically provided by 1/1/19 with a final lag file provided by 1/15/19. Once the test file is received, OptumRx will bump the test file up against eligibility to determine if there is any



fallout. OptumRx will work with the State prior to receipt of the production file to mitigate any outliers prior to go live. Once the ORT file is received, OptumRx will send an ORT letter to members with transferred scripts confirming for them which medication were transferred and next steps. In the event a script is not transferred (i.e.no refills available) OptumRx can reach out to the members physician on their behalf to facilitate refills if available.

24. Provide a brief description of how existing specialty drug patients would be transitioned over to your Specialty Pharmacy seamlessly, including those patients whose medication is not considered a specialty drug by client current vendor and those taking medications with limited distribution rights.

Specialty medications can be transitioned to OptumRx via the mail order ORT file. The file will first go to OptumRx Home Delivery where it will be determine what is specialty and what is not. Any non-specialty medications included would be transitioned to mail and the member would be notified via a letter with transferred scripts and next steps, see question 23. Anything considered specialty will be transitioned to BriovaRx, OptumRx's specialty pharmacy. OptumRx will then make contact with the member and physician via phone and letter. Briova will work closely with the member to set up mailing preferences and ensure the member is comfortable and has what is needed to manage their therapy ongoing.

25. If your patient management programs are supported by pharmaceutical manufacturer revenue in any way, please describe.

Not applicable.

26. Confirm you agree the State's can request a third-party to perform an Implementation Audit of the pharmacy plan set-up prior to and after the Effective Date of the Agreement. No charge will be assessed in conjunction with these services.

Confirmed.

27. Confirm that you will set up the State's account structure based upon their requirements.

Confirmed.



PROJECT SCHEDULE

A high-level schedule of the project (with major milestones or tasks) and if requested, a detailed milestone schedule. This may include transition and implementation.

Milestone	Milestone Description	Milestone Status	Assigned To	Planned Finish	Revised Finish	Actual Finish	State	Notes/Status Update
Implementation Kick Off Meeting	Initial Onsite Kick Off Meeting. During this meeting OptumRx will begin the process of populating the Implementation Blueprint Document.	Open	OptumRx	7/20/2018			Green	
Implementation Blueprint Document Approval	The Implementation Blueprint Document serves as our scope document for the implementation. This document will require client approval.	Open	State of Alaska	8/24/2018			Green	
Confirm Eligibility Layout	OptumRx will work with The State to determine the agreed upon eligibility layout.	Open	OptumRx/State of Alaska	8/31/2018			Green	
Member Services Process Documentation / Call Flow Process	OptumRx will work with The State to document the member services set up and expectations. This document will require client approval.	Open	State of Alaska	8/31/2018			Green	
Custom Formulary Build Template	If necessary, OptumRx will work with The State to document any and all	Open	State of Alaska	9/10/2018			Green	



Milestone	Milestone Description	Milestone Status	Assigned To	Planned Finish	Revised Finish	Actual Finish	State	Notes/Status Update
	custom formulary and UM requirements. This document will require client approval.							
Carrier/Account/Group Structure Approval	OptumRx will work with The State to determine the business structure (CAG). We will work to accommodate invoicing and reporting needs to fit The State's needs. The CAG will require client approval.	Open	State of Alaska	9/12/2018			Green	
Member Communication Approval	OptumRx will work with The State to determine member communication needs. All member communication will require client approval.	Open	State of Alaska	9/15/2018			Green	
SCD – Setup Confirmation Document	OptumRx will document all eligibility details and client expectations in the SCD. This document will require client approval.	Open	State of Alaska	9/21/2018			Green	



Milestone	Milestone Description	Milestone Status	Assigned To	Planned Finish	Revised Finish	Actual Finish	State	Notes/Status Update
BDT – Benefit Design Template	OptumRx will work with the State to document any and all benefit requirements. This will include, but is not limited to, patient pays, COB requirements, plan processing information, max day supplies and refill limits, compound coverage, maintenance medication coverage, eligibility processing, manual claim requirements, mail, retail and specialty network confirmation, etc. This document will require client approval.	Open	State of Alaska	9/27/2018			Green	
Public Portal	OptumRx will work with the State on public portal requirements as necessary. This will include content determination and testing prior to deployment.	Open	OptumRx	10/1/2018			Green	
Fully Executed OptumRx Agreement	OptumRx will work with The State on negotiation and	Open	OptumRx/State of Alaska	10/1/2018			Green	



State of Alaska
Pharmacy Benefit Management RFP# 180000053

Clarification Document

Milestone	Milestone Description	Milestone Status	Assigned To	Planned Finish	Revised Finish	Actual Finish	State	Notes/Status Update
Eligibility Testing (Member/Group)	execution of the agreement. Initial test eligibility file will be due to OptumRx.	Open	State of Alaska	10/3/2018			Green	
OptumRx Toll Free Number Assigned	Once member services requirements are determined, OptumRx will assign a TFN for the commercial and EGWP lines of business.	Open	OptumRx	10/9/2018			Green	
Manual Claims Set Up	Once the BDT is approved, OptumRx will work with the manual claims department to set up the benefit as expected by The State.	Open	OptumRx	10/17/2018			Green	
sFTP Connectivity	OptumRx will work with The State and other vendors to set up secure file transfer methods.	Open	OptumRx	10/22/2018			Green	
Benefit Plan Build Complete	OptumRx to complete the BDT benefit plan build in RxClaim.	Open	OptumRx	10/31/2018			Green	
Production Historical Claim File	Incumbent to provide initial production historical claim file to OptumRx.	Open	Incumbent	11/1/2018			Green	



State of Alaska
Pharmacy Benefit Management RFP# 180000053

Clarification Document

Milestone	Milestone Description	Milestone Status	Assigned To	Planned Finish	Revised Finish	Actual Finish	State	Notes/Status Update
Production Historical PA File	Incumbent to provide initial production historical PA file to OptumRx.	Open	Incumbent	11/1/2018			Green	
Production Eligibility File Due	Production eligibility file due to OptumRx.	Open	State of Alaska	11/1/2018			Green	
Prior Authorization Setup	OptumRx to complete set up of Prior Authorization expectations.	Open	OptumRx	11/6/2018			Green	
Benefit QA Testing Complete	OptumRx to work with The State to review and approve benefit QA testing.	Open	OptumRx/State of Alaska	12/1/2018			Green	
Member Portal Setup	OptumRx to configure the member portal based on client expectations and benefit build.	Open	OptumRx	12/1/2018			Green	
Security/System Access	OptumRx will work with The State to determine system access and level of access needed. Training will be provided the month of December.	Open	OptumRx	12/1/2018			Green	
Claim Extracts Complete	OptumRx will work with The State to determine claim extract needs.	Open	OptumRx	12/1/2018			Green	
Billing Setup	OptumRx will set up billing, invoicing and reporting based on client needs.	Open	OptumRx	12/4/2018			Green	



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Clarification Document

Milestone	Milestone Description	Milestone Status	Assigned To	Planned Finish	Revised Finish	Actual Finish	State	Notes/Status Update
Test ORT File	OptumRx to receive test ORT file from incumbent.	Open	Incumbent	12/13/2018			Green	
Go Live Readiness Review	OptumRx Implementation Project Manager will review the Go Live Command Center document with The State. This document will outline the OptumRx go live command center process, determine go live call cadence, outline go live point of contact for OptumRx and The State and provide samples of go live reporting.	Open	OptumRx	12/14/2018			Green	
Production ORT File	OptumRx to receive production ORT file from incumbent.	Open	Incumbent	1/1/2019			Green	
Go-Live	OptumRx to start processing claims for The State.	Open	OptumRx	1/1/2019			Green	
Lag Historical Claim File	Incumbent to provide lag historical claims file to OptumRx.	Open	Incumbent	1/15/2019			Green	
Lag Historical PA File	Incumbent to provide lag historical PA file to OptumRx.	Open	Incumbent	1/15/2019			Green	
Lag ORT File	Incumbent to provide lag historical PA file to OptumRx.	Open	Incumbent	1/15/2019			Green	



Milestone	Milestone Description	Milestone Status	Assigned To	Planned Finish	Revised Finish	Actual Finish	State	Notes/Status Update
OptumRx Claim Review	OptumRx will monitor claims every 4 hours as part of the go live command center process.	Open	OptumRx	1/1/2019 - 1/15/2019			Green	
Transition to Account Management	OptumRx will work with The State on the appropriate time to transition from implementation to the ongoing relationship with account management. At this time the account management team will take over recurring calls with The State.	Open	OptumRx	1/15/2019 - 2/1/2019			Green	
Implementation Satisfaction Surveys	OptumRx will send Implementation Satisfaction Surveys to key stakeholders at the State.	Open	OptumRx	2/1/2019 - 2/15/2019			Green	



STATE ACTION ITEM SCHEDULE

A schedule of any/all activities, actions, or decisions needed from the state (including specific due dates and state personnel responsible for the activities). This must be a separate document from the overall project schedule. This should be provided in a very simple format and identify the roles and responsibilities of the state or its personnel.

Milestone Timeline and Project Plan for the State of Alaska High Level Client Action Requirements – Commercial and EGWP

Deliverables Key Milestones	Finish Date	Owner
Approved Client Requirements Documents		
Implementation Source Document	8/24/2018	State of AK
Carrier/Account/Group Structure	9/12/2014	State of AK
Benefit and Clinical Document	9/27/2018	State of AK
Custom Program Criteria Forms, as applicable	9/10/2018	State of AK
Member Service Sign Off Document	8/31/2018	State of AK
Eligibility Set Up Confirmation Document	9/21/2018	State of AK
Member Materials Approval		
<ul style="list-style-type: none"> • ID Card • Welcome Letter • Tips Brochure • Member Letters (EGWP) • Formulary/UM Disruption Letters • Retail Network Disruption Letters 	9/15/2018	State of AK
Test Results Approval		
Quality Assurance Output Summary	12/1/2018	State of AK
Data Inputs Required		
Claims History Files	Multiple Files, Varies	Incumbent
Active Prior Authorization Files	Multiple Files, Varies	Incumbent
Open Refill Transfer Files (if necessary)	Multiple Files, Varies	Incumbent
Eligibility Files	EGWP – No later than 11/1/18 Comm. – No later than 12/1/18	State of AK



ALIGN EXPECTATIONS

Coordinate the project/service (schedule, cost, activities) with all critical parties (subcontractors, consultants, suppliers, manufacturers, networks, etc.). Create a detailed project plan including any unique technical requirements with the state.

A detailed Microsoft Office project plan can be provided to the State upon request.



RISK MITIGATION APPROACH

All risks, activities, or concerns that may be controllable or non-controllable. This should include everything (realistically) that may prevent the offeror or the state from being successful on this project and what is most concerning or very unique about this project. This may include: contractor risks, designer risks, owner risks, other party risks, and unforeseen risks. Identify if there are any strategies to mitigate these items and provide a plan of how they will be managed.

Assessment of Controllable Risks

Risk 1: Implementation Challenges That Can Compromise a Timely and Successful Plan Installation.

Description: A successful implementation is crucial to the overall success of the State's plan. We offer a collaborative environment where the dedicated implementation manager works closely with the State to document operational and system requirements for all components of the program. Requirements are determined during detailed discovery sessions with the State. Because of this collaborative approach, we rarely encounter unanticipated difficulties during the implementation process.

Strategy: Quality and accuracy are critical components to administering the State's benefits. The client management team, which includes a dedicated implementation manager, works with the State to collect business requirements, which are used to initiate a service request. The service request contains detailed specifications of the requested modification or enhancement. Our programming staff uses this request to make any applicable system changes. A key part of this process is obtaining the State sign off on the business requirements. Obtaining this sign off prior to any work being initiated allows both the State and us to have the same understanding of what the end results are expected to be. As a best practice for consistent project tracking, the State has access to our client portal. This tool supports tracking and management of all open items. Your client management team meets with the State on a weekly basis to provide comprehensive updates on the issues/project tracking log.

In the event that a target date is missed or a challenge arises that directly impacts the critical path, the project plan is promptly addressed and reviewed to determine an action plan that is mutually agreed upon. We are prepared to establish workable and effective solutions and act quickly to resolution. We remain accountable to deliver a successful plan implementation. To identify issues quickly, determine magnitude and get speedy resolution, we assign a dedicated business analyst that monitors new installations hourly for a mutually agreeable period of time. This includes the review of paid and rejected claims to verify set up is accurate and claims are adjudicating as intended. This real time monitoring and comparison to plan intent results in minimal adverse impact to the plan and membership.

Risk 2: Natural and Emergency Disaster Impact on Mail Service Operations

Description: If any one of our mail service facilities becomes inoperable, we have policies and procedures in place to maintain continuity of service for our customers and their members.

Strategy: Our mail service facilities are positioned in geographically diverse locations and have complete integration and redundancy in terms of their operation. Should one facility be inoperable, orders may be routed directly to another facility.



We may work with local contracted vendors and retail locations to provide timely delivery to State of Alaska's (the State) members during critical weather conditions, disasters, or other circumstances that would otherwise disrupt our normal shipping process. We work closely with our members to keep them informed of the situation and their options as we monitor conditions so that we may best provide continuance of service.

We are also in position to leverage our network of retail pharmacies to help the State's members receive prescriptions in times of crisis or catastrophe when our mail service facilities may be offline or unable to dispense or send orders.

We take special care with members when areas are affected by natural disaster. When extraordinary circumstances such as a hurricane, blizzard, flood or another natural disaster occurs, many members lose their medications and need to refill them without being subject to the usual refill limitations, quantity limitations, or prior authorization requirements. We work with the State to create a regional disaster override table to provide direction on refill instructions for its members.

Risk 3: Security and Protection of Member and Company Data

Description: Prevention of data being compromised or loss due to human error, hardware failure, natural disaster and/or theft.

Strategy: Our Information Security policies and standards have been developed on the ISO (International Organization for Standardization) framework. The Information Security Risk Management and Privacy Program protocols are based on industry practices (National Institute of Standards and Technology (NIST), ISO) and applicable regulatory obligations such as U.S. Department of Health and Human Services (HHS), Office of Civil Rights (OCR), Office of E-Health Standards & Services (OEHS), Department of Insurance (DOI), Federal Trade Commission (FTC), State Attorney General's, International Implications (EU 95/46EC), Centers for Medicare & Medicaid Services (CMS), and other regulatory guidance.

We endorse the mission, charter, authority, and structure of the Information Risk Management organization. Our Information Risk Management team is charged with the responsibility for developing, maintaining, and communicating a comprehensive information security program to protect the confidentiality, integrity, and availability of information assets. These policies and standards apply to all employees, third parties, and subcontractors. Our Enterprise Information Security organization is responsible for developing and maintaining comprehensive Information Security policies and control standards.

Information Security policies and standards are reviewed annually to confirm legal and regulatory compliance, proper governance, and alignment with the business objectives. The mission of our Data Protection Governance organization is to protect the privacy of customers, members, employees, shareholders, and vendors by implementing and overseeing an enterprise-wide data risk management program. Through managed and repeatable processes, we confirm controls and security policies and standards are in place to protect sensitive data. For example, risk analysis is performed for the following:

- Information, data security, and privacy policies, and standards
- Payment Card Industry compliance (PCI)
- Health Insurance Portability & Accountability Act Security Rule (HIPAA)
- Gramm-Leach-Bliley Act compliance (GLBA)
- Social Security Number (SSN) use, handling, controls and standards
- Alliance Partner processes



Personnel are responsible for safeguarding communications to protect the confidentiality of information assets. Confidential and protected information is reviewed by information owners, resource administrators, and information users to determine if encryption is required when it is at rest or in transit. If encryption is required, only approved encryption tools may be used. Our personnel, third party consultants, contractors, and vendors may not implement encryption, digital signatures, digital certificates or key escrow tools without prior authorization from Information Risk Management. The selected algorithm used to encrypt data uses a tested and best practice standard.

Risk 4:**Eligibility Impact & Enrollment****Description:**

Correct & prompt eligibility files are crucial to the success of an implementation.

Eligibility files are the first critical requirement to ensuring all other pieces of an implementation fall in to place. If eligibility files are late or incorrect, it can have many detrimental impacts to an implementation. In addition, the receipt of Eligibility files is the starting point for all CMS enrollment activities and member communications. There is inherent risk here for employer groups who use a third party eligibility vendor to manage the process. There is also risk in terms of the accuracy, completeness, and timeliness of the file submission in order to ensure proper enrollment/disenrollment into/from the EGWP. This is a critical part of the process.

Strategy:

- If files are late, members could be impacted in the following ways:
 - ✓ Inability to fill medications.
 - ✓ Our inability to load historical data prior to go live, which could also affect the member's ability to fill a medication.
 - ✓ For EGWP members, late eligibility files would affect our ability to enroll members for go live do to CMS requirements.
 - ✓ Our ability to send member communication pieces based on agreed upon schedule.
 - ✓ Our ability to service member services phone calls.
- If files are incorrect, members could be impacted in the following ways:
 - ✓ Inability to fill medications.
 - ✓ Unnecessary termination of members. For EGWP members, it is a very large undertaking to get members re-enrolled.
 - ✓ Our ability to have membership loaded prior to go live.

Mitigation strategies include review of all files to ensure they meet proper standards, escalations when files are late or missing, eligibility discrepancy reporting, reconciliation against the claim adjudication system, detailed discussions during implementation to establish the process, and ongoing monitoring of data files to quickly address and resolve outliers.

Risk 5:**Member Communications – Accuracy, Understandability, Timeliness****Description:**

The success of any new employer group implementation includes the proper development, approval, and timely fulfillment of CMS required member communications. This is a time consuming process and is designed to ensure that we not only meet CMS requirements for how the communications are prepared, but also meet each client's expectations on how and what they want reflected to clearly and accurately reflect their plan design and benefits.



Strategy: To mitigate these risks, every implementation includes a thorough review of all CMS required materials and required timeframes for fulfillment, creation of CMS materials for review and approval by the employer group prior to going to print, an annual review of any CMS required changes to model templates, an annual review to determine how to better communicate the messaging to each individual, and a full Quality Assurance process which includes review, proper versioning, template and live proof review, and a process for updating any specific communication when applicable.

Risk 6: Benefit Coding, Formulary & UM Coding Errors

Description: To minimize member noise, we would like to mitigate benefit, formulary and UM coding errors prior to go live and post implementation.

Strategy: We have a comprehensive benefit QA process. In addition to the standard test bed offered, client specific testing scenarios will be added based on the needs of the client. Comprehensive formulary and UM testing are part of this process. All testing is reviewed in detail with the client. In addition to our standard QA, if time allows a pre-implementation audit can be performed to further audit the plan prior to go live. This greatly decreases the chance for coding errors. If a pre-implementation audit is done, this will be built in to the timeline for the implementation to ensure benefit/formulary coding and standard QA is complete in time to allow for the additional audit.

Risk 7: Member Services

Description: Customer service advocates giving out inaccurate information to members or inappropriately referring them back to the plan.

Strategy: The designated team of customer service advocates (CSAs) who will take the State’s member calls will receive client-specific training on your plans in advance of go-live/open enrollment. We also encourage our client’s to participate in culture training of our designated CSAs whereby we would obtain a deeper understanding of your population’s makeup, norms, preferences, values, etc. In addition, we use an advanced tool to capture your plan designs that the CSAs access when taking calls which allows the CSAs to provide first call resolution. If first call resolution is not achievable then there is an established escalation process which includes our Research & Resolution team as well as your Account Management team. Our goal is to provide 100% call resolution and customer service satisfaction with each and every call we take on behalf of The State.

Risk 8: Billing & Invoicing Post Go Live

Description: Our goal is to work with the State to set up billing and invoicing correctly

Strategy: We will work to configure the State’s business structure in a manner that accommodates both reporting and invoicing needs. Items we work to avoid are client misunderstanding of the Carrier/Account /Group set up in relation to invoicing requirements. We also have standard processing in place to ensure correct agreed upon rates are coded, correct admin fees, clinical fees and mailing fees are set up appropriately. We will work with the State on the timing of billing and invoicing as well as the account management team will reviewing invoicing post go live to ensure accuracy.

Risk 9: Member and Public Portal Outages and Loading Issues

Description: Member and public portal displaying inaccurate information or unavailability for member use.

Strategy: We have a robust business continuity plan that provides for back up of its server housing the member and public portals. However should an outage occur, the account management team will immediately notify The State of any planned or unplanned outages. If an individual



member experiences technical issues with the member portal then we have trained staff available to assist them via the member services toll-free line. Our member and public portals are driven by the claims adjudication system. Formulary status results as well as Price & Save results are provided by running an actual trial claim against the members benefit plan in the system. We regularly test our member and public portals to ensure that correct benefit plan information is being accessed. However should an error occur, your Account Management team will work the Web Portal team to ensure quick resolution.

Risk 10: Ongoing Data/Accumulator File Exchange Set Up

Description: We will work with the State on data file and accumulator needs during the implementation. We will work with The State to determine what data files need to be exchanged with the State as well as its partners and vendors. A discovery phase will be dedicated to this critical function and the following will be derived:

Strategy:

- What entities require data exchange
- What data needs to be exchanged with each entity
- Custom or standard file formats
- Frequency of data exchange
- Location of data output/input (i.e. sFTP)
- File naming convention
- File notification process
- Any system configuration requirements necessary to import data

During this phase we will also establish a resolution process if a data file run issue or data file load issue were to occur. This will ensure that if automation were to fail that it would be immediately identifiable and corrected.

Risk 11: Member Disruption Due to Network Access

Description: Members may experience disruption due to rural pharmacy access within the state of Alaska.

Strategy:

We have a robust national pharmacy network with over 67,000 pharmacies nationwide. Based on our preliminary review, we are currently contracted with 148 (85%) of the 174 pharmacies in the state of Alaska. The remaining 26 pharmacies appear to be clinics, hospitals or medical centers not currently contracted in our national network nor do they have any current utilization based on the claims data provided. This would show zero disrupted pharmacies for both active and retiree members based on provided claims utilization. During the contracting and negotiation period, we will conduct an updated review of potential network disruption within the state of Alaska, focusing on rural access. If a currently utilized pharmacy is not contracted with us, we will reach out the pharmacy and solicit them for a contract to participate in our network.

Risk 12: Documentation During Implementation Phase

Description: When the State transitions from the implementation phase to the ongoing relationship with account management, it is critical that they have a clear understanding of the client and all implementation documentation is available to them.

Strategy:

The Implementation team uses a best practices approach for requirements gathering and documentation which includes the use of the Implementation Blueprint Document (IBD), Benefit Design Template (BDT) and Clinical Benefit Design Template (cBDT), all requiring client



sign-off. We provide published agendas and meeting notes for all implementation meetings. The implementation process includes creation of State of AK specific procedure documents for PA, manual claims, member services, etc. Implementation will establish a central repository SharePoint site specific to the State to house all implementation documents that is easily accessible post go live.

Risk 13: Transition to Account Management from Implementation

Description: The Account Management team will be a critical participant in the State of AK implementation from Day 1.

Strategy: Implementation will establish a SharePoint site specific to the State to house all implementation documents so they are available to all internal partners. Implementation and Account Management will work collaboratively with the State to determine the most appropriate date to transition to Account Management post go-live.

Risk 14: Preparing Network Pharmacies for the Change to the New PBM

Description: It is extremely important to properly notify network pharmacies of the State's intention to move to a new PBM.

Strategy: We will employ a strategy to determine the highest utilized pharmacies by the State members and create targeted fax blasts to these pharmacies to educate them on the upcoming change in BIN, PCN and Group. We also provide a sample of the new member ID card.

Risk 15: Open Enrollment Opportunities

Description: We will partner with the State to ensure we take full opportunity during open enrollment and be available to educate members on the new and/or existing benefit programs.

Strategy: We encourage our participation in the State open enrollment events as well as meetings with your various employee groups (i.e. Unions if applicable). Our representatives knowledgeable in your pharmacy benefit program and any upcoming changes will be present to provide on the spot answers to questions and concerns and have written materials for members to take home with them.

Risk 16: Member Disruption & Proper notification (if applicable) – Commercial Only

Description: Gaps in identifying disrupted members and properly notifying via written letter with enough time prior to go-live. Disruption includes members impacted by changes to PA, QL, ST, formulary exclusions and changes to plan design rules (DAW penalty, manufacturer copay assistance programs, etc.)

Strategy: Our Clinical Analytics team will perform a rigorous multi-step analysis and quality check on data to determine those impacted by UM and plan design changes both prior to go-live and ongoing as formulary/UM changes occur. Prior to go-live, members will be lettered with 60 days advance notice (contingent upon us receiving utilization data from the incumbent by the date identified in the IBD). Members will be lettered 60 days in advance of annual or bi-annual formulary/UM changes.

Risk 17: Understanding Client Intent

Description: We strive to avoid Miscommunication/misunderstanding of client intent for plan design parameters, PA program elections, manual claim procedures, administrative overrides, etc.

Strategy: We have a proven implementation process that ensures our new clients experience a successful and smooth implementation. This proven process is based upon best practices, lessons learned, and a deep understanding of how pharmacy benefit plans should function. During implementation, we will lead The State through a series of discovery phases where we will examine all aspects of your pharmacy benefits. We have created templates to capture



your unique plan design parameters including the BDT and the cBDT. Our deep understanding of pharmacy benefits allows us to ask you the right questions so that we can accurately administer and operationalize your benefit plans. Collaboration and open dialogue during the discovery phases is critical to ensuring that we capture your intent.

Risk 18: Plan Change Documentation Post Go Live

Description: On an annual basis, The State's account management team will conduct a thorough plan design review with you and use established templates and change order forms to document any desired changes.

Strategy: Plan design changes will be communicated to all downstream internal departments including but not limited to the benefit coding team, member services, finance, rebates, network management, formulary/UM teams, web portal and marketing & communications. In addition to the annual plan design review, The State's account management team will utilize the same established forms to document any off cycle plan design changes that are requested. Plan design templates and change order forms will be housed on SharePoint and available to the greater team.

Risk 19: Account Management Response to Client Inquiries

Description: It is critical that the account management team respond timely to client inquiries, resolve member issues, track client projects, and provide agreed upon deliverables.

Strategy: As a best practice for consistent project tracking, the State has access to our client portal. This tool supports tracking and management of all open items. Your account management team meets with the State on a weekly basis to provide comprehensive updates on the issues/project tracking log.

In the event that a target date is missed or a challenge arises that directly impacts the critical path, the project plan is promptly addressed and reviewed to determine an action plan that is mutually agreed upon. We are prepared to establish workable and effective solutions and act quickly to resolution.

Risk 20: Prior Authorization and Timeliness or Coverage Determination

Description: We will work to avoid Member/Provider frustration with the prior authorization process and/or timeliness of coverage determination.

Strategy: We offer prescribers an innovative connection that provides prescribers with real-time member-specific data within their workflow. It directly improves the member experience and overall plan performance by empowering prescribers to make better clinical decisions through better access to cost, coverage and clinical data.

Our tool leverages real-time trial claims to provide patient and plan specific costs and benefit information, considering elements such as coinsurance, deductibles, drug alternatives, and plan design. Prescribers can see where clinical programs such as prior authorizations (PAs) are required and submit them directly within the medical record while the patient is still in the office.

Risk 21: Pharmacy refusal to fill scripts

Description: Pharmacy's refusal to fill prescriptions due to the reimbursement.

Strategy: Depending on how the pharmacy is contracted (PSAO or independently), we will work with pharmacy to ensure they understand their contractual obligations. If the dispute is based on a Generic Drug, there is a MAC appeals process the pharmacy can access. If the pricing dispute is based on a brand drug, we will review current pricing and assess network reimbursement. Review



	the contracting with pharmacy if need be and additional obligations outlined in the contract and Provider Manual.
Risk 22:	Pharmacy attempts to negotiate pricing directly with the State or contacts the State directly with reimbursement complaints
Description:	Pharmacy not following the appropriate process and channels of communication and going directly to the client.
Strategy:	We will implement an onboarding strategy to minimize noise from pharmacies. We will work directly with the pharmacy and our PSAO providers of any pricing changes and proactively communicate. Set meeting cadence with our PSAO providers and ensure downstream flow of communication to their affiliated pharmacies.
Risk 23:	Accuracy of Mail and Specialty pharmacy transition
Description:	Ensuring all historical information is transitioned accurately from the incumbent OptumRx will work with the State's incumbent(s) to facilitate mail order and specialty open refill transfer files. For a 1/1/19 go live, OptumRx would expect a test ORT file no later than 12/15/18. Production files are typically provided by 1/1/19 with a final lag file provided by 1/15/19. Once the test file is received, OptumRx will bump the test file up against eligibility to determine if there is any fallout. OptumRx will work with the State prior to receipt of the production file to mitigate any outliers prior to go live. Once the ORT file is received, OptumRx will send an ORT letter to members with transferred scripts confirming for them which medication were transferred and next steps. In the event a script is not transferred (i.e.no refills available) OptumRx can reach out to the members physician on their behalf to facilitate refills if available.
Strategy:	Specialty pharmacy participants will receive outreach phone calls to assist them in transitioning to Briova. Briova will work closely with the member to set up mailing preferences and ensure the member is comfortable and has what is needed to manage their therapy ongoing.
Risk 24:	Member does not receive or discards ID card mailing
Description:	Ensuring members have all information necessary for pharmacy to process claims on 1/1/19 In the event a member does not receive an ID card, there are multiple ways this can be rectified. The members have the following options:
Strategy:	<ul style="list-style-type: none"> • Additional cards can be ordered on the online member portal. • Members and the State can contact OptumRx member services to order additional cards. • The State will have access in the claim system to order ID cards on the member's behalf. • OptumRx can also provide a temporary ID card that can be printed or emailed to the members.
Risk 25:	Plan Administration/COB for dual covered and accurate OHI data for COB
Description:	OptumRx to ensure COB is administered appropriately based on the States unique COB Requirements.
Strategy:	We provide coordination of benefits (COB) electronically at the point of service. Understanding the State's unique internal COB requirements, we collaborate with the State to confirm that the correct COB information is provided in the eligibility file. OptumRx plans to also work with the state on a unique business structure to assist in accommodating the requirements. These claims may be paid as normal, flagged, or reported as COB claims covered by another insurance carrier. They may also include messaging instructing the submitting pharmacy to use the alternative insurance (in which case the member can cover the product at 100 percent). Alternatively, the messaging may tell the pharmacy to adjudicate the claim and submit it to the State for filing with the alternate carrier



	If the member submits a claim to a primary insurance carrier and then sends the carrier’s explanation of benefits (EOB) to us, we process the claim as a direct member reimbursement. We then reimburse the member in full or in part for the remaining amount less the applicable copayment.
Risk 26:	Delay in receiving historical data and mail order open refill files (See Uncontrollable Risk #3)
Description:	
Strategy:	
Risk 27:	Incomplete or inaccurate eligibility data (See Controllable Risk #4)
Description:	
Strategy:	
Risk 28:	Integration with medical TPA and Accumulator files delayed or otherwise not set up on plan Effective Date (See Controllable Risk #10)
Description:	
Strategy:	
Risk 29:	Specialty Medication delivery timeline, weather, remote location related
Description:	Ensure timely delivery of sensitive specialty medications to remote and harsh weather locations
Strategy:	We provide specialized expertise in delivering specialty medications to geographically isolated members. Prior to shipment, an outbound call is placed to arrange delivery at the most convenient location for the member at that time. Delivery solutions use a combination of national, regional, and local carriers to facilitate on-time delivery and determine the method of delivery based on a member’s locations. Through a proprietary tracking system and access to specialized couriers, our Guardian Angel enhanced concierge delivery service achieves on-time delivery of specialty medications using a broad range of delivery capabilities including private charter, boat, weather-adverse prepared couriers, dog sled and other methods. When an unexpected delay occurs, logistics specialists provide solutions to get the package delivered to members on the committed day and provides 24 hour a day, seven day a week customer support to keep the member informed.

EGWP Specific Controllable Risks

Risk 30:	CMS Enrollment – Out of Area / Address Changes
Description:	As part of every new client implementation, we discuss the process for managing members who do not reside in the EGWP PDP service area as submitted to CMS with our annual bid and for ensuring we have an established process for ensuring all address changes are properly updated and any members who do not have a permanent residential address (e.g. P.O. Box) are aware of the risks associated with the process. Individuals who do not have a permanent residential address on file with CMS are subject to disenrollment from the plan after 12 months.
Strategy:	To mitigate this risk, we review the entire CMS process with every new client during implementation and how we administer these changes. We use a series of address verification letters when we become aware of a potential change (e.g. returned mail) to ensure we have the most up to date information. These letters are designed to go out during the 12 month period and helps ensure we obtain updated information to prevent unintended disenrollments from the EGWP.
Risk 31:	CMS Enrollment – Opt Out, COB/Alternative Insurance, POA, Late Enrollment Penalty



Description:	These are core processes for any Part D plan sponsor and defines the parameters for members who do not wish to participate in the EGWP, have other primary insurance on file with CMS that may result in rejected claims, have a Power of Attorney in place for critical health care decisions (e.g. enrollment), and who did not have creditable prescription drug coverage resulting in the imposition of a late enrollment penalty which is added to their Part D premium.
Strategy:	<ul style="list-style-type: none"> ▪ Opt Out – All new members eligible for enrollment receive an Opt-Out Letter along with the plan’s Summary of Benefits. The objective is to communicate the options available to a member who does not wish to participate in the plan, the risks associated with opting out (e.g. loss of medical coverage), and to make an informed decision. We also have specific script wizarding tools when we receive calls requesting to opt out. This helps ensure members do not opt out inadvertently. ▪ COB/Alternative Insurance – We provide members with letters that identify alternate primary / secondary prescription insurance and what steps must be taken to correct the information on file with Medicare. We also have a defined process to ensure that while this information is being updated, we update our claims adjudication system to prevent rejected claims. ▪ POA – We have a process to receive and image all POA’s which are required in order for anyone other than the member to make certain changes impacting enrollment. This is done to prevent unauthorized changes and to mitigate identify theft and protect the employer group. ▪ Late Enrollment Penalty – There is a defined process for obtaining verification of prior creditable drug coverage that may be used to reduce or eliminate the penalty including attestations of prior creditable coverage from either the member or the employer group.
Risk 32:	Medicare Retirees & CMS Approval
Description:	Medicare eligible retirees without access to benefits while waiting for CMS approval.
Strategy:	When all the information that we receive on the eligibility file is accurate, the process to enroll a member into the State’s EGWP is quick and seamless. However if for some reason information is missing and or not in alignment with what CMS has on file, then a retiree may have to wait until corrective actions have been taken before enrollment into the State’s EGWP. We have an automated solution to ensure that your retirees do not go without access to benefits during this interim period. Since the retiree is not officially enrolled in EGWP yet, we can set up our system so that they will automatically be able to access commercial benefits during this interim period. Our clients find this automated solution a very beneficial capability and it reduces member disruption.
Risk 33:	State unable to provide HICN or MBI for EGWP members
Description:	If the State is not able to obtain HICNs or MBIs for all of their 48,000 Medicare-eligible retirees, then any members with a missing HICN/MBI will not be able to be enrolled in the EGWP. HICN/MBI is a REQUIRED for a valid enrollment transaction to CMS.
Strategy:	The best way for the State to be able to easily obtain HICNs/MBIs for their Medicare-eligible retiree population is to execute a Voluntary Data Sharing Agreement (VDSA) with CMS. OptumRx will assist the State in completing all required documentation for the VDSA to ensure all HICN or MBI’s are obtained.
Risk 34:	Confusion on coverage determination and appeal under EGWP



Description:	Members new to EGWP could be confused with the Coverage Determination and Appeals process under Part D.
Strategy:	OptumRx will provide educational support to ensure the State's Medicare-eligible retiree population understand the basics and flow of the standard Part D PA and Appeals process.
Risk 35:	EGWP Financial operations
Description:	The State needs to be able to verify the accuracy of all of the various Government subsidies payable under Part D/EGWP (i.e. Direct Subsidy, Coverage Gap Discounts, Low-Income Cost Sharing Subsidy, Low-Income Premium Subsidy, and Catastrophic Reinsurance).
Strategy:	Detailed financial reporting for each type of subsidy will be provided to the State to back up/correspond to all CMS subsidy payments.
Risk 36:	Part B vs. Part D determinations for EGWP
Description:	The potential of Part B vs. Part D determinations under the EGWP not being processed appropriately.
Strategy:	OptumRx closely follows the CMS-required Part B vs. Part D determination processes to ensure these determinations are made correctly.
Risk 37:	Part D Income Related Monthly Adjustment Amount (IRMAA)
Description:	Risk of the State not being able to have visibility into which Medicare-eligible retirees are being charged the Part D IRMAA (Income Related Monthly Adjustment Amount) by the Social Security Administration (SSA).
Strategy:	Unfortunately, Part D plans (OptumRx) currently do not receive any reporting from SSA or CMS which identifies members who are being assessed the Part D IRMAA by the SSA. However, this is an enhancement that could possibly be suggested to CMS through our CMS Regional Office.
Risk 38:	Low Income Premium Subsidy
Description:	Possible risk of the Part D Low-income Premium Subsidies not being properly passed through to members and/or the State.
Strategy:	During implementation, we will gather information from the State regarding the monthly member premiums/self-pay amounts that they charge to their retirees for the Rx portion of the benefit. Based on that information, we will design a custom LIPS passthrough strategy for the State which will ensure that all LIPS amounts are being passed through in accordance with CMS guidance.
Risk 39:	Ensuring non-EGWP coverage is terminated upon CMS enrollment approval in EGWP
Description:	Possible risk of members being erroneously enrolled in both the State's Commercial and EGWP plans at the same time.
Strategy:	OptumRx has a process in place that would detect the approved application within the EGWP Carrier, which would be the trigger to find the member record within Commercial Carrier and systematically terminate that eligibility one (1) day prior to the effective EGWP enrollment date, thereby ensuring continuity of care.
Risk 40:	EGWP Utilization Management
Description:	Possible member noise regarding PAs or other types of UM that are required under Part D that the member was not previously subject to.
Strategy:	Educate members that the only UM edits that are required under Part D/EGWP are those that are needed to determine if a product should be covered under Part D or not. Examples include Part B vs Part D edits, and Part D vs. Part D Excluded edits.



Assessment of Non-Controllable Risks

Risk 1: The Inflation of Drug Pricing

Description: We continually evaluate opportunities to help customers manage drug costs and proactively monitor and anticipate price increases. As more opportunities become available for managing price inflation, information is shared with customers.

Strategy: Our strong relationships with pharmaceutical manufacturers maximizes contracting and reimbursement opportunities. Our scope and size creates leverage to negotiate aggressive pricing to lower costs for the State and its members. We have relationships with every major specialty drug manufacturer and most specialty biotech and research and development manufacturers.

Along with negotiating aggressive pricing, and our single-source pharmacy model, we manage drug costs for the State through:

- Rewarding pharmaceutical manufacturers who keep costs down
- Using exclusions to block less effective products and drive lower cost alternatives
- Protecting the State from excessive price inflation through Price Protection and price surveillance

LOWEST NET COST APPROACH

We take the lowest net cost by therapeutic class approach to evaluate a drug's value and determine its tier placement and management needs. We look at clinical efficacy, cost savings; member choice and disruption. When considering a drug's formulary placement and management strategies, our Pharmacy & Therapeutics (P&T) Committee reviews products first for clinical efficacy and therapeutic equivalency. Only after the clinical review is complete do we begin to evaluate the financial impact of formulary decisions. We analyze the business impact each decision would make not only to us, but also to our customers. Unlike our competition, we try to align our decisions with our customers' goals and consider the big picture before making any final decision that impacts our customers and members.

PRICE SURVEILLANCE

We use a proprietary Price Surveillance Tool to detect drugs with impactful price changes on a bi-weekly basis. The Price Surveillance Tool incorporates traditional and specialty drug utilization data and monitors the percentage price increases in wholesale acquisition cost (WAC)/trend impact for brand drugs on a week-to-week, month-to-month, and year-to-year basis. This report facilitates prompt identification of significant drug price increases and formulation of an action plan without delay. We conduct a daily review of industry publications, business news articles and press releases for drug price-related intelligence. Drugs identified through these methods undergo a rigorous review and assessment process and are evaluated for potential management strategies. These potential management strategies are reviewed by the P&T Committee for clinical appropriateness.

PRICE PROTECTION

We help the State mitigate the risk of increased drug costs by implementing a ceiling, or Maximum Allowable Price, on the majority of brand name, rebateable drugs. In fact, we have successfully negotiated Price Protection on nearly 99 percent of our rebated drugs.



-
- Our inflation cap payments or Price Protection is a guarantee by drug manufacturers that the wholesale price inflation of a drug does not exceed a certain level within a given timeframe. If a drug's inflation does exceed the threshold within this timeframe, the manufacturer refunds the difference between the actual inflation and that threshold as a percent of WAC.
-

Risk 2: Pharmacy Fraud, Waste and Abuse that Increases Costs for Customers and Members

Description: Our Advanced Pharmacy Services offer a suite of additional, detailed options for preventing and identifying possible fraud, waste and abuse. Working in conjunction with our standard auditing programs, Advanced Pharmacy Audit Services provides the State a greater degree of insight and analytics which have been shown to increase recoveries while reducing drug spend.

Strategy: Our Advanced Pharmacy Audit Services offer:

- Proactive monitoring and analyses of network pharmacies with highest billed claims or highest number of claims specific to your member utilization to determine potential for audit. This brings additional value as these audits/investigations allow for more in-depth review of pharmacy claim submissions.
- Selective outreach to the State's members and their prescribers to validate receipt of medication by the member and treatment by prescriber.
- State-specific weekly drug spikes reports which identify drugs that may be quickly increasing in volume and drug cost. The State is notified with recommendations to evaluate and potentially place edits, limits or other restrictions. For example, a Humalog drug report identifies spikes in billing and errors in quantity submitted. The average recovery for customers has been approximately \$140K per month.
- Close monitoring of high cost claims on a daily basis to identify erroneous claims exceeding \$100K amount paid.
- Review of member data including filling patterns, Geo-analysis and link analysis to identify members with potential drug-seeking behavior. This brings value from the health and safety perspective of the State's members. Any inconsistencies or concerns identified are referred to the customer for further review of their member.
- Dedicated point of contact and subject matter expert for audit requests/referrals. Any requests are further analyzed by reviewing drug volume, pharmacy volume, medical claims data (if applicable), or reviewing for invalid or violation of pharmacy law.

Risk 3: Historical Data File from Incumbent Vendor

Description: We will work with the State's Incumbent vendor to schedule expected dates for historical claims, PAs, Accum's (if applicable) and mail/Specialty Open Refill Transfer files.

Strategy: In the event files are late or not received, this will impact our ability to load historical data prior to go live. This is not the norm, however. We will work closely with the State to keep you updated on the status of the files and if any risks or concerns arise during the implementation phase. If files are late or not received we will work with the State on strategies to assist our members and limit disruption as much as possible. This could include grandfathering, member services education and intervention to assist members and pharmacies as well fax communication to pharmacies.

Risk 4: Pharmacy MAC Reimbursement Appeals

**Description:**

Pharmacies may experience a MAC reimbursement dispute for a submitted claim. This occurs when the reimbursement paid to the pharmacy by us is not adequate to cover the pharmacy's acquisition cost of the dispensed prescription.

We have a pharmacy MAC appeal process for pharmacies when they dispute the reimbursement on a MAC drug. Our pharmacy appeals process for MAC pricing is outlined below:

Pharmacy MAC Appeal Process:

- Providers must go to our website to access the Provider MAC pricing appeal form available within the Health Care Professionals area
- The Microsoft Excel must be completed as requested and can be emailed to us
- Appeal requests not completed as requested will be denied and not researched any further
- Responses will ONLY be responded to via email to the original requestor.

Our appeals process is the same for all pharmacies (chains, PSAOs, and independents).

Strategy:

We understand the importance of ongoing quality assurance, especially as it pertains to issues that affect payment to providers. Accurate payments to pharmacies help to secure relationships with providers and ultimately impact the services that our clients receive. Prior to implementation and utilization of a MAC list, we follow internal procedures to ensure that files are loaded accurately into the RxClaim system. We combine these procedures with a final post promotion review.

However, it is still possible that the provider community may be in disagreement with posted MAC list pricing. When a discrepancy is reported, we initiate a formal quality assurance process. Our Industry Relations Team records the drug/strength/dosage form, current MAC price, and detailed issues and forwards the information to the Clinical Team for verification and validation of the MAC price in our claims processing system against current acquisition pricing through application of the algorithm logic. We investigate the availability of the drug and after a final disposition, contact the provider with an explanation of findings.

We review and updates the MAC list twice weekly with additional updates implemented on an as needed basis based on market forces and other additional information. We routinely monitors pricing activity in the wholesale channel, expansion and contraction in the sourcing of products, new generic additions, and other factors to determine our proprietary MAC pricing algorithms. Our MAC team works with our clients to identify additional cost savings thru the MAC programs as available by identifying products for addition.

Please note that all non-MAC related reimbursement and/or contract inquiries should be directed to Provider Relations.

Risk 5:**State or Federal Regulatory Healthcare Changes****Description:**

State and Federal regulatory healthcare changes can happen often.

Strategy:

We have Regulatory Affairs and Government Programs teams that are dedicated to monitoring and acting upon State or Federal healthcare changes. The teams participate on CMS watch calls for Medicare updates and put together proactive solutions and



	<p>recommendation for our Medicare clients. We also closely watch State healthcare mandates to ensure that we are in compliance when changes do occur.</p>
Risk 6:	Drug supply shortages
Description:	<p>We act quickly to support our clients and members in maintaining access to needed medications during times of drug shortages.</p>
Strategy:	<p>We are constantly monitoring the pharmaceutical marketplace, current market trends, price changes and new clinical information. We act quickly to support our clients and members in maintaining access to needed medications during times of drug shortages. A recent example of this is our response to the severity of the 2017/2018 influenza season, we took swift action to address current shortages in the supply of the generic anti-flu medicine, oseltamivir, to ensure access and affordability to these medications for our members. We were the first pharmacy benefits manager to make proactive adjustments to our formulary/PDL, allowing the brand version, Tamiflu, to process as a single source brand effective immediately for all clients. We ensured that extra costs associated with the brand product when there is a generic available did not apply for most patients and penalties or ancillary charges will not apply for most clients. We provided this information directly to the 67,000 pharmacies in our network that support our members and clients to make them aware of these adjustments. The Centers for Disease Control and Prevention (CDC) leadership valued our quick actions and called us out specifically as a great example of how nimble the health industry can be in order to meet public health needs.</p>
Risk 7:	Drug Recalls
Description:	<p>We continually monitor the pharmaceutical marketplace and is vigilant about bringing awareness when a drug is recalled by its manufacturer.</p>
Strategy:	<p>On an ongoing basis, We publish a document which details drug recalls to our clients and stakeholders. This publication is sent via email with links to our health care professional's portal which includes the latest drug industry news and more. Additionally, depending on the circumstances and impact of the drug recall we will post notification to the member portals as well as conduct mailings to impacted members and providers.</p>
Risk 8:	FDA approval of new drugs and/or new indications for existing drugs.
Description:	<p>We vigilantly monitor the drug pipeline for new drugs coming to the market as well as drugs that get FDA approval for expanded indications.</p>
Strategy:	<p>We notify our clients about the drug pipeline on a quarterly basis at the Quarterly Plan Performance Review. Once a new drug is FDA approved or a drug's indication is expanded, we also provide this information to our clients and stakeholders via an email publication. Our P&T committee will expeditiously review the new drug and determine formulary placement and/or UM strategy. For drugs with expanded indications, we will evaluate and update utilization management programs to reflect the expanded FDA indication.</p>

EGWP Specific Non-Controllable Risks

Risk 9:	CMS Enrollment – Member Responsiveness
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Description:	<p>In order to be successful and ensure all risks identified above are addressed timely, it is critical that members respond to any action items / requirements outlined in the various enrollment communications they receive. For example, if members do not provide a timely response to an address verification change letter where only a P.O. Box is on file as their permanent address, they will be disenrolled after 12 months and will lose all drug coverage. This may also impact other benefits such as medical coverage if the employer group requires the member to remain active in the EGWP to be eligible for medical benefits.</p>
Strategy:	<p>There are defined processes in place for monitoring all specific requirements for each letter we send which are reviewed internally and also provided to employer groups to help manage member responsiveness. All the reporting is reviewed as part of each new implementation which also includes training. The approach includes escalations when necessary which includes follow up communications, notification of non-responders to each employer groups account management team, and timelines for when each response is required.</p>
Risk 10:	<p>CMS Communications – Turnaround Times, Accuracy</p>
Description:	<p>In order to meet CMS requirements, we are required to follow all mandated timeframes for providing member communications and for ensuring that they are accurate. These timeframes help ensure we not only meet CMS requirements, but employer requirements so that materials are available for review and approval, are properly set up for fulfillment, are posted to the employers internal website for benefit fairs or other communications initiated by each employer, and are clear and understandable.</p>
Strategy:	<p>The approach to ensuring we mitigate this risk includes:</p> <ul style="list-style-type: none"> ▪ A review of each required communication during implementation to ensure they meet client requirements and expectations. ▪ No implementation of any communication without prior review and approval by each employer group. ▪ All timelines are clearly communicated at least 3 months in advance to allow sufficient time for revisions, certain customizations, or coordination with other communications to members. ▪ Walk through the employer group process for review and approval of materials to ensure those timelines and processes are factored into the process. For example, most employer groups set their benefits at a specific time of the year which then require Board of Director approval. Knowing those timelines helps ensure all required timelines are met in total. <p>Review of all unique benefit parameters to ensure the materials are clear, concise, and easy to understand to provide the optimal member experience.</p>



FINANCIAL RESOURCES AND RESPONSIBILITY

Necessary information on the offeror's ability to meet its financial obligations. Financial analysis includes and is not limited to standard accounting ratio analysis. Offeror will be required to provide the most recent three years audited financial statements (Balance Sheet, Income Statement, and Cash-Flow Statement), including notes to the financial statements or the period of the company's existence, if shorter. Provide the most recent interim financial statements. Required if the latest available financial statement date is six months or more than the RFP document submission date. Interim financial statements must be signed and attested to by an authorized officer as a fair representation, in all material aspects, of the company's financial condition in accordance with generally accepted accounting principles. Provide any subconsultant's financial stability information and qualifications of the subconsultant's key personnel (if the subconsultant will perform at least 25% of the work). The state may request clarifications or additional documentation, other than the aforementioned documents as stated above. However, no request by the offeror to submit additional information for re-evaluation of financial resources and responsibility will be accepted.

OptumRx, Inc. is a wholly-owned indirect subsidiary of UnitedHealth Group Incorporated. UnitedHealth Group, Inc. is a publicly traded company on the New York Stock Exchange, trading under the symbol UNH.

Our most recent Form 10-K reports, including certified financial statements can also be accessed from the Investors page of the company's website at the links below:

[Annual Report on Form 10-K for period ended December 31, 2017](#)

[Annual Report on Form 10-K for period ended December 31, 2016](#)

[Annual Report on Form 10-K for period ended December 31, 2015](#)

The most recent interim filing, Form 10-Q, can also be accessed from the Investor page at the link below:

[Quarterly Report on Form 10-Q for the Quarterly period ended March 31, 2018](#)

Paper copies are available by request.

In addition, we encourage you to refer to our Dun & Bradstreet number, 86-866-7106, for the company's credit and financial information.

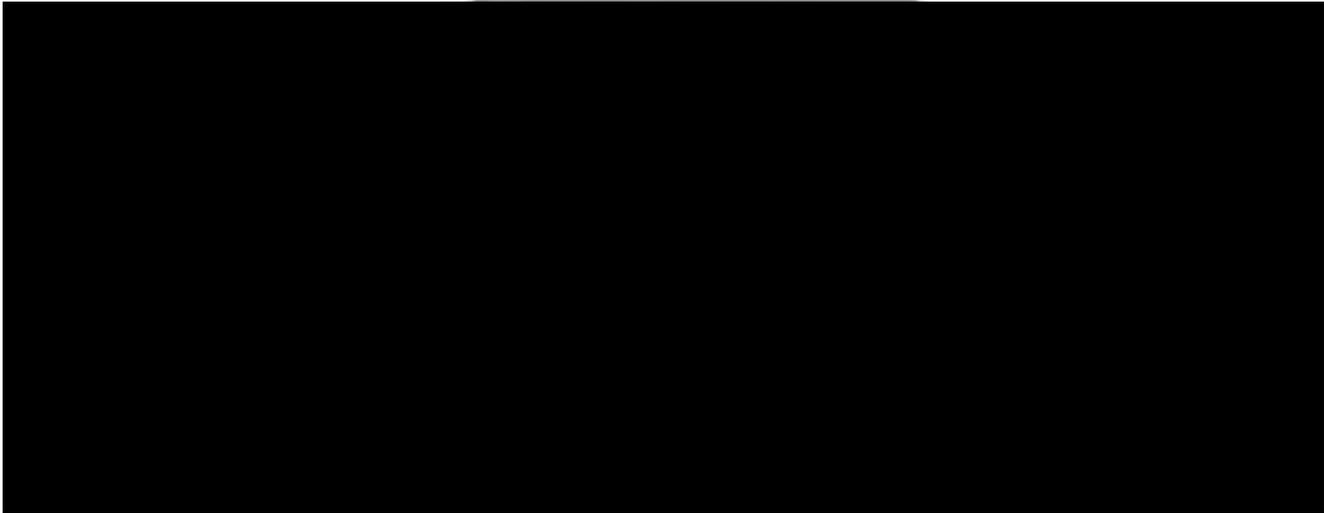


ORGANIZATIONAL CHART

An organizational chart specific to the personnel assigned to accomplish the work called for in the RFP; illustrate the lines of authority; designate the individual responsible and accountable for the completion of each component and deliverable of the RFP. If requested, provide resumes on all key personnel.

State of Alaska account management team

Executive Sponsor
Dr. Ellen Nelson
Sr. Vice President,
Government Markets,
Relations & Reform





**Enterprise Resiliency & Response Program
OptumRx Customer Overview
January 2018**

STATE OF ALASKA REQUEST FOR PROPOSALS



PHARMACY BENEFIT MANAGEMENT (PBM) SERVICES

RFP 180000053

Issued January 22, 2018

ISSUED BY:

DEPARTMENT OF ADMINISTRATION
DIVISION OF RETIREMENT AND BENEFITS

PRIMARY CONTACT:

JASON GROVE, CPPB
CONTRACTING OFFICER
JASON.GROVE@ALASKA.GOV
(907) 465-5679

OFFERORS ARE NOT REQUIRED TO RETURN THIS FORM.

IMPORTANT NOTICE: IF YOU RECEIVED THIS SOLICITATION FROM THE STATE OF ALASKA'S "ONLINE PUBLIC NOTICE" WEB SITE, YOU MUST REGISTER WITH THE CONTRACTING OFFICER LISTED ABOVE TO RECEIVE SUBSEQUENT AMENDMENTS. FAILURE TO REGISTER WITH THE CONTRACTING OFFICER MAY RESULT IN THE REJECTION OF YOUR OFFER.

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SECTION 1. INTRODUCTION & INSTRUCTIONS

SEC. 1.01 PURPOSE OF THE RFP

The Department of Administration, Division of Division of Retirement and Benefits, is soliciting proposals from qualified and experienced firms to provide statewide services for Pharmacy Benefit Management (PBM). The services are administrative only services for the state's self-funded Prescription Drug Plan for both its active and non-Medicare-eligible membership (commercial plan) and for its enhanced Medicare-eligible EGWP population.

SEC. 1.02 DEADLINE FOR RECEIPT OF PROPOSALS

Proposals must be received no later than **2:00 p.m.**, Alaska Time, on **March 15, 2018**. See Section 1.07 for further instructions.

SEC. 1.03 RFP SCHEDULE

The RFP schedule set out herein represents the state's best estimate of the schedule that will be followed. If a component of this schedule, such as the deadline for receipt of proposals, is delayed, the rest of the schedule may be shifted accordingly. All times are Alaska Time.

ACTIVITY	TIME	DATE
Issue Date / Draft RFP Released		1/22/18
Educational Meeting	10:00 am	1/29/18
Draft RFP Period Ends		2/1/18
Pre-Proposal Conference and Second Educational Meeting	2:00 pm	2/6/18
Deadline to Submit Questions	4:30 pm	2/27/18
Deadline for Receipt of Proposals / Proposal Due Date	2:00 pm	3/15/18
Initial Evaluations and Proposal Analysis		3/16/18
Present Financial Analysis (Segal) to Procurement		4/17/18
Present Proposal Analysis (Segal) to State		4/17/18
Shortlisting (optional)		4/18/18
Interviews	TBD	5/1/18
Clarification Period Begins		5/4/18
Notice of Intent to Award		6/15/18
Contract Issued		6/25/18
Start Date		6/26/18

The first 10 days after the RFP is released will be considered a draft RFP period. Offerors should submit any initial questions or concerns about the RFP to the contracting officer in writing during this time.

This RFP does not, by itself, obligate the state. The state's obligation will commence when the contract is approved by the Commissioner of the Department of Administration, or the Commissioner's designee. Upon written notice to the contractor, the state may set a different starting date for the contract. The state will not be responsible for any work done by the contractor, even work done in good faith, if it occurs prior to the contract start date set by the state or prior to a fully signed contract.

SEC. 1.04 EDUCATIONAL AND PRE-PROPOSAL CONFERENCES

An educational meeting will be held at **10:00 a.m.** Alaska Time on **January 29, 2018**. The meeting will be held via webinar and will be an introduction to the RFP process being used for this procurement.

Webinar link:

<https://stateofalaska.webex.com/stateofalaska/j.php?MTID=maafdbbf09f570c6fd073328ab2604e26>

Call-in number: (907) 269-3000

Meeting ID: 800 060 289

An in-person pre-proposal conference and second educational meeting will be held in Juneau at **2:00 p.m.** Alaska Time on **February 6, 2018**, to discuss the RFP with prospective offerors, allow them to ask questions concerning the RFP, and to provide a thorough education on the RFP process being used. To obtain the greatest benefit of this meeting, offerors are strongly encouraged to send their direct supervisory personnel/critical project team members (in lieu of executives, business development, or sales personnel).

Offerors should read the RFP in full and come to the meeting prepared to discuss any questions or concerns. Offerors with a disability needing accommodation should contact the contracting officer prior to the date set for the pre-proposal conference so that reasonable accommodation can be made. The meeting will be held at the following location:

Building: **University of Alaska Southeast**

Address: **12300 Mendenhall Loop Rd., Room 116**

Parking is available onsite. If parking becomes unavailable, you may park at the UAS main campus, 11120 Glacier Hwy, and it is a short walk to shuttle ride to the Recreation Center. Offeror representatives who wish to participate over the phone may dial into the conference at **(800) 315-6338 Access Code 05024**. Note that the conference may be recorded.

SEC. 1.05 REQUIRED REVIEW

Offerors should carefully review this solicitation for defects and questionable or objectionable material. Comments concerning defects and objectionable material must be made in writing and received by the contracting officer at least ten days before the deadline for receipt of proposals. This will allow time for the issuance of any necessary amendments. It will also help prevent the opening of a defective solicitation and exposure of offeror's proposals upon which award could not be made. Protests based on any omission or error, or on the content of the solicitation, will be disallowed if these faults have not been brought to the attention of the contracting officer, in writing, at least ten days before the deadline for receipt of proposals.

SEC. 1.06 QUESTIONS PRIOR TO DEADLINE FOR RECEIPT OF PROPOSALS

All questions must be in writing and directed to the contracting officer. The interested party must confirm telephone conversations in writing. Two types of questions generally arise. One may be answered by directing the questioner to a specific section of the RFP. These questions may be answered over the telephone. Other questions may be more complex and may require a written amendment to the RFP. The contracting officer will make that decision.

SEC. 1.07 RETURN INSTRUCTIONS

Offerors must submit their proposals via email to doa.dgs.info@alaska.gov prior to the deadline for receipt of proposals. Emails must contain the RFP number in the subject line of the email.

The **maximum** size of a single email (including all text and attachments) that can be received by the state is **20mb (megabytes)**. If the email containing the proposal exceeds this size, the proposal must be sent in multiple emails that are each less than 20mb. It is the offeror's responsibility to contact the above email address or (907) 465-2250 to confirm that the proposal has been received. The state is not responsible for unreadable, corrupt, or missing attachments.

An offeror's failure to submit its proposal prior to the deadline will cause the proposal to be disqualified. Late proposals will not be opened or accepted for evaluation.

SEC. 1.08 ASSISTANCE TO OFFERORS WITH A DISABILITY

Offerors with a disability may receive accommodation regarding the means of communicating this RFP or participating in the procurement process. For more information, contact the contracting officer no later than ten days prior to the deadline for receipt of proposals.

SEC. 1.09 AMENDMENTS TO PROPOSALS

Amendments to or withdrawals of proposals will only be allowed if acceptable requests are received prior to the deadline that is set for receipt of proposals. No amendments or withdrawals will be accepted after the deadline unless they are in response to the state's request in accordance with 2 AAC 12.290.

SEC. 1.10 AMENDMENTS TO THE RFP

If an amendment is issued before the deadline for receipt of proposals, it will be provided to all who notified of the RFP and to those who have registered with the contracting officer after receiving the RFP from the State of Alaska Online Public Notice web site.

After receipt of proposals, if there is a need for any substantial clarification or material change in the RFP, an amendment will be issued. The amendment will incorporate the clarification or change, and a new date and time established for new or amended proposals. Evaluations may be adjusted as a result of receiving new or amended proposals.

SEC. 1.11 ALTERNATE PROPOSALS

Offerors may only submit one proposal for evaluation. In accordance with 2 AAC 12.830 alternate proposals (proposals that offer something different than what is asked for) will be rejected.

SEC. 1.12 NEWS RELEASES

News releases related to this RFP will not be made without prior approval of the project director or contracting officer.

SECTION 2. BACKGROUND INFORMATION

SEC. 2.01 ABOUT THE DIVISION

The Division of Retirement and Benefits (DRB) manages the State of Alaska's retirement systems and health benefit plans. The Division's scope of work includes serving as the point of contact for administrative, legal, legislative, and procedural issues regarding the management of the state-sponsored health plans. Currently the Division internally handles some of the work related to customer service, benefits processing, counseling and appeals.

The Department of Administration's commissioner is the plan administrator but delegates policy development and the operation of state-sponsored health benefit plans to the Division's health team. This team is comprised of a Division Director, Chief Health Policy Administrator, Chief Health Operations Official, and support staff.

The State of Alaska provides employee health benefit plans to: (1) a portion of state employees; (2) defined benefit retired employees of the state and its political subdivisions; and (3) defined contribution retired employees of the state and its political subdivisions. The plans have different provisions and funding structures, but the state's group health plans are self-funded. Benefits for most active state employees are subject to collective bargaining agreements. The Commissioner of Administration is the plan administrator.

SEC. 2.02 ABOUT THE EXISTING PBM SERVICES

The current PBM contract has been in place since January 1, 2014. The duties include:

- Claims Adjudication
- Pricing Administration
- Integrate with other vendors (e.g. Disease Management, Medical, Data Warehouse Vendors, etc.), if applicable
- Eligibility Maintenance
- Paper Claims Submission – Include Process for Compounded Drugs and Foreign Claims
- Online Access Capabilities – Include Prior Authorization and Override Entries
- Coordination of Benefits and Subrogation support services
- Comprehensive IT capabilities including Access to Claims History – with Denial Reasons
- Discount Programs for Non-Covered Drugs or Cash Claims (no Pharmacy Benefit)
- Clinical programs including Patient and Provider Education, clinical support, Prospective, Concurrent, and Retrospective Drug Utilization Review, and medication compliance enhancement
- Network Pharmacy Management
- Formulary Management and Rebate Sharing
- Data Reporting (standard and ad-hoc reporting)
- Distribution of ID Cards and Pharmacy Directories
- Mail Service Pharmacy - Includes Optional Auto-Renewal and Auto-Refill Programs
- Specialty Pharmacy Program
- Member Services: Include Claims Resolution, Claims Appeals, Clinical Support and Patient and Provider Education, Website with membership portal
- State Services – Dedicated or Designated Account Management and CSR telephonic support, Problem-Solving Team with Access to Call Logs and Historical Claims Data
- Medicare Part D and Retiree Drug Subsidy administrative services – Include Access to an Online System providing Covered Participants and Dependents with a Designated Contact for Issue Resolution and Reconciliation
- Coordination with HRA Administrator

Different aspects of the service are provided in different geographical areas, but all services are provided in the United States.

SEC. 2.03 FINANCIAL STRUCTURE/MODEL

The state is currently under a contract with traditional pricing terms with 100% rebate pass-through/transparent pricing terms.

SEC. 2.04 CURRENT PLAN FEATURES AND COVERAGE

The state administers three self-funded separate pharmacy benefit plans, and seeks to add an employer group waiver plan for Medicare eligible retirees. The employee and defined contribution plans have the same non-preventive member cost share provisions, limitations and exclusions. However, Medicare eligible retirees and dependents in the defined contribution retiree plan benefits are not provided first dollar preventive benefits. The third plan, the defined benefit retiree plan, varies greatly from the other two. For example, the defined benefit retiree plan covers contraceptives, but does not cover other ACA defined preventive drugs. The defined benefit plan also covers medication that is excluded under our other plans, such as bulk chemical compounds and prescriptions with an over-the counter equivalent.

Full details on the employee plan can be found in the summary of plan benefits available online at:

<http://doa.alaska.gov/dr/alaskacare/employee/publications/booklet.html>

The summary of plan benefits available under the defined contribution retirement plan is available online at:

<http://doa.alaska.gov/dr/pdf/ghlb/retiree/AlaskaDcrRetireeHealthPlan-Final-0118.pdf>.

The key member cost share benefits for the employees and defined contribution retirees are summarized below:

ALASKACARE 2018 PHARMACY PLAN SUMMARIES			
Prescription Tier	Coinsurance	Min. Covered Person Payment	Max. Covered Person Payment
Retail 30 Day at Network Pharmacy			
Generic prescription drug	80%	\$10	\$50
Preferred brand-name prescription drug	75%	\$25	\$75
Non-preferred brand-name prescription drug	65%	\$80	\$150
Mail Order 31-90 Day at Network Pharmacy			
Prescription Tier	Copayment		
Generic prescription drug	\$20		
Preferred brand-name prescription drug	\$50		
Non-preferred brand-name prescription drug	\$100		
Out-of-Network Pharmacy			
Coinsurance for all prescription drugs	60%		
Out-of-Pocket Limit			
Annual individual out-of-pocket limit	\$1,000		
Annual family out-of-pocket limit	\$2,000		
Effective: Jan. 1 - Dec. 31, 2018			

The defined benefit retiree plan details can be found in the summary of plan benefits booklet available online at:

<http://doa.alaska.gov/dr/alaskacare/retiree/publications/booklets.html>

The key member cost share benefits for defined benefit retirees are summarized below:

b. Prescription Drug Schedule

	Generic up to 90 Day or 100 Unit Supply	Brand Name up to 90 Day or 100 Unit Supply
Network pharmacy copayment	\$4	\$8
Mail order copayment	\$0	\$0
Supply Limit		
Depo-Provera (injectable contraceptive)	5 vials per benefit year	

Other Major Plan Features:

- The state currently has a broad retail network that covers all major retail networks and is seeking a similar broad retail network that covers all major retail networks as well as key Alaskan independent pharmacies for its upcoming contract.
- The state currently has an Open Specialty Arrangement that allows fills at any participating retail pharmacies.
- The state currently offers coverage in the employee and defined contribution retiree plans of the following ACA defined preventive drugs in the active plan with zero-member copays, when obtained at network pharmacy:
 - ✓ Aspirin: Benefits are available to adults.
 - ✓ Oral Fluoride Supplements: Benefits are available to children whose primary water source is deficient in fluoride.
 - ✓ Folic Acid Supplements: Benefits are available to adult females planning to become pregnant or capable of pregnancy.
 - ✓ Iron Supplements - benefits are available to children without symptoms of iron deficiency. Coverage is limited to children who are at increased risk for iron deficiency anemia.
 - ✓ Vitamin D Supplements: Benefits are available to adults to promote calcium absorption and bone growth in their bodies.
 - ✓ Risk-Reducing Breast Cancer Prescription Drugs - covered expenses include charges incurred for generic prescription drugs prescribed by a physician for a woman who is at increased risk for breast cancer and is at low risk for adverse medication side effects.
 - ✓ FDA-approved prescription drugs and over-the-counter (OTC) drugs to help stop the use of tobacco products.
 - ✓ Female generic contraceptive prescription drugs or devices.
 - ✓ FDA-approved female generic emergency contraceptives.
 - ✓ Low to moderate dose statins.
- Although excluded from the employee and defined contribution retirement pharmacy benefits, the state currently covers bulk chemical compound prescriptions and prescription drugs with an over the counter equivalent in the defined benefit retiree plan.
- There is a high volume of members covered under one or more AlaskaCare plans as the member and a dependent, requiring coordination of benefits between the plans.
- There is a high volume of members covered under one or more of their own AlaskaCare plans (i.e. active plan and retiree plan, or more than one retiree plan coverage), requiring coordination between the plans.

SEC. 2.05 ALASKACARE

AlaskaCare are the health plans administered through the state. These plans are provided in accordance with Alaska Statute to a subset of state employees, and to public employees, teachers, and judicial officers of the state and political subdivisions who are eligible for retiree health benefits. The coverage provided is good worldwide.

The retirement health benefits fall into two major categories, those of the defined benefit retirement plan (members who entered the retirement system prior to July 1, 2006), and the defined contribution retirement plan (members who entered the retirement system on or after July 1, 2006). The defined benefit retiree plan is an older plan design and has not been substantially updated since 2000. The defined contribution retirement medical plan was implemented in 2016, and currently has under 24 members. The state currently receives subsidies through CMS Retiree Drug Subsidy program, but is looking to implement an employer group waiver program in both retiree health plans.

There is a union labor/management committee that provide recommendations to the plan administrator for changes to the employee plan, and there is a newly established Retiree Health Plan Advisory Board to provide recommendations to the plan administrator related to the retiree health plans.

The AlaskaCare plans have many members who are covered by more than one AlaskaCare plan. This can be through coverage as a member and a dependent of their spouse, or through two of their own plans (i.e. employee plan and retiree plan, or two retirement plan benefits). The active and defined benefit plan allow coordination of benefits up to 100% of the allowed charge, and require the ability to coordinate at point of sale. The defined contribution plan has a government carve out type coordination of benefits, where AlaskaCare applies the coinsurance calculation to the amount not covered by the primary plan.

SEC. 2.06 HISTORICAL FACTS AND FIGURES

Summary of Services (from August 2016 – September 2017)

DESCRIPTION	EMPLOYEE PLAN	DEFINED BENEFIT RETIREE PLAN	DEFINED CONTRIBUTION RETIREE PLAN	TOTAL
Members	16,539	71,641	22	88,202
Annual Number of Paid Prescription Claims	103,233	1,353,242	Not Available	1,456,475
Total Drug Spend	\$16.2 Million	\$228.3 Million	Not Available	\$244.5 Million
Mail Order Utilization	6.6%	12.7%	Not Available	
Generic Utilization	82.5%	80.8%	Not Available	
Medicare Eligible	N/A	67%	86%	

SEC. 2.07 STRENGTHS AND OPPORTUNITIES

(a) STRENGTHS

- The state currently has a broad retail network that covers all major retail networks and is seeking a similar broad retail network that covers all major retail networks for its upcoming contract.

(b) OPPORTUNITIES

- The state is seeking a vendor to provide excellent customer service, and provide a service that will “take the member out of the middle.”
- The state would like to see increased transparency and communication around MAC pricing.
- The state is seeking a vendor with the ability to make real-time benefit coverage determinations for Part B and Part D drugs to ensure timely routing to the appropriate payor.

- The state would like to explore innovative specialty management strategies without limitations such as an exclusive network.
- The state is seeking a vendor that can implement network management strategies with aggressive pricing, without restriction of the network.
- The state is seeking a vendor with enhanced EGWP expertise and capabilities to deal with complex member issues.

SEC. 2.08 BACKGROUND ON CLINICAL PROGRAMS AND INITIATIVES

Current pharmacy programs include pre-authorizations, evidence-based clinical policies, analysis of individual's prescription drug claims to identify opportunities to improve care, prevent misuse and reduce waste. Includes alerts to providers of possible drug-to-drug interactions, duplication in therapy or other serious issues.

SEC. 2.09 EXISTING CHALLENGES

The rising cost of pharmaceutical drugs is a significant challenge for the AlaskaCare Plan. Not only are there more specialty drugs emerging but they are increasing in cost and use. See section 3.07 for other unique operating and location considerations.

A technical challenge includes the issue of administering coordinated benefits to a member that might be covered by multiple plans within AlaskaCare, but reported under one unique identifier (i.e. Social Security Number).

SECTION 3.SCOPE OF WORK & CONTRACT INFORMATION

SEC. 3.01 SUMMARY

The state, is soliciting proposals from qualified and experienced firms to provide PBM services to the AlaskaCare employee and retiree health plans. With the issuance of this RFP, the state is focusing on providing exceptional customer service coupled with reduced costs for members and the plan while improving overall value. This RFP provides an opportunity for offerors to showcase what they bring to the table plus demonstrate leadership in these areas. We encourage offerors to demonstrate a strong customer service component and show how they can achieve significant and lasting cost reductions for the state while maintaining quality benefits. Accurate, consistent, timely, and comprehensive management reporting is also critically important.

The state seeks to replicate the current plan design for the Commercial benefit and to move Medicare eligible retirees to an enhanced EGWP benefit. The enhanced EGWP will be designed to ensure that from a member perspective, the Medicare eligible retiree benefits mirror those of the current commercial plan design.

SEC. 3.02 GOALS AND OBJECTIVES

The critical goals and objectives of these services are:

- Providing high-quality, exceptional customer service that will “take the member out of the middle.”
- Providing fiscally sustainable, high-quality benefits.
- Providing transparency in pricing and fees structures.
- Ensuring the use of evidence-based guidelines in clinical determinations.
- Strong support and demonstrated flexibility to support plan changes or initiatives including implementation of a Medicare Part D enhanced EGWP.
- Providing high accuracy in claims processing.
- Demonstrated ability to manage drug mix with an emphasis on specialty drug management, formulary management and generic drug utilization (ability to identify, dispense and track utilization of authorized generics).
- Supporting the state in identifying, recommending and implementing innovative quality-oriented claims administration processes and procedures to achieve state objectives, reduce costs, and improve quality of service.
- Providing effective tools and resources to support members in managing their health.
- Providing seamless implementation for state and its members.
- Coordinating clinical management with the medical administrator, wellness and disease management vendor, and any other vendor or administrator contracted by the state.
- Increased transparency and communication around MAC pricing.
- Making real-time benefit coverage determinations for Part B and Part D drugs to ensure timely routing to the appropriate payor.
- Exploring innovative specialty management strategies without limitations such as an exclusive network.
- Implementing network management strategies with aggressive pricing, without restriction of the network.
- Enhanced EGWP expertise and capabilities to deal with complex member issues.

SEC. 3.03 MAJOR DELIVERABLES

The awarded offeror will be required to provide, perform, or deliver the following (including but not limited to):

1. Pharmacy Benefit Management services.
2. Exceptional customer service, preferable through a dedicated customer/member service unit with CSR telephonic support, problem-solving team with access to call logs and historical claims data.

3. Competitive financial arrangement and guaranteed pricing terms.
4. Transparent and concise contract language that accurately reflects all responses provided in the RFP.
5. Proactive, flexible, and expert support for all clinical programs including full disclosure of cost and rebate implications.
6. Claims adjudication.
7. Pricing administration.
8. Integrated PBM services with other vendors (e.g. disease management, medical, data warehouse vendors, etc.), if applicable.
9. Comprehensive collection, and utilization of data to inform and guide policy and plan design decisions.
10. Eligibility maintenance.
11. Paper claims submission – include process for compounded drugs and foreign claims.
12. Online access capabilities – include prior authorization and override entries.
13. Coordination of benefits and subrogation support services.
14. Comprehensive IT capabilities including access to claims history – with denial reasons.
15. Discount programs for non-covered drugs or cash claims (no pharmacy benefit).
16. Clinical programs including patient and provider education, clinical support, prospective, concurrent, and retrospective drug utilization review, and medication compliance enhancement.
17. Robust process for tracking and monitoring fraud/abuse.
18. Network pharmacy management.
19. Formulary management and rebate sharing.
20. Data reporting (standard and ad-hoc reporting).
21. Distribution of ID cards and pharmacy directories - include web link to online directories.
22. Mail service pharmacy - include optional auto-refill program.
23. Specialty pharmacy program.
24. Member Services: include claims resolution, claims appeals, clinical support and patient and provider education, website with membership portal, and decision support tools.
25. Contract with externa review organizations to review clinical appeals.
26. State Services – dedicated or designated account management.
27. Medicare Part D and Retiree Drug Subsidy administrative services – include access to an online system providing covered participants and dependents with a designated contact for issue resolution and reconciliation.
28. Enhanced EGWP for Medicare eligible retirees.
29. Adherence to CMS enhanced EGWP guidelines.
30. Coordination with Health Reimbursement Arrangement Administrator.
31. Coordination with TPA.
32. Coverage of members in the same household in enhanced EGWP/Commercial plans based on a member’s individual eligibility.
33. Support point of sale adjudication and coordinate benefits for members who are simultaneously covered under more than one AlaskaCare plan.

SEC. 3.04 MANDATORY REQUIREMENTS

The mandatory requirements for this contract are provided in Submittal Form F – Mandatory Requirements. The offeror must meet all of these requirements. Failure to meet all mandatory requirements will result in immediate disqualification.

SEC. 3.05 CONTRACTUAL REQUIREMENTS

The state’s contractual requirements are provided in Submittal Form G – Contractual Requirements. The form is for the offeror to confirm if they can or cannot meet each contractual requirement listed in the form. Space is provided to explain “no” responses.

SEC. 3.06 CONTRACT TERM AND WORK SCHEDULE

The length of the contract will be for an initial period of three years beginning January 1, 2019, with eight additional one-year renewal options. Renewals will be exercised at the sole discretion of the state.

Unless otherwise provided in this RFP, the state and the successful offeror/contractor agree: (1) that any holding over of the contract excluding any exercised renewal options, will be considered as a month-to-month extension, and all other terms and conditions shall remain in full force and effect and (2) to provide written notice to the other party of the intent to cancel such month-to-month extension at least 30-days before the desired date of cancellation.

SEC. 3.07 UNIQUE CONSIDERATIONS

The AlaskaCare members can earn multiple retiree health plan benefits. This results in a member having two or more of their own coverage plans under the AlaskaCare retiree plan, as well as coverage as dependent if they are married to another retiree or State of Alaska employee. This requires the AlaskaCare plan to customize plan coordination to address the multiple plans for a single member.

The AlaskaCare membership is spread throughout Alaska from our main population hubs of Anchorage and Fairbanks to small villages of less than 100 residents. Only 20% of Alaska is accessible by road, and due to Alaska's size, even communities connected by roads can still be 8 or more hours drive away.

Due to the extremely rugged, mountainous nature of Southeastern Alaska, almost all communities (with the exception of Hyder, Skagway, and Haines) have no road connections outside of their locale, so aircraft and boats are the major means of transport. This includes Juneau, the state's capital and the third largest concentration center of AlaskaCare members.

There are members who live in rural locations, and commercial airlines do not provide service to most of these areas.

There can be extreme weather conditions which can hinder travel and mail order delivery. Mail order pharmacy deliveries may require special packaging.

Alaska is in its own time zone. Member contact centers will need to provide service based on Alaska Standard Time.

In addition, approximately 40% of the retiree population live outside of Alaska, including some who live abroad.

SEC. 3.08 STATE OF ALASKA ROLES AND RESPONSIBILITIES

State is responsible for the plan, its operation, and the benefits provided thereunder. The state has the sole and complete authority to determine eligibility of persons to participate in the plan. The state is responsible to supply the PBM in writing or by electronic medium acceptable to the PBM all information regarding the eligibility of individuals identified as plan participants under the plan, including but not limited to the identification of dependents under the plan, and shall notify PBM of any changes in eligibility.

All administrative appeals identified in the plan documents beyond Level I and Level II/External Review shall be administered by the state which retains the status as the final fiduciary for appeals of adverse benefit determinations.

The state is responsible for reimbursement of all benefit payments which have been paid by PBM on behalf of the state on or before the termination date or that relate to runoff claims.

The state is responsible for satisfying any and all plan reporting and disclosure requirements imposed by law, including updating the Plan to reflect any changes in benefits.

Under PPACA the state is responsible to provide additional reports and disclosures to federal agencies and employees, including, without limitation: Uniform notices of coverage requirements under Section 2715 of the PHSA; information to the Secretary of Health and Human Services (the "Secretary") regarding claims data and policies, financial information, information to the Secretary on denied claims, and other information under Section 2715A of the PHSA; information to the Secretary relating to provider reimbursement structures that improve quality of care, including wellness and health promotion activities under Section 2717 of the PHSA; notices to employees regarding state based health insurance exchanges and information related to the Plan under Section 18B of the Fair Labor Standards Act; and information to the Internal Revenue Service and employees related to the employees covered under the Plan, Plan premiums, and other Plan information under Sections 6055 and 6056 of the Internal Revenue Code.

SEC. 3.09 LOCATION OF WORK

The location the work is to be performed, completed and managed is the United States. The state will not provide workspace for the contractor.

If the offeror cannot certify that all work will be performed in the United States, the offeror must contact the contracting officer in writing to request a waiver at least 10 days prior to the deadline for receipt of proposals. The request must include a detailed description of the portion of work that will be performed outside the United States, where, by whom, and the reason the waiver is necessary.

Failure to comply with these requirements may cause the state to reject the proposal as non-responsive, or cancel the contract.

SEC. 3.10 CONTRACT PAYMENT

No payment will be made until the contract is approved by the Commissioner of the Department of Administration or the Commissioner's designee. Under no conditions will the state be liable for the payment of any interest charges associated with the cost of the contract. The state is not responsible for and will not pay local, state, or federal taxes. All costs associated with the contract must be stated in U.S. currency.

SEC. 3.11 PROPOSED PAYMENT PROCEDURES

The state will make payments based on a negotiated payment schedule. This schedule will be negotiated during the clarification period (reference RFP Section 5.20).

SEC. 3.12 THIRD PARTY SERVICE PROVIDERS

The contractor must provide, on an annual basis, a Type 2 Statement on Standards for Attestation Engagements (SSAE) SOC 2 report. Failure to provide this report may be treated as a material breach and may be a basis for a finding of default.

SEC. 3.13 SUBCONTRACTORS

U.S. based subcontractors may be used to perform work under this contract. If an offeror intends to use subcontractors, the offeror must complete Submittal Form J – Subcontractors, provided as an attachment to the RFP.

Subcontractor experience shall not be considered in determining whether the offeror meets the requirements set forth in Submittal Form F – Mandatory Requirements.

An offeror's failure to provide this information with their proposal may cause the state to consider their proposal non-responsive and reject it.

During the Clarification Period (RFP Section 5.20), the state will require a signed written statement from each subcontractor proposed in Submittal Form J – Subcontractors that clearly verifies the subcontractor is committed to performing the services required by the contract. Prior to the contract award, the state will also require evidence that each subcontractor possesses a valid Alaska Business License.

During the course of the contract, the substitution of one subcontractor for another may be made only at the discretion and prior written approval of the project director or contracting officer.

SEC. 3.14 JOINT VENTURES

Joint ventures are acceptable. If submitting a proposal as a joint venture, the offeror must submit a copy of the joint venture agreement which identifies the principals involved and their rights and responsibilities regarding performance and payment.

SEC. 3.15 RIGHT TO INSPECT PLACE OF BUSINESS

At reasonable times, the state may inspect those areas of the contractor's place of business that are related to the performance of a contract. If the state makes such an inspection, the contractor must provide reasonable assistance.

SEC. 3.16 CONTRACT PERSONNEL

Any change of the project team members named in the proposal must be approved, in advance and in writing, by the project director or contracting officer. Personnel changes that are not approved by the state may be grounds for the state to terminate the contract.

SEC. 3.17 INSPECTION & MODIFICATION – REIMBURSEMENT FOR UNACCEPTABLE DELIVERABLES

The contractor is responsible for the completion of all work set out in the contract. All work is subject to inspection, evaluation, and approval by the project director. The state may employ all reasonable means to ensure that the work is progressing and being performed in compliance with the contract. The project director may instruct the contractor to make corrections or modifications if needed in order to accomplish the contract's intent. The contractor will not unreasonably withhold such changes.

Substantial failure of the contractor to perform the contract may cause the state to terminate the contract. In this event, the state may require the contractor to reimburse monies paid (based on the identified portion of unacceptable work received) and may seek associated damages.

SEC. 3.18 CONTRACT CHANGES – UNANTICIPATED AMENDMENTS

During the course of this contract, the contractor may be required to perform additional work. That work will be within the general scope of the initial contract. When additional work is required, the project director will provide the contractor a written description of the additional work and request the contractor to submit a firm time schedule for accomplishing the additional work and a firm price for the additional work. Cost and pricing data must be provided to justify the cost of such amendments per AS 36.30.400.

The contractor will not commence additional work until the project director has secured any required state approvals necessary for the amendment and issued a written contract amendment, approved by the Commissioner of the Department of Administration or the Commissioner's designee.

SEC. 3.19 NONDISCLOSURE AND CONFIDENTIALITY

Contractor agrees that all confidential information shall be used only for purposes of providing the deliverables and performing the services specified herein and shall not disseminate or allow dissemination of confidential information except as provided for in this section. The contractor shall hold as confidential and will use reasonable care (including both facility physical security and electronic security) to prevent unauthorized access by, storage, disclosure, publication, dissemination to and/or use by third parties of, the confidential information. "Reasonable care" means compliance by the contractor with all applicable federal and state law, including the Social Security Act and HIPAA. The contractor must promptly notify the state in writing if it becomes aware of any storage, disclosure, loss, unauthorized access to or use of the confidential information and provide any required remedies. Confidential information, as used herein, means any data, files, software, information or materials (whether prepared by the state or its agents or advisors) in oral, electronic, tangible or intangible form and however stored, compiled or memorialized that is classified confidential as defined by State of Alaska classification and categorization guidelines provided by the state to the contractor or a contractor agent or otherwise made available to the contractor or a contractor agent in connection with this contract, or acquired, obtained or learned by the contractor or a contractor agent in the performance of this contract. Examples of confidential information include, but are not limited to: technology infrastructure, architecture, financial data, trade secrets, equipment specifications, user lists, passwords, research data, and technology data (infrastructure, architecture, operating systems, security tools, IP addresses, etc.).

If confidential information is requested to be disclosed by the contractor pursuant to a request received by a third party and such disclosure of the confidential information is required under applicable state or federal law, regulation, governmental or regulatory authority, the contractor may disclose the confidential information after providing the state with written notice of the requested disclosure (to the extent such notice to the state is permitted by applicable law) and giving the state opportunity to review the request. If the contractor receives no objection from the state, it may release the confidential information within 30 days. Notice of the requested disclosure of confidential information by the contractor must be provided to the state within a reasonable time after the contractor's receipt of notice of the requested disclosure and, upon request of the State, shall seek to obtain legal protection from the release of the confidential information.

The following information shall not be considered confidential information: information previously known to be public information when received from the other party; information freely available to the general public; information which now is or hereafter becomes publicly known by other than a breach of confidentiality hereof; or information which is disclosed by a party pursuant to subpoena or other legal process and which as a result becomes lawfully obtainable by the general public.

SEC. 3.20 INDEMNIFICATION

The contractor shall indemnify, hold harmless, and defend the state from and against any claim of, or liability for error, omission or negligent act of the contractor, its agents, or network pharmacies, under this agreement. The contractor shall not be required to indemnify the contracting agency for a claim of, or liability for, the independent negligence of the state. If there is a claim of, or liability for, the joint negligent error or omission of the contractor and the independent negligence of the state, the indemnification and hold harmless obligation shall be apportioned on a comparative fault basis. "Contractor" and "state", as used within this and the following article, include the employees, agents and other contractors who are directly responsible, respectively, to each. The term "independent negligence" is negligence other than in the contracting agency's selection, administration, monitoring, or controlling of the contractor and in approving or accepting the contractor's work.

SEC. 3.21 INSURANCE REQUIREMENTS

Without limiting contractor's indemnification, it is agreed that contractor shall purchase at its own expense and maintain in force at all times during the performance of services under this agreement the following policies of insurance. Where specific limits are shown, it is understood that they shall be the minimum acceptable limits. If

the contractor's policy contains higher limits, the state shall be entitled to coverage to the extent of such higher limits.

Certificates of Insurance must be furnished to the contracting officer prior to beginning work and must provide for a notice of cancellation, non-renewal, or material change of conditions in accordance with policy provisions. Failure to furnish satisfactory evidence of insurance or lapse of the policy is a material breach of this contract and shall be grounds for termination of the contractor's services. All insurance policies shall comply with and be issued by insurers licensed to transact the business of insurance under AS 21.

Workers' Compensation Insurance: The contractor shall provide and maintain, for all employees engaged in work under this contract, coverage as required by AS 23.30.045, and; where applicable, any other statutory obligations including but not limited to Federal U.S.L. & H. and Jones Act requirements. The policy must waive subrogation against the State.

Commercial General Liability Insurance: covering all business premises and operations used by the Contractor in the performance of services under this agreement with minimum coverage limits of \$300,000 combined single limit per claim.

Commercial Automobile Liability Insurance: covering all vehicles used by the contractor in the performance of services under this agreement with minimum coverage limits of \$300,000 combined single limit per claim.

Professional Liability Insurance: covering all errors, omissions or negligent acts in the performance of professional services under this agreement with minimum coverage limits of \$5,000,000 per claim /annual aggregate.

SEC. 3.22 TERMINATION FOR DEFAULT

If the project director or contracting officer determines that the contractor has refused to perform the work or has failed to perform the work with such diligence as to ensure its timely and accurate completion, the state may, by providing written notice to the contractor, terminate the contractor's right to proceed with part or all of the remaining work. This clause does not restrict the state's termination rights under the contract provisions of Appendix A, attached along with this RFP.

SECTION 4. PROPOSAL FORMAT AND CONTENT

SEC. 4.01 RFP SUBMITTAL FORMS

This RFP contains Submittal Forms, which must be completed by the offeror and submitted as their proposal. An electronic copy of form is posted along with this RFP. Offerors shall not re-create these forms, create their own forms, or edit the format structure of the forms unless permitted to do so. Do not exceed any page limits identified on the attachments. All attachment documents must be written in the English language, be single sided, and be single-spaced with a minimum font size of 10.

Unless otherwise specified in this RFP, the Submittal Forms shall be the offeror's entire proposal. Do not include any marketing information in the proposal.

Any proposal that does not follow these requirements may be deemed non-responsive and rejected.

SEC. 4.02 SPECIAL FORMATTING REQUIREMENTS

The offeror must ensure that their proposal meets all of the special formatting requirements identified in this section. This includes requirements regarding anonymity and maximum page limits.

Anonymity: Some Submittal Forms listed below must not contain any names that can be used to identify who the offeror is (such as company names, offeror name, company letterhead, personnel names, project names, subconsultant names, manufacturer or supplier names, or product names).

Page Limits: Some Submittal Forms listed below have maximum page limit requirements. Offerors must not exceed the maximum page limits. Note, the page limit applies to the front side of a page only (for example, '1 Page' implies that the offeror can only provide a response on one side of a piece of paper).

Submittal Form	Anonymous Document	Maximum Page Limits
Submittal Form A – Offeror Information and Certifications		
Submittal Form B – Service Approach – Network Plan (Commercial)	YES	4
Submittal Form B – Service Approach – Network Plan (EGWP)	YES	4
Submittal Form B – Service Approach – Customer & Member Support	YES	4
Submittal Form B – Service Approach – Medicare Part D Enhanced EGWP	YES	4
Submittal Form C – Risk Assessment Plan – Controllable Risks	YES	2
Submittal Form C – Risk Assessment Plan – Non-Controllable Risks	YES	2
Submittal Form D – Value Opportunity Assessment	YES	2
Submittal Form E – Performance Qualifications		
Submittal Form F – Mandatory Requirements		
Submittal Form G – Contractual Requirements		
Submittal Form H – GeoAccess Analysis		
Submittal Form I – Network Disruption Analysis		
Submittal Form J – Subcontractors		
Submittal Form K – Fee Schedule		

Any Submittal Form that is being evaluated and does not follow these instructions may receive a '1' score for the evaluated Submittal Form, or the entire response may be deemed non-responsive and rejected. The state also reserves the right, in its sole discretion, to modify a proposal to remove any minor information that may be non-compliant.

SEC. 4.03 OFFEROR INFORMATION AND CERTIFICATIONS (SUBMITTAL FORM A)

The offeror must complete and submit this Submittal Form. The form must be signed by an individual authorized to bind the offeror to the provisions of the RFP.

By signature on the form, the offeror certifies they comply with the following:

- a) the laws of the State of Alaska;
- b) the applicable portion of the Federal Civil Rights Act of 1964;
- c) the Equal Employment Opportunity Act and the regulations issued thereunder by the federal government;
- d) the Americans with Disabilities Act of 1990 and the regulations issued thereunder by the federal government;
- e) all terms and conditions set out in this RFP;
- f) a condition that the proposal submitted was independently arrived at, without collusion, under penalty of perjury;
- g) that the offers will remain open and valid for at least 90 days; and
- h) that programs, services, and activities provided to the general public under the resulting contract conform with the Americans with Disabilities Act of 1990, and the regulations issued thereunder by the federal government.

If any offeror fails to comply with [a] through [h] of this paragraph, the state reserves the right to disregard the proposal, terminate the contract, or consider the contractor in default.

The Submittal Form also requests the following information:

- a. The complete name and address of offeror's firm along with the offeror's Tax ID.
- b. Information on the person the state should contact regarding the proposal.
- c. Names of critical team members/personnel
- d. Addenda acknowledgement
- e. Conflict of interest statement
- f. Alaska preference qualifications

An offeror's failure to address/respond/include these items may cause the proposal to be determined to be non-responsive and the proposal may be rejected.

SEC. 4.04 SERVICE APPROACH (SUBMITTAL FORM B)

The offeror must complete and submit this Submittal Form. This document should demonstrate to the state that the offeror can visualize what they are going to do to successfully deliver this service. The service approach is separated into three major topics, which should summarize the following:

1. **Network Plan:** summarize the offeror's comprehensive network plan, operations, capabilities, and offerings, regarding retail, mail-order and specialty pharmacy networks for both a commercial plan and an enhanced EGWP plan.
2. **Customer and Member Support:** summarize the offeror's comprehensive customer service approach. This may include clinical and pharmacist support, advantages with the claims and appeals process, quality control procedures, and customer satisfaction.
3. **Medicare Part D Enhanced EGWP:** summarize the offeror's enhanced EGWP administrative capabilities. Provide any documented advantages to the program.

SPECIAL NOTE: The offeror must not disclose their costs in this Submittal Form. This form shall be kept anonymous and must not contain any names that can be used to identify who the offeror is, and cannot exceed the page limit (described in Section 4.02).

SEC. 4.05 RISK ASSESSMENT PLAN (SUBMITTAL FORM C)

The offeror must complete and submit this Submittal Form. The Risk Assessment Plan should address risks that may impact the successful delivery of this project, considering all expectations as described in this RFP. The offeror should list and prioritize major risk items that are unique and applicable to this project. This includes areas that may cause the project to not be completed on time, not finished within budget, generate any change orders, or may be a source of dissatisfaction for state. The offeror should rely on and use their experience and knowledge of completing similar projects to identify these potential risks.

Each risk should be described in non-technical terms and should contain enough information to describe to a reader why the risk is a valid risk. The offeror should also explain how it will avoid or minimize the risks from occurring. If the offeror has a unique method to minimize the risk, the offeror should explain it in non-technical terms. The Risk Assessment Plan gives the opportunity for the offeror to differentiate its capabilities based on its ability to visualize, understand, and minimize risk to the state and the risk to a successful outcome of the system. The offeror should categorize the 'risks' into the following definitions:

- a. **Assessment of Controllable Risks:** This includes risks, activities, or tasks that are controllable by the offeror, or by entities/individuals that are contracted to by the offeror. This includes things that are part of the technical scope of what the offeror is being hired to do. This may also include risks that have already been minimized before the project begins due to the offeror's expertise (i.e. risks that are no longer risks due to the offeror's expertise in delivering this type of project). All controllable risks and strategies to mitigate them must be included in the offeror's base proposal cost and schedule (if there are any impact at all).
- b. **Assessment of Non-Controllable Risks:** This includes risks, activities, or tasks that are not controllable by the offeror. This may include risks attributed by state, state personnel, parties hired by state, risks that are caused by other agencies, or completely uncontrollable risks. These can also be areas/risks that can contribute to contingency. Although these risks may not be controlled by the offeror, the offeror should identify a strategy that can be followed or used to mitigate these risks. All non-controllable risks and strategies to mitigate them must not be included in the offeror's base proposal cost or schedule.

Please use the following format when completing the Submittal Form:

- Risk = Title of the risk
- Description = A brief description of why the risk is a risk? Background of how the risk may impact the project/service if it occurs.
- Strategy = Strategy to prevent/minimize the risk from occurring, or strategy to minimize the impact of the risk if it occurs.

SPECIAL NOTE: The offeror shall not disclose their costs in this Submittal Form. This Submittal Form shall be kept anonymous and must not contain any names that can be used to identify who the offeror is and cannot exceed the page limit (as described in Section 4.02).

SEC. 4.06 VALUE OPPORTUNITY ASSESSMENT (SUBMITTAL FORM D)

The offeror must complete and submit this Submittal Form. The purpose of the Value Opportunity Assessment is to provide offerors with an opportunity to identify any value-added options or ideas that may benefit state, the project, or the service. If the offeror can include more scope or service within the constraints of state, the offeror should provide an outline of potential value-added options. This may include ideas or suggestions on alternatives

in implementation timelines, project scope, project cost, goals, deliverables, methodologies, etc. Value-added ideas must not be included in the offeror's base cost proposal.

Please use the following format when completing the Submittal Form:

- Idea = Title of the idea/opportunity
- Description = A brief description of why the idea adds value to the client or service (what benefits or impacts the idea will bring in the short/long term). Do not make any reference to the proposed cost, but you may refer to the potential impact to the cost and schedule in terms of estimated percentages.

SPECIAL NOTE: The offeror must not disclose their costs in this Submittal Form. This Submittal Form shall be kept anonymous and must not contain any names that can be used to identify who the offeror is and cannot exceed the page limit (as described in Section 4.02).

SEC. 4.07 PERFORMANCE QUALIFICATIONS (SUBMITTAL FORM E)

The offeror will be required to collect Performance Qualifications (PQ) as outlined in this section. The offeror will be responsible for collecting customer satisfaction surveys from clients/departments/references (herein referred to as 'references') and submitting this information with their proposal. PQ surveys will be required for both the offeror and the Account Manager (listed in Submittal Form A).

Step 1) Identify who to survey:

- Identify a list of past references that will complete the surveys
- The offeror should survey references that are highly satisfied with their work
- The offeror should survey references that have similar requirements (as outlined in this RFP)
- The survey must be evaluated by the owner. The survey cannot be completed by any third-party representatives/consultants of the owner
- The offeror must submit at least one survey and no more than three surveys evaluating the account manager. The offeror must submit three surveys evaluating the offeror/firm.

Step 2) Preparing the surveys:

- The offeror is responsible for preparing the surveys.
- The survey questionnaire is separated into three different parts. In order to receive credit for a returned survey, the offeror shall provide all required information in Parts A and B on the survey.
- The offeror shall enter their company name / key personnel names (in Part A of the survey)
- The offeror shall enter background information about the project being evaluated (in Part B of the survey). All information is required. Failure to provide this information, or listing "n/a" or "confidential" may result in no credit for the survey.

Step 3) Distributing and collecting the surveys:

- Prior to distributing the surveys, the offeror should contact each reference to ensure that they are able and willing to complete the survey.
- The offeror should fax, email, mail, or deliver the survey to each reference.
- The offeror must modify the return information (located at the bottom of the survey) so the survey is returned to the offeror for collection.
- The reference must provide their customer satisfaction ratings and any general comments in Part C of the Survey. All returned surveys must be evaluated and signed by the reference. If a survey is not signed, it will not be considered.

- The state may contact the reference to clarify a survey rating, check for accuracy, or to obtain additional information. If the reference cannot be contacted, the survey may be deleted and no credit given for that reference.
- Returned surveys must be packaged together and submitted with the proposal.
- Failing to submit surveys will not disqualify an offeror, but may significantly impact the offeror's overall competitiveness (the offeror will be given a 1 rating for their PQ score).

SEC. 4.08 MANDATORY REQUIREMENTS (SUBMITTAL FORM F)

The offeror must complete and submit this Submittal Form. In order to be considered responsive, the offeror must acknowledge that they can meet all mandatory technical requirements identified in Submittal Form F. An offeror's failure to respond, or failure to meet these minimum prior experience requirements may cause their proposal to immediately be considered non-responsive and their proposal may be rejected.

SEC. 4.09 CONTRACTUAL REQUIREMENTS (SUBMITTAL FORM G)

The offeror must complete and submit this Submittal Form.

SEC. 4.10 GEOACCESS ANALYSIS (SUBMITTAL FORM H)

The offeror must complete and submit this Submittal Form.

SEC. 4.11 NETWORK DISRUPTION ANALYSIS (SUBMITTAL FORM I)

The offeror must complete and submit this Submittal Form.

SEC. 4.12 SUBCONTRACTORS (SUBMITTAL FORM J)

The offeror must complete and submit this Submittal Form.

SEC. 4.13 FEE SCHEDULE (SUBMITTAL FORM K)

The offeror must complete and submit this Submittal Form.

Proposed costs must all direct and indirect costs associated with the performance of the contract, including, but not limited to, total number of hours at various hourly rates, direct expenses, payroll, supplies, overhead assigned to each person working on the project, percentage of each person's time devoted to the project, and profit.

SEC. 4.14 INTENT TO PROPOSE AND NON-DISCLOSURE AGREEMENT

To access the claims file and census files needed to prepare the Fee Schedule, GeoAccess Analysis and Network Disruption Analysis, the offeror must complete and submit an intent to propose and non-disclosure agreement form to the contracting officer, as provided as an attachment to this RFP. The agreement must be emailed to the contracting officer as an attachment. The offeror must also provide the phone number and email address of the person who is to receive the files.

The state will not furnish or provide these files to any offeror until receipt of this agreement. The state reserves the right to clarify and verify any offeror's ability to perform the services required under this solicitation prior to granting access to any of the files.

Upon receipt of the non-disclosure agreement and verification of the offeror's eligibility to receive the files, the offeror will be provided access to the following information:

Claims File: This file provides claims detail for the state for the period of October 2, 2016, through September 30, 2017. The file includes zip codes for all pharmacies utilized in the data period and should be used to conduct the Network Disruption Analysis.

Census Files: These files provide information including participant residence zip codes and should be utilized for the GeoAccess analysis.

The files will be provided to the offeror by the contracting officer via a secure file transfer site.

Under no circumstances will an offeror be provided the files via any other method than through the secure file transfer site.

SECTION 5. EVALUATION CRITERIA AND CONTRACTOR SELECTION

SEC. 5.01 THIRD-PARTY CONSULTING ASSISTANCE

The state has retained The Segal Group (Segal) as a subject matter expert to assist the state with this RFP process. This assistance includes:

- Developing language and content for the RFP.
- Attending and participating in the pre-proposal meetings.
- Developing the GeoAccess Analysis, Network Disruption Analysis, and Fee Schedule.
- Analyzing proposals and serving as an overall technical industry resource for the proposal evaluation committee (PEC).
- Analyzing and developing reports related to the proposals, contractual requirements responses, GeoAccess Analysis, Network Disruption Analysis, and Submittal Form K - Fee Schedule.
- Presenting findings from analysis to procurement and the PEC at the PEC meeting(s).
- Developing questions and areas of interest for the interviews and attending interviews.
- Attending meetings and assisting the state during the clarification period (reference RFP Section 5.20).

SEC. 5.02 SUMMARY OF EVALUATION PROCESS

The state will use the following steps to evaluate and prioritize proposals:

- 1) Proposals will be assessed for overall responsiveness and compliance with mandatory requirements. Proposals deemed non-responsive or not in compliance with mandatory requirements will be eliminated from further consideration.
- 2) Each responsive proposal that has passed all mandatory requirements will be assigned a unique code.
- 3) A proposal evaluation committee (PEC), made up of at least three state employees or public officials, will evaluate specific parts of the responsive proposals.
- 4) The anonymous Submittal Forms, from each responsive proposal, will be sent to the PEC. No cost information, schedule information, or team information will be shared or provided to the PEC.
- 5) The PEC will independently evaluate and score the documents based on the degree to which the proposal has met the requirements of the Submittal Form.
- 6) After independent scoring, the PEC will have a meeting, chaired by the contracting officer, where the PEC will have a group discussion prior to finalizing their scores. Prior to the meeting, Segal will analyze the proposals, GeoAccess Analysis, and Network Disruption Analysis, and present their analysis in writing to the contracting officer. This analysis will also be anonymous and will be reviewed by the contracting officer to ensure anonymity prior to sending to the PEC for the group meeting. The PEC may take the analysis into consideration prior to finalizing their scores. Segal may also participate in the PEC meeting but will provide any identifying information in any discussions with PEC members prior to the PEC members finalizing their scores.
- 7) The evaluators will submit their final individual scores to the contracting officer, who will then average and compile the evaluator's scores.
- 8) Segal will perform the financial analysis of Submittal Form K (see Section 5.10 for details on this analysis, including the points allocations).
- 9) The contracting officer will prioritize the proposals based on: evaluator scores, fee/cost information, and Alaska preferences (as outlined in this section).
- 10) The contracting officer may shortlist the proposals and the state may conduct interviews with the top-rated offerors. Segal may assist in preparing questions for the interviews and assisting the state with follow-up questions during the interviews.

- 11) The PEC will evaluate and score the interviews and submit their scores to the contracting officer, who will incorporate these scores into the final prioritization. The PEC may consult with Segal for technical assistance before finalizing the interview scores.
- 12) The state, with Segal’s assistance, will then conduct clarifications, negotiations, and award a contract if the clarifications and negotiations are successful.

SEC. 5.03 EVALUATION CRITERIA

Proposals will be evaluated based on their overall value to state, considering both cost and non-cost factors as described below. Note: An evaluation may not be based on discrimination due to the race, religion, color, national origin, sex, age, marital status, pregnancy, parenthood, disability, or political affiliation of the offeror.

Overall Criteria		Weight
Responsiveness		Pass/Fail
Mandatory Requirements Compliance	(Submittal Form F)	Pass/Fail

Qualifications Criteria		Weight
Service Approach – Network Plan (Commercial and EGWP)	(Submittal Form B)	50
Service Approach – Customer & Member Support	(Submittal Form B)	25
Service Approach – Medicare Part D Enhanced EGWP	(Submittal Form B)	20
Risk Assessment Plan	(Submittal Form C)	100
Value Opportunity Assessment	(Submittal Form D)	75
Performance Qualifications	(Submittal Form E)	10
Interviews – Account Manager		30
Interviews – Implementation Manager		30
Interviews – Clinical Pharmacist		30
Interviews – Member Services Manager		30
Total		400

Cost Criteria		Weight
Fee Schedule		500
Total		500

SEC. 5.04 SCORING METHOD AND CALCULATION

The PEC will evaluate responses against the questions set out in Sections 5.05 through 5.09 and assign a single score for each section. Offeror’s responses for each section will be rated comparatively against one another with each PEC member assigning a score of 1, 5, or 10 (with 10 representing the highest score, 5 representing the average score, and 1 representing the lowest score). Responses that are similar or lack dominant information to differentiate the offerors from each other will receive the same score. Therefore, it is the offeror’s responsibility to provide dominant information and differentiate themselves from their competitors.

After the PEC has scored each section, the scores for each section will be totaled and the following formula will be used to calculate the amount of points awarded for that section:

$$\frac{\text{Offeror Total Score}}{\text{Highest Total Score}} \times \text{Max Points} = \text{Points Awarded}$$

Example (Max Points for the Section = 100):

	PEC Member 1 Total Score	PEC Member 2 Total Score	PEC Member 3 Total Score	PEC Member 4 Total Score	Combined Total Score	Award Points
Offeror 1	10	5	5	10	30	75
Offeror 2	5	5	5	5	20	50
Offeror 3	10	10	10	10	40	100

In this example, **Offeror 3** received the highest combined total score and thus was awarded the maximum amount of points for that section.

Offeror 1 was awarded 75 points:

$$\frac{\text{Offeror Total Score (30)}}{\text{Highest Total Score (40)}} \times \text{Max Points (100)} = \text{Points Awarded (75)}$$

Offeror 2 was awarded 50 points:

$$\frac{\text{Offeror Total Score (20)}}{\text{Highest Total Score (40)}} \times \text{Max Points (100)} = \text{Points Awarded (50)}$$

SEC. 5.05 MANDATORY TECHNICAL REQUIREMENTS (PASS/FAIL)

The offeror must confirm that they meet all mandatory requirements as identified in Submittal Form F. An offeror's failure to meet these requirements will cause their proposal to be considered non-responsive and rejected.

SEC. 5.06 SERVICE APPROACH

Each portion of the Service Approach (Network Plan, Customer & Member Support, and Medicare Part D Enhanced EGWP) will be evaluated against the following questions:

- 1) How well has the offeror demonstrated an understanding of the purpose and scope of the project?
- 2) How logical is the approach/methodology to fulfilling the scope objectives and goals of the state?
- 3) How well has the offeror demonstrated an understanding of the deliverables the state expects it to provide?

SEC. 5.07 RISK ASSESSMENT PLAN

The Risk Assessment Plan will be evaluated against the questions set out below:

- 1) How well has the offeror identified pertinent risks, issues, challenges, and potential problems related to this specific project/service?
- 2) How well has the offeror identified a clear and concise approach/methodology that can logically mitigate the risks?
- 3) The offeror's ability to provide verifiable documented results of mitigation strategies (the impacts of their mitigation approach).

SEC. 5.08 VALUE OPPORTUNITY ASSESSMENT

The Value Opportunity Assessment will be evaluated against the questions set out below:

- 1) How well has the offeror identified pertinent ideas or opportunities that are specific to this project/service?
- 2) The offeror's ability to provide verifiable documented results of the ideas/opportunities (actual impacts of these ideas).

SEC. 5.09 PERFORMANCE QUALIFICATIONS

Experience will be evaluated against the customer satisfaction with the offeror and the account manager as outlined below. Note: These scores will not be evaluated/scored by an evaluation committee. The state will use the actual average scores in the analysis.

- 1) Regarding the firm: The customer satisfaction ratings will be averaged together to obtain an overall average customer satisfaction rating.
- 2) Regarding the account manager: The customer satisfaction ratings will be averaged together to obtain an overall average customer satisfaction rating.

The offeror with the highest average ratings will received the maximum number of points for this section. Points will be awarded to the other offerors using the formula set out in Section 5.04.

SEC. 5.10 CONTRACT COST

Costs will not be evaluated/scored by the PEC. Offerors must use the tables in Submittal Form K – Fee Schedule to display their proposed fees. Please note that pricing terms should be offered on your proposed traditional or transparent basis with 100% pass through rebates. Footnotes to the form(s) may be used to provide supplemental explanations, if necessary.

Segal will then perform a financial analysis of the proposed fees and produce a document equivalent to the document titled RFP Results – Financial, provided as an attachment to the RFP. Segal utilizes client specific claims data to get average per drug wholesale unit costs. These costs and utilization statistics are then trended to the renewal contract period using Segal's internal industry assumptions for market trends, and then each bidder's proposed pricing guarantees are applied to trended costs. In this way, each bid is compared using the client specific utilization and spending patterns and projected forward using Segal's industry knowledge on emerging drug market trends.

The RFP Results – Financial document will display the total costs for each offeror. The distribution of points based on cost will be determined as set out in 2 AAC 12.260(c). After the contracting officer applies any applicable preferences, the offeror with the lowest total costs will receive the maximum number of points allocated to cost. The point allocations for cost on the other proposals will be determined using the following formula:

$$[(\text{Price of Lowest Cost Proposal}) \times (\text{Maximum Points for Cost})] \div (\text{Cost of Each Higher Priced Proposal})$$

SEC. 5.11 NETWORK DISRUPTION ANALYSIS AND GEOACCESS ANALYSIS

These documents will not be scored. They will be analyzed by Segal and Segal may present their findings to the PEC for consideration after the PEC has completed their initial round of individual scoring. Segal will evaluate the Network Disruption Analysis based upon the information submitted in proposals and will be measured upon the pharmacies used by the active and retired participants in the plans for which a proposal is being submitted, as measured from the experience of the plan over the past one year. Special consideration will be made of the offeror's ability to provide a network of providers in all of the areas in which participants reside (including rural and remote areas). The census file submitted to offerors includes residence zip code locations. Network disruption will be analyzed as follows:

- The percentage of pharmacy dispensing facilities in the offeror's network that dispensed prescriptions and are included in the claims data file.
- An evaluation of the number of facilities that are available to participants based upon a distribution within the state.

SEC. 5.12 APPLICATION OF PREFERENCES

Certain preferences apply to all contracts for professional services, regardless of their dollar value. The Alaska Bidder, Alaska Veteran, and Alaska Offeror preferences are the most common preferences involved in the RFP process. Additional preferences that may apply to this procurement are listed below. Guides that contain excerpts from the relevant statutes and codes, explain when the preferences apply and provide examples of how to calculate the preferences are available at the following website:

<http://doa.alaska.gov/dgs/pdf/pref1.pdf>

- Alaska Products Preference - AS 36.30.332
- Recycled Products Preference - AS 36.30.337
- Local Agriculture and Fisheries Products Preference - AS 36.15.050
- Employment Program Preference - AS 36.30.321(b)
- Alaskans with Disabilities Preference - AS 36.30.321(d)
- Alaska Veteran's Preference - AS 36.30.321(f)

The Division of Vocational Rehabilitation in the Department of Labor and Workforce Development keeps a list of qualified employment programs and individuals who qualify as persons with a disability. As evidence of a business' or an individual's right to the Employment Program or Alaskans with Disabilities preferences, the Division of Vocational Rehabilitation will issue a certification letter. To take advantage of these preferences, a business or individual must be on the appropriate Division of Vocational Rehabilitation list prior to the time designated for receipt of proposals. Offerors must attach a copy of their certification letter to the proposal. **An offeror's failure to provide this certification letter with their proposal will cause the State to disallow the preference.**

Sec. 5.13 ALASKA BIDDER PREFERENCE

An Alaska Bidder Preference of 5% will be applied to the price in the proposal. The preference will be given to an offeror who:

- 1) holds a current Alaska business license prior to the deadline for receipt of proposals;
- 2) submits a proposal for goods or services under the name appearing on the offeror's current Alaska business license;
- 3) has maintained a place of business within the State staffed by the offeror, or an employee of the offeror, for a period of six months immediately preceding the date of the proposal;
- 4) is incorporated or qualified to do business under the laws of the State, is a sole proprietorship and the proprietor is a resident of the State, is a limited liability company (LLC) organized under AS 10.50 and all members are residents of the State, or is a partnership under AS 32.06 or AS 32.11 and all partners are residents of the State; and
- 5) if a joint venture, is composed entirely of ventures that qualify under (1)-(4) of this subsection.

SEC. 5.14 ALASKA VETERAN PREFERENCE

An Alaska Veteran Preference of 5%, not to exceed \$5,000, will be applied to the price in the proposal. The preference will be given to an offeror who qualifies under AS 36.30.990(2) as an Alaska bidder and is a:

- A. sole proprietorship owned by an Alaska veteran;
- B. partnership under AS 32.06 or AS 32.11 if a majority of the partners are Alaska veterans;
- C. limited liability company organized under AS 10.50 if a majority of the members are Alaska veterans; or
- D. corporation that is wholly owned by individuals, and a majority of the individuals are Alaska veterans.

SEC. 5.15 ALASKA OFFEROR PREFERENCE

If an offeror qualifies for the Alaska Bidder Preference, the offeror will receive an Alaska Offeror Preference. 2 AAC 12.260(e) provides Alaska offerors a 10% overall evaluation point preference. Alaska bidders, as defined in AS 36.30.990(2), are eligible for the preference. An Alaska offeror will receive 10 percent of the total available points added to their overall evaluation score as a preference.

SEC. 5.16 SHORTLISTING

After proposals have been prioritized, the state may shortlist and interview the top three highest ranking offerors. The state may increase or decrease the number of offerors in this list based on the competitiveness of the proposals and/or from feedback from the PEC.

SEC. 5.17 INTERVIEWS OF KEY PERSONNEL

The state may conduct interviews with the key personnel from each of the shortlisted offerors, as identified below (the state reserves the right to request additional personnel):

- 1) **Account Manager** – Individual that will lead the overall program/service and will be responsible for the day-to-day operations of the program
- 2) **Implementation Manager** – The implementation manager coordinates all set-up activities, team members, and deadlines.
- 3) **Clinical Pharmacist** – Provides clinical management for the plan, including oversight or prior authorizations, formularies, and adherence to evidence based guidelines.
- 4) **Member Services Manager** – The person in charge of ensuring the customer service representatives are trained and prepared to provide accurate information and exceptional customer service to members.

The individuals that will be interviewed must be the same individuals that are identified in Submittal Form A of the offeror’s proposal. No substitutes, proxies, phone interviews, or electronic interviews will be allowed. No other individuals (from the offeror’s organization) will be allowed to sit in or participate during the interview session. Individuals who fail to attend the interview will be given a “1” score, which may jeopardize the offeror’s competitiveness.

Interviews are expected to last approximately 30 minutes per individual. Interviewees may not bring notes, presentation materials, or handouts. The state will interview individuals separately (not as a team). Interviewees may be prohibited from making any reference to their proposed cost/fees. Interviewees may be asked questions regarding their experience, knowledge and understanding of the scope of work, obstacles and challenges, strategies, and their plan/approach. The state may request additional information prior to interviews. Segal will attend interviews and may assist the state in asking follow up questions during the interviews. The PEC will score each interview individually, and may consult with Segal before finalizing the interview scores.

SEC. 5.18 FINAL PRIORITIZATION

After the shortlisted offerors have been interviewed and scored by the PEC, the contracting officer will compile all scores and perform a final prioritization of offerors.

SEC. 5.19 COST REASONABLENESS

Prior to performing clarifications and negotiations, the contracting officer will perform a cost reasonableness assessment of all shortlisted proposals in the following manner:

- a. If the highest prioritized offeror’s total cost points is within 5% of the second highest prioritized offeror’s total cost points, the state reserves the right to proceed to invite the highest prioritized offeror to the clarification period.

- b. If the highest prioritized offeror exceeds this range, the state reserves the right to invite the second highest prioritized offeror to the clarification period.

SEC. 5.20 CLARIFICATION PERIOD

The state will invite the highest (or second highest) prioritized offeror to the clarification period. The clarification period is carried out prior to the signing of a contract. The intent of this period is to allow the apparent best-value offeror an opportunity to clarify any assumptions, issues, or risks, and confirm that their proposal is accurate. The state's objective is to have the services completed on time, without any cost increases, in a timely and efficient manner, and with high customer satisfaction. It is the offeror's responsibility to ensure that the offeror understands the state's expectations. The offeror is at risk, and part of the risk is understanding state's expectations.

The offeror will be required to pre-plan the project in detail to ensure that there are no surprises, and to prepare a clarification document (which will be incorporated into the contract), containing at a minimum the information as described below:

- a. Verify the Fee/Cost Proposal: Clarify the fee schedule. The offeror is expected, in good faith, to incorporate in and submit any additional data, supporting schedules, or substantiation reasonably required.
- b. Provide a Project Schedule: Prepare a high-level schedule of the project (with major milestones or tasks). If requested, prepare a detailed milestone schedule. This may include transition and implementation.
- c. Provide a Client Action Item Schedule: Prepare a schedule of any/all activities, actions, or decisions needed from the state (including specific due dates and client names responsible for the activities). This must be a separate document from the overall project schedule. This should be provided in a very simple format. Identify the roles and responsibilities of the state or its personnel
- d. Align Expectations: Coordinate the project/service (schedule, cost, activities) with all critical parties (subcontractors, consultants, suppliers, manufacturers, networks, etc.). Create a detailed project plan. Review any unique technical requirements with the state.
- e. Key Assumptions: Provide a summary of the major assumptions that have been made in preparing the proposal. This should include items/tasks that the offeror has assumed the state will perform, items/tasks required from the state, and items/tasks that have not been included in the proposal (items that the offeror feels are outside the scope of work). This should also include any critical expectations or responsibilities that the offeror has of the state, state personnel, or other parties/organizations that are not contracted to by the offeror.
- f. Risk Mitigation Approach: Identify all risks, activities, or concerns that may be unforeseen or not within the control of the offeror. This should include everything (realistically) that may prevent the offeror from being successful on this project. This may include: contractor risks, designer risks, owner risks, other party risks, and unforeseen risks. Identify if there are any strategies to mitigate these items. Provide a plan of how unforeseen risks will be managed. Identify what (if anything) concerns you the most, or is very unique about this project
- g. Financial Resources and Responsibility: Provide necessary information on the offeror's ability to meet its financial obligations. Financial analysis includes and is not limited to standard accounting ratio analysis. Offeror will be required to provide the most recent three years audited financial statements (Balance Sheet, Income Statement, and Cash-Flow Statement), including notes to the financial statements or the period of the company's existence, if shorter. Provide the most recent interim financial statements.

Required if the latest available financial statement date is six months or more than the RFP document submission date. Interim financial statements must be signed and attested to by an authorized officer as a fair representation, in all material aspects, of the company's financial condition in accordance with generally accepted accounting principles. Provide any subconsultant's financial stability information and qualifications of the subconsultant's key personnel (if the subconsultant will perform at least 25% of the work). The state may request clarifications or additional documentation, other than the aforementioned documents as stated above. However, no request by the offeror to submit additional information for re-evaluation of financial resources and responsibility will be accepted.

- h. Provide an organizational chart specific to the personnel assigned to accomplish the work called for in this RFP; illustrate the lines of authority; designate the individual responsible and accountable for the completion of each component and deliverable of the RFP. If requested, provide resumes on all key personnel.
- i. Provide any additional requested documentation: Provide a detailed project/work plan, past and current client references, staffing plans, contracts, insurance, background checks, additional references and reference information, etc.

The potential best-value offeror will be required to conduct and participate in several meetings throughout the clarification period. At a minimum, the state will require the offeror to conduct a kickoff meeting at the beginning of the clarification period. The offeror will lead the kickoff meeting and is expected to be prepared to present the following information:

- Description of their plan for project execution and management
- High level schedule for project delivery
- Address any major concerns provided by the state
- Address all project assumptions
- Identify major risks to project delivery (focusing on risks that the offeror does not directly control) and the associated risk mitigation strategy. Clearly identify any information or actions needed from the state to support successful project delivery.
- Propose a schedule for items that must be reviewed in detail and resolved during the clarification period.

The potential best-value offeror will be required to hold a final summary meeting at the end of the clarification period. This meeting is to present a summary of the final details that were discussed and resolved during the clarification period. The offeror will lead the meeting to present the entire proposal, project execution plan, and identified risks and mitigation plans.

The state reserves the right at its sole discretion to negotiate with the potential best-value offeror during the clarification period. This may include, but is not limited to, modifying the scope of the project (time, cost, quality, expectations, etc.). An invitation to the clarification period does not constitute a legally binding offer to enter into a contract on the part of the state to the offeror. At any time during the clarification period, if the state is not satisfied with the progress being made by the invited offeror, the offeror fails to provide the information in a timely manner, fails to negotiate in good faith, or if the offeror and the state fail to agree to terms or fail execute a contract, the state may terminate the clarification period activities and then commence or resume a new clarification period with an alternative offeror.

SEC. 5.21 OFFEROR NOTIFICATION OF SELECTION

If the state and offeror are able to agree to terms and complete the clarification period, the contracting officer will issue a written Notice of Intent to Award (NIA) and send copies to all offerors who submitted proposals. The NIA will set out the names of all offerors and identify the proposal selected for award.

SECTION 6. POST AWARD PROCEDURES AND ACTIVITIES

SEC. 6.01 INFORMAL DEBRIEFING

When the contract is completed, an informal debriefing may be performed at the discretion of the contracting officer or project director or contracting officer. If performed, the scope of the debriefing will be limited to the work performed by the contractor.

SEC. 6.02 MONTHLY REPORTING

The state will require the awarded contractor to prepare and submit monthly reports. These reports are a tool for the state in analyzing changes or addressing issues that may occur throughout the contract period. A change or issue is defined as anything that impacts (or may potentially impact) the contract costs or contract schedule/duration. This includes deviations that are caused by:

- The contractor (or entities contracted by the state)
- The state (scope changes or client-caused deviations)
- Third parties (which are not hired or contracted by the contractor)
- Unforeseen conditions

The monthly report is an MS Excel spreadsheet file. As new or potential deviations occur (to cost or schedule), the contractor must identify it in the report, along with a short and concise description of the deviation, reasons why the deviation occurred, and a plan/strategy to mitigate the deviation. Each deviation must have an estimated impact to the awarded cost or awarded schedule.

A template shall be provided by the state and must be used. The contractor will not be permitted to recreate or modify this template in any way. The state will assist the contractor in setting up this spreadsheet but it is the contractor's responsibility to complete and submit these reports as required. Note: These reports do not substitute or eliminate progress reports or any other traditional reporting systems or meetings (that the contractor may perform).

The monthly report must be prepared and submitted by the contractor the first day of every month. If the first day of the month is on the weekend, the report shall be submitted the following Monday. The state will review and analyze each monthly report for accuracy, following format requirements, and timely submittals.

SEC. 6.03 PERFORMANCE EVALUATIONS

The awarded contractor will be closely monitored for contract compliance. In summary, the state will evaluate the contractor's overall performance on the awarded contract. This may include, but is not limited to:

- Ability to follow state rules, policies, and regulations
- Ability to successfully manage and deliver the project
- Ability to minimize delays
- Ability to minimize cost increases
- Ability to provide and submit accurate monthly reports
- Overall quality and performance of the services
- Accuracy of billing

- Responsiveness to correct deficiencies
- Conformance to the terms and conditions of the contract

The project evaluation assessment will be performed at regular intervals. These ratings may be used and considered during the solicitation and competition of future projects within the State of Alaska.

SECTION 7. GENERAL LEGAL INFORMATION

SEC. 7.01 ALASKA BUSINESS LICENSE AND OTHER REQUIRED LICENSES

Prior to the award of a contract, an offeror must hold a valid Alaska business license. However, in order to receive the Alaska Bidder Preference and other related preferences, such as the Alaska Veteran and Alaska Offeror Preference, an offeror must hold a valid Alaska business license prior to the deadline for receipt of proposals. Offerors should contact the **Department of Commerce, Community and Economic Development, Division of Corporations, Business, and Professional Licensing, PO Box 110806, Juneau, Alaska 99811-0806**, for information on these licenses. Acceptable evidence that the offeror possesses a valid Alaska business license may consist of any one of the following:

- copy of an Alaska business license;
- certification on the proposal that the offeror has a valid Alaska business license and has included the license number in the proposal;
- a canceled check for the Alaska business license fee;
- a copy of the Alaska business license application with a receipt stamp from the State's occupational licensing office; or
- a sworn and notarized statement that the offeror has applied and paid for the Alaska business license.

You are not required to hold a valid Alaska business license at the time proposals are opened if you possess one of the following licenses and are offering services or supplies under that specific line of business:

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

Prior the deadline for receipt of proposals, all offerors must hold any other necessary applicable professional licenses required by Alaska Statute.

SEC. 7.02 STANDARD CONTRACT PROVISIONS

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

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

SEC. 7.03 PROPOSAL AS A PART OF THE CONTRACT

Part or all of this RFP and the successful proposal may be incorporated into the contract.

SEC. 7.04 ADDITIONAL TERMS AND CONDITIONS

The state reserves the right to add terms and conditions during contract negotiations. These terms and conditions will be within the scope of the RFP and will not affect the proposal evaluations.

SEC. 7.05 HUMAN TRAFFICKING

By signature on their proposal, the offeror certifies that the offeror is not established and headquartered or incorporated and headquartered in a country recognized as Tier 3 in the most recent United States Department of State's Trafficking in Persons Report. The most recent United States Department of State's Trafficking in Persons Report can be found at the following website: <http://www.state.gov/j/tip/>

Failure to comply with this requirement will cause the state to reject the proposal as non-responsive, or cancel the contract.

SEC. 7.06 RIGHT OF REJECTION

Offerors must comply with all of the terms of the RFP, the State Procurement Code (AS 36.30), and all applicable local, state, and federal laws, codes, and regulations. The contracting officer may reject any proposal that does not comply with all of the material and substantial terms, conditions, and performance requirements of the RFP. Offerors may not qualify the proposal nor restrict the rights of the state. If an offeror does so, the contracting officer may determine the proposal to be a non-responsive counter-offer and the proposal may be rejected.

Minor informalities that:

- do not affect responsiveness;
- are merely a matter of form or format;
- do not change the relative standing or otherwise prejudice other offers;
- do not change the meaning or scope of the RFP;
- are trivial, negligible, or immaterial in nature;
- do not reflect a material change in the work; or
- do not constitute a substantial reservation against a requirement or provision;

may be waived by the contracting officer.

The state reserves the right to refrain from making an award if it determines that to be in its best interest. **A proposal from a debarred or suspended offeror shall be rejected.**

SEC. 7.07 STATE NOT RESPONSIBLE FOR PREPARATION COSTS

The state will not pay any cost associated with the preparation, submittal, presentation, or evaluation of any proposal.

SEC. 7.08 DISCLOSURE OF PROPOSAL CONTENTS

All proposals and other material submitted become the property of the State of Alaska and may be returned only at the state's option. AS 40.25.110 requires public records to be open to reasonable inspection. All proposal information, including detailed price and cost information, will be held in confidence during the evaluation process and prior to the time a Notice of Intent to Award is issued. Thereafter, proposals will become public information.

Trade secrets and other proprietary data contained in proposals may be held confidential if the offeror requests, in writing, that the contracting officer does so, and if the contracting officer agrees, in writing, to do so. The offeror's request must be included with the proposal, must clearly identify the information they wish to be held confidential, and include a statement that sets out the reasons for confidentiality. Unless the contracting officer agrees in writing to hold the requested information confidential, that information will also become public after the Notice of Intent to Award is issued.

SEC. 7.09 ASSIGNMENT

Per 2 AAC 12.480, the contractor may not transfer or assign any portion of the contract without prior written approval from the contracting officer.

SEC. 7.10 DISPUTES

A contract resulting from this RFP is governed by the laws of the State of Alaska. If the contractor has a claim arising in connection with the agreement that it cannot resolve with the State by mutual agreement, it shall pursue the claim, if at all, in accordance with the provisions of AS 36.30.620 – AS 36.30.632. To the extent not otherwise governed by the preceding, the claim shall be brought only in the Superior Court of the State of Alaska and not elsewhere.

SEC. 7.11 SEVERABILITY

If any provision of the contract or agreement is declared by a court to be illegal or in conflict with any law, the validity of the remaining terms and provisions will not be affected; and, the rights and obligations of the parties will be construed and enforced as if the contract did not contain the particular provision held to be invalid.

SEC. 7.12 SUPPLEMENTAL TERMS AND CONDITIONS

Proposals must comply with Section 7.05 Right of Rejection. However, if the state fails to identify or detect supplemental terms or conditions that conflict with those contained in this RFP or that diminish the state's rights under any contract resulting from the RFP, the term(s) or condition(s) will be considered null and void. After award of contract:

If conflict arises between a supplemental term or condition included in the proposal and a term or condition of the RFP, the term or condition of the RFP will prevail; and

If the state's rights would be diminished as a result of application of a supplemental term or condition included in the proposal, the supplemental term or condition will be considered null and void.

SEC. 7.13 CONTRACT INVALIDATION

If any provision of this contract is found to be invalid, such invalidation will not be construed to invalidate the entire contract.

SEC. 7.14 SOLICITATION ADVERTISING

Public notice has been provided in accordance with 2 AAC 12.220.

SEC. 7.15 SITE INSPECTION

The state may conduct on-site visits to evaluate the offeror's capacity to perform the contract. An offeror must agree, at risk of being found non-responsive and having its proposal rejected, to provide the state reasonable access to relevant portions of its work sites. Individuals designated by the contracting officer at the state's expense will make site inspection.

SEC. 7.16 PROTEST

AS 36.30.560 provides that an interested party may protest the content of the RFP.

An interested party is defined in 2 AAC 12.990(a) (7) as "an actual or prospective bidder or offeror whose economic interest might be affected substantially and directly by the issuance of a contract solicitation, the award of a contract, or the failure to award a contract."

If an interested party wishes to protest the content of a solicitation, the protest must be received, in writing, by the contracting officer at least ten days prior to the deadline for receipt of proposals.

AS 36.30.560 also provides that an interested party may protest the award of a contract or the proposed award of a contract.

If an offeror wishes to protest the award of a contract or the proposed award of a contract, the protest must be received, in writing, by the contracting officer within ten days after the date the Notice of Intent to Award the contract is issued.

A protester must have submitted a proposal in order to have sufficient standing to protest the proposed award of a contract. Protests must include the following information:

- the name, address, and telephone number of the protester;
- the signature of the protester or the protester's representative;
- identification of the contracting agency and the solicitation or contract at issue;
- a detailed statement of the legal and factual grounds of the protest including copies of relevant documents; and the form of relief requested.

Fax copies containing a signature are acceptable.

The contracting officer will issue a written response to the protest. The response will set out the contracting officer's decision and contain the basis of the decision within the statutory time limit in AS 36.30.580. A copy of the decision will be furnished to the protester by certified mail, fax or another method that provides evidence of receipt.

All offerors will be notified of any protest. The review of protests, decisions of the contracting officer, appeals, and hearings, will be conducted in accordance with the State Procurement Code (AS 36.30), Article 8 "Legal and Contractual Remedies."

STATE OF ALASKA
Department of Administration
Division of Retirement and Benefits



PHARMACY BENEFIT MANAGEMENT (PBM) SERVICES

RFP 180000053

Amendment #1

February 9, 2018

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

A handwritten signature in blue ink that reads "Jason Grove".

Jason Grove, CPPB

Contracting Officer

Phone: (907) 465-5679

Email: jason.grove@alaska.gov

Questions submitted by potential offerors and answers from the state:

Question 1: Our company is interesting in responding to your RFP and feel we can offer some solutions and cost savings for the state, however we do not meet the following RFP requirements:

Confirm your organization is contracted directly with CMS to provide an enhanced EGWP and subcontractors will not be used to provide any enhanced EGWP services to the state.

Confirm your organization has at least 3 million covered lives across your pharmacy benefit management book of business.

We do not have 3,000,000 million lives under management. We are slightly under a million currently. However, our company does have the talent, depth and breadth of knowledge to be able to provide excellent service to your membership. We are owned by a publicly traded company and

have multiple years of experience in servicing and providing proven cost savings strategies to support pharmacy benefit plans across the nation. We would respectfully request that the RFP is modified to remove this requirement or change the threshold to a lower value such as 500,000.

The second requirement we do not currently meet is the direct contract with CMS for an EGWP. We currently provide subcontractor services for multiple MA-PD plans across the nation and have provided these services since 2006. We also support several directly contracted EGWPs that the company themselves has a direct contract with CMS. We have assisted the plan in submitting the application and all filing requirements in these situations, and can offer subcontractor services. We feel that our 12 plus years of experience will greatly benefit your plan, and would respectfully request that the criteria is changed to allow for experience in supporting a EGWP plan to meet the requirements versus holding a direct contract.

Alternatively, if the above two considerations are not allowed we would like to be allowed to submit a proposal to be a Specialty Benefit Manager for your plan's Specialty Drug spend. Our company and our parent have decades of experience in managing specialty medications and would respectfully request the opportunity to provide a Specialty Benefit Manager proposal to the state.

Answer:

It is imperative that our pharmacy benefit manager have the depth and breadth of expertise, experience and resources associated with a sizable book of business. Our plan's membership is diverse and can be demanding. However, upon further consideration, we believe that a bidder with a book of business of at least 2,500,000 will possess these critical characteristics. This requirement has been updated in Submittal Form F – Mandatory Requirements.

Due to the size of the AlaskaCare Medicare membership and the diverse and complex nature of their individual circumstances, it is imperative that the primary contractor have a direct relationship with CMS. Our program provides retiree health care to every employee that retires from one of the 200 participating public entities in the State of Alaska, many of whom move to, or spend considerable time outside of Alaska in retirement. It is imperative that our pharmacy benefit manager have the stability and flexibility associated with a direct CMS relationship.

Regarding the request to provide a Specialty Benefit Manager proposal to the state, the offeror must be able provide the full of range of services required by the RFP. Alternative proposals for this RFP are not permitted.

Question 2: Regarding the RFP Results – Financial document, will the state score the PBM bidders for the two prescription drug plans on a combined or separate scoring basis?

Answer:

Segal will analyze the Commercial and EGWP plans (Submittal Form K) separately and then combine to produce the total costs as indicated in the RFP Results – Financial document. The contracting officer will then award the maximum points for cost (500) to the offeror with the lowest total costs. The other offerors will be awarded points using the formula set out in Section 5.10 of the RFP.

Question 3: Will the state allow a vendor to provide PBM services for only one of the two prescription drug plans (Commercial plan and EGWP plan?).

Answer: No. The vendor will need to provide PBM services for both plans.

Question 4: Section 3.13 of the RFP says that “subcontractor experience shall not be considered in determining whether the offeror meets the requirements set forth in Submittal Form F – Mandatory Requirements.” Would you be able to elaborate on the reason for and objective of this requirement? Is 3.13 absolute, meaning absolutely none of the mandatory requirements can be fulfilled by a subcontractor only?

Answer: The objective of this requirement is to fulfill the state’s reasonable and legitimate business need to hold the PBM services provider directly accountable for their performance during the course of the contract. Section 3.13 will not be changed. The RFP does allow for joint ventures.

Question 5: Will the chosen PBM administrator be allowed to bid on the SOA Medical RFP? Or the Travel Benefit RFP?

Answer: In general, vendors are allowed to submit bids on any State of Alaska solicitation. All bids are evaluated for responsiveness prior to being evaluated further.

Question 6: What is the reasoning behind each of the mandatory requirements in Form F? How much flexibility is allowed in meeting these requirements? If a bidder's score on Form F is Fail, will the rest of the offeror's bid still be evaluated?

Answer: The mandatory requirements in Submittal Form F are to ensure the state’s business needs and customer expectations are met. If an offeror does not meet all of the mandatory requirements, their proposal will be deemed non-responsive and their proposal will not be evaluated.

Question 7: Can offerors include bold or italic text, bullet points, colored text, charts, etc. in their response to Submittal Forms B to help differentiate different sections and ideas?

Answer: Yes, as long as the page limits are not exceeded.

Question 8: Submittal Form C (both the controllable and uncontrollable Risk templates) has five blanks for Risks. Are vendors required to provide exactly five of each risk, or can they provide more or less risks, assuming they are within the two page limit? Further, can you confirm the two page limit is for all the risks combined (i.e. two pages for all controllable risks and two pages for all uncontrollable risks)?

Answer: Offerors may list as few or as many risks as they want, as long as the page limits are not exceeded. Controllable risks are limited to two pages and non-controllable risks are limited to two pages.

Question 9: Can you confirm offerors should break out Submittal Forms A through J into separate documents? (i.e. not keep them all in one combined Word document like they were issued)?

Answer: Offerors may submit the documents combined or separate. In either case, the state does recommend submitting in one email if possible.

Question 10: Can you confirm that electronic signatures are acceptable for Submittal Form A and Submittal Form E, since the proposal is to be emailed?

Answer: While proposals are being submitted electronically, signatures on the Submittal Forms must either be handwritten or handwritten but digitally captured.

Question 11: Can you provide a copy of the reporting template that the state references in Sec. 6.02, or would this be something created during the Clarification Period?

Answer: This is something that will be created during the Clarification Period. The report format, content, and frequency may also be adjusted as a result of discussion between the state and the offeror.

Question 12: Does the state require copies of our Alaska Business License and/or any other associated items discuss in Sec 7.01 with our proposal submittal, or are we just required to have these on file?

Answer: Any of the forms of evidence of an Alaska Business License that are listed in Sec. 7.01 are acceptable and can be submitted with your proposal. However, a row in Submittal Form A has been added for the offeror to provide their Alaska Business License number and that is all that needs to be provided. Note that if you do not have an Alaska Business License, that must be obtained prior to contract award. If the offeror is claiming any Alaska preferences, the business license must be obtained prior to the deadline for receipt of proposals and the business license number should be included in Submittal Form A. The offeror should also complete the Alaska Preferences section of Submittal Form A.

Question 13: Can you confirm that drafts of the items discussed in Section 5.20 Clarification Period do not need to be submitted with the proposal response?

Answer: Correct. These are items that will be addressed in the Clarification Period.

Question 14: Will the state accept a cover letter and/or executive summary with our proposal response, or are we just to submit the Proposal Forms?

Answer: A cover letter and/or executive summary is acceptable, however, any documents or forms submitted outside of those specified in the RFP will not be reviewed or evaluated by the state.

Question 15: Regarding Sec. 7.08 (Disclosure of Proposal Contents), should bidders include the list of items (and corresponding reasoning) that they deem Trade Secret and/or Proprietary as a separate document?

Answer: Yes, a list of items and reasons should be included. The offeror may also highlight the specific areas in the proposal to correspond with the list of items.

Question 16: Can the state please elaborate on what it means by “take the member out of the middle?”

Answer: The state is seeking a vendor that can provide customer service in a manner that results in the least amount of effort by the member to coordinate or resolve pharmacy claims issues or concerns across vendors, prescribers, and pharmacists.

Question 17: What are the data points that need to be shared with the incumbent during the transition? Does this data need to be shared daily, weekly, or monthly?

Answer: These are items that will be addressed in the Clarification Period.

Question 18: Can the state provide more specific information about what these three dollar amount items in Submittal Form G - Contractual Requirements would be used for:

1. Implementation Credit in Section 10 - Item 1,
2. Pre-Implementation Audit Allowance in Section 10 - Item 2
3. Procurement Allotment of \$175,000 in Section 10 - Item 4

Answer: The items will assist in defraying any state costs associated with the implementation of the pharmacy benefit manager services contract.

Question 19: Given the very short timeframe to analyze the claims data/census data and then formulate the most attractive strategies for the state, we respectfully ask the state to consider an extension of the due date.

Answer: The deadline for receipt of proposals is extended until **2:00 p.m.**, Alaska Time, on **March 9, 2018**.

Changes to the RFP

Note the extension to the deadline for receipt of proposals. Revise the RFP Schedule as follows:

ACTIVITY	TIME	DATE
Issue Date / Draft RFP Released		1/22/18
Educational Meeting	10:00 am	1/29/18
Draft RFP Period Ends		2/1//18
Pre-Proposal Conference and Second Educational Meeting	2:00 pm	2/6/18
Deadline to Submit Questions	4:30 pm	2/27/18
Deadline for Receipt of Proposals / Proposal Due Date	2:00 pm	3/9/18
Initial Evaluations and Proposal Analysis		3/12/18
Present Financial Analysis (Segal) to Procurement		4/6/18
Present Proposal Analysis (Segal) to State		4/6/18
Shortlisting (optional)		4/9/18
Interviews	TBD	4/16/18
Clarification Period Begins		4/18/18
Notice of Intent to Award		5/31/18
Contract Issued		6/11/18
Start Date		6/12/18

Section 3.02 Goals and Objectives

This section is **deleted** and **replaced** with the following (eliminating repetitive bullet and minor language changes):

The critical goals and objectives of these services are:

- Providing high-quality, exceptional customer service that will “take the member out of the middle.”
- Providing fiscally sustainable, high-quality benefits.
- Providing transparency in pricing and fees structures.
- Ensuring the use of evidence-based guidelines in clinical determinations.
- Strong support and demonstrated flexibility to support plan changes or initiatives including implementation of a Medicare Part D enhanced EGWP.
- Providing high accuracy in claims processing.
- Demonstrated ability to manage drug mix with an emphasis on specialty drug management, formulary management and generic drug utilization (ability to identify, dispense and track utilization of authorized generics).
- Supporting the state in identifying, recommending and implementing innovative quality-oriented claims administration processes and procedures to achieve state objectives, reduce costs, and improve quality of service.
- Providing effective tools and resources to support members in managing their health.
- Providing seamless implementation for state and its members.
- Coordinating clinical management with the medical administrator, wellness and disease management vendor, and any other vendor or administrator contracted by the state.
- Increased transparency and communication around MAC pricing.
- Making real-time benefit coverage determinations for Part B and Part D drugs to ensure timely routing to the appropriate payor.
- Exploring innovative specialty management strategies without limitations such as an exclusive network.

- Implementing network management strategies with aggressive pricing, without restriction of the network.
- Enhanced EGWP expertise and capabilities to deal with complex member issues.

Delete the word “Past” from Submittal Form E. The document is now titled “Performance Qualifications” and is included on the state’s Online Public Notice website along with the RFP and this amendment. The main RFP document has also been updated to remove the word past from Section 4.07. Offeror clients may be current clients.

Section 4.14 Intent to Propose and Non-Disclosure Agreement

The non-disclosure agreement has been revised and is posted on the state’s Online Public Notice website along with the RFP and this amendment. If you have already submitted this paperwork, please resubmit (the intent to propose portion of the form does not need to be resubmitted).

Section 5.02 Summary of Evaluation Process

Delete number 6) of Section 5.02 and replace with the following:

6) After independent scoring, the PEC will have a meeting, chaired by the contracting officer, where the PEC will have a group discussion prior to finalizing their scores. Prior to the meeting, Segal will analyze the proposals, GeoAccess Analysis, and Network Disruption Analysis, and present their analysis in writing to the contracting officer. This analysis will also be anonymous and will be reviewed by the contracting officer to ensure anonymity prior to sending to the PEC for the group meeting. The PEC may take the analysis into consideration prior to finalizing their scores. Segal may also participate in the PEC meeting but will not provide any identifying information in any discussions with PEC members prior to the PEC members finalizing their scores.

Section 5.03 Evaluation Criteria

The technical evaluation criteria is revised as follows:

Qualifications Criteria		Weight
Service Approach – Network Plan (Commercial and EGWP)	(Submittal Form B)	50
Service Approach – Customer & Member Support	(Submittal Form B)	25
Service Approach – Medicare Part D Enhanced EGWP	(Submittal Form B)	20
Risk Assessment Plan	(Submittal Form C)	100
Value Opportunity Assessment	(Submittal Form D)	75
Performance Qualifications	(Submittal Form E)	10
Interviews – Account Manager		30
Interviews – Implementation Manager		30
Interviews – Clinical Pharmacist		30
Interviews – Member Services Manager		30

Total	400
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Submittal Form A: Add a line for an Alaska Business License number. Note that if you do not have an Alaska Business License and are not claiming any Alaska preferences, Alaska Business License information does not need to be included in your proposal, but an Alaska Business License will be required prior to contract award. If you are claiming any Alaska preferences, your Alaska Business License number should be included on Submittal Form A and you should complete the Alaska Preferences section of Submittal Form A.

The updated Submittal Form A is posted on the state's Online Public Notice website along with the RFP and this amendment.

End of Amendment #1

STATE OF ALASKA
Department of Administration
Division of Retirement and Benefits



PHARMACY BENEFIT MANAGEMENT (PBM) SERVICES

RFP 180000053

Amendment #2

February 23, 2018

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

Jason Grove

Jason Grove, CPPB

Contracting Officer

Phone: (907) 465-5679

Email: jason.grove@alaska.gov

Questions submitted by potential offerors and answers from the state:

(Note: the question numbering reflects a continuation from RFP Amendment #1)

Question 20: Please clarify the intent of the pricing inflation guarantee. It is not an industry standard to include a pricing inflation guarantee as part of the Pharmacy pricing proposal, so we would like to obtain more details including a description of the request, so we can work internally to accommodate.

Answer: The state is interested in the market's capabilities to manage trend and would find value in a bidder's ability to guarantee the impact of its cost management programs.

Question 21: Many of the competitor's offer a broad, open formulary that also includes mandatory formulary exclusions. We can offer this type of formulary or we can offer a formulary that matches what is in place today. Will the state be considering "open formularies with mandatory exclusions" from

bidders? If not, will the state submit an amendment stating that no exclusions will be considered on the proposed formulary to ensure they receive comparable quotes?

Answer: The state is requesting a formulary that closely matches the current formulary. The current formulary is a broad, open formulary that is subject to change (additions/removals of drugs), however, there are no mandatory drug coverage exclusions. All proposals must be based on an open, broad formulary and the cost proposal will be scored based on the pricing associated with your open broad formulary. However, additional approaches utilizing alternative formulas may also be proposed. They will not be scored, but may be discussed during the Clarification Period. Additional approaches may be submitted as separate documents with your proposal, and please reference them on Submittal Form D – Value Opportunity Assessment.

Question 22: Please consider changing the contract requirements (Submittal Form G – Contractual Requirements) to include Yes and No boxes separately for Commercial and EGWP plans. In the information meeting on February 6th, a verbal instruction was given to answer “no” if the answer was different by plan. We believe this will lead to a number of “no”s, with clarifications just because of the potential different response by product, and think an adjusted format would be beneficial for all bidders.

Answer: Offerors must utilize the current form as provided. If it is not possible to confirm “yes” for both EGWP and Commercial for a specific requirement, then please check “no” and provide an explanation (up to 250-word maximum) in the No Answers Clarification section of Submittal Form G.

Question 23: Please confirm how you want us to handle the identification of the four key personnel that must be available for separate interviews, when those positions may be different for the commercial plan and the EGWP plan, due to certain staff members being specialized in Medicare business affected by CMS rules.

Answer: The four-key personal required to participate in the interview process are outlined in section 5.17 of the RFP. Each offeror is responsible for identifying the personnel that most appropriately fits the description. The interviews are limited to four individuals, and in the case where offerors have different leads for EGWP and commercial plans, offerors must select the individual most suited to answer questions relative to both plans.

Question 24: Can the state consider allowing bidders to submit two versions of each of the Form C – Risk Assessment Plans - one for Commercial and the other for EGWP (i.e. we would be allowed two pages of controllable EGWP risks, two pages of controllable Commercial risks, two pages of non-controllable EGWP risks, two pages of non- controllable Commercial risks.

Answer: Submittal Form C contains two pages for controllable risks and two pages for non-controllable risks. This will not be changed. Offerors will have to use that space efficiently to identify risks for both commercial and EGWP.

Question 25: Should Submittal Form B – Service Approach – Part 2- Customer & Member Support be limited to just the commercial plan, or should it also include the EGWP Plan? We ask this because Submittal Form B – Service Approach – Part 3- Medicare Part D is specific just to the Enhanced EGWP, and not the Commercial.

Answer: The offeror should use this part of the Submittal Form to efficiently communicate critical information regarding overall Customer Service and Member Support. If there are special considerations regarding the EGWP plan the offeror should include that information.

Question 26: RFP Section 2.04 – Please describe how 90-day supply prescriptions are covered currently at retail pharmacies for the Employee Plan and Defined Contribution Plan, including at which pharmacies.

Answer: Currently, a member locates a network pharmacy using a website Aetna provides (DocFind). A member presents their ID card to this network pharmacy when a prescription is filled to be eligible for network benefits. The network pharmacy calculates this claim online, and the member pays the deductible, copayment or coinsurance directly to the network pharmacy. The member does not submit claims forms.

At retail pharmacies, each prescription is limited to a 90-day supply, and the member’s copay applies to each 30-day supply.

Question 27: RFP Section 1.11 – Please confirm that offering a different program, e.g. Exclusive Specialty in the Value Opportunity Assessment, does not violate the prohibition here of an alternate offering.

Answer: Yes, offering a different program such as an Exclusive Specialty in the Value Opportunity Assessment does not violate the prohibition of alternate proposals.

Question 28: RFP Section 2.06 – For the 71,641 retirees in the Defined Benefit Retiree Plan, please indicate how many have dual (or more) benefits? How many are “double-counted”? How many distinct retired members in total?

Answer: At the start of FY 2017 (July 1, 2016) the defined benefit retiree plan has 63,121 members, lending to about 9,000 to 10,000 duplicates.

Question 29: RFP Section 4.05(b) – Please provide additional detail on “non-controllable risks” relative to their not being included in the costs for the basic offering.

Answer: As indicated in the RFP, costs related to non-controllable risks must not be included in the offeror's base cost proposal. Costs related to non-controllable risks can be discussed during the Clarification Period.

Question 30: RFP Section 6.4 – For medications in “bubble wrap/blister packs” please explain when and how these are currently used in the AlaskaCare program.

Answer: The state is interested to know what capabilities a vendor has and what they can do to accommodate the request. We are not necessarily using this today, however we are interested in discussing opportunities further in the Clarification Period.

Question 31: Submittal Form G, Section 11.2 – Is the state's intent to allow members to determine whether specialty medications are on the PBM's specialty list? If so, please explain to what extent member input is to be considered.

Answer: Member input would be considered by the state and ultimately determined by the state.

Question 32: Submittal Form G, Section 16.9 – Regarding the “100% member paid plan” referred to here, please confirm that this is not to include a fully unfunded benefit for which the state has no responsibility for any costs, such as a discount card program.

Answer: The offeror must confirm all pricing will be effective and guaranteed for the term of the agreement and will not be modified or amended if the state modifies the current plans or implements additional plan options. If the answer is no, check “no” and provide an explanation (up to 250-word maximum) in the No Answers Clarification section at the end of Submittal Form G.

Question 33: Submittal Form E – Please confirm that the references need not be “previous” clients.

Answer: Confirmed. This was addressed with Amendment #1 to the RFP and the word “past” has been removed from the RFP documents. Offeror clients may be current clients. Also, if you have already collected references prior to “past” being removed, it is ok to submit the original form since it contains all the same fields.

Question 34: Submittal Form F, Number 3 – Please confirm that the mention of subcontractors here is not intended to prohibit the use of subcontractors in minor roles but rather to prohibit the use of subcontractors to meet the minimum requirements related to EGWP and to confirm that the bidder is the direct contract holder with CMS.

Answer: Correct. This requirement does not prohibit the use of subcontractors in general, just not for providing enhanced EGWP services to the state, and the offeror must have a direct contract with CMS to provide enhanced EGWP.

Question 35: Submittal Form G – For questions that do not specify commercial or EGWP, and for which the answers would differ between commercial or EGWP, what is the state’s preference as to how the “yes/no” boxes are checked, and how to differentiate between the responses?

Answer: If the answers would differ between commercial or EGWP, the offer should check “no” and provide clarification (up to 250-word maximum) in the No Answers Clarification section of Submittal Form G.

Question 36: Submittal Form G, Section 12.1 – Please indicate the state’s willingness to allow the bidder to offer the most beneficial account team structure, whether that may be separate teams for EGWP and Commercial or not.

Answer: Each offeror is responsible for identifying the personnel that most appropriately meet the needs of the client. In the case where offerors have different leads for EGWP and commercial plans, offerors must develop and provide the structure that best serves the client.

Question 37: Submittal Form J – Please confirm if all subcontractors must have an Alaska Business License even when the contract holder is the PBM, and the PBM is fully responsible and liable for the subcontractor(s).

Answer: Yes, all subcontractors must hold an Alaska Business License and the PBM is ultimately responsible and liable for the subcontractor performance. Subcontractors will be required to submit a signed written statement that clearly verifies that the subcontractor is committed to render the services required by the contract. However, subcontractors do not need to hold an Alaska Business License at the deadline for receipt of proposals. The Alaska Business License # column of Submittal Form J – Subcontractors has been removed and Section 3.13 of the RFP is revised as follows (new language in blue):

SEC 3.13 SUBCONTRACTORS

U.S. based subcontractors may be used to perform work under this contract. If an offeror intends to use subcontractors, the offeror must complete Submittal Form J – Subcontractors, provided as an attachment to the RFP.

Subcontractor experience shall not be considered in determining whether the offeror meets the requirements set forth in Submittal Form F – Mandatory Requirements.

An offeror's failure to provide this information with their proposal may cause the state to consider their proposal non-responsive and reject it.

During the Clarification Period (RFP Section 5.20), the state will require a signed written statement from each subcontractor proposed in Submittal Form J – Subcontractors that clearly verifies the subcontractor is committed to performing the services required by the contract. Prior to the contract award, the state will also require evidence that each subcontractor possesses a valid Alaska Business License.

During the course of the contract, the substitution of one subcontractor for another may be made only at the discretion and prior written approval of the project director or contracting officer.

Question 38: Submittal Form K, Section 8.6 – If the Specialty program includes specialty pharmacies in addition to or instead of retail pharmacies, please explain why the heading refers only to retail pharmacies.

Answer: Offerors should utilize Form K 8.6 to provide guarantees and information for all specialty drugs, regardless of pharmacy type or distribution channel. This applies to exhibits for both Commercial and EGWP pharmacies.

Question 39: Submittal Form K, Section 8.6 – In addition to an open Specialty program being offered and priced here, please confirm that an alternative offer, e.g. Exclusive Specialty, may be provided in the Value Opportunity Assessment response including the applicable pricing guarantee.

Answer: Yes, an Exclusive Specialty offering may be provided in the Value Opportunity Assessment response.

Question 40: Do you anticipate that SB74 could potentially affect this solicitation?

Answer: The state does not anticipate SB74 will have any impact on this solicitation.

Question 41: Are there specific service or performance issues with current vendor? If yes, please provide information regarding the issues so bidders can address how they will ensure such issues will be addressed.

Answer: Historically, the most complex challenges facing the plan are not limited to the current vendor. Over the years, perhaps the most difficult aspect for vendors to support is the plan’s coordination with itself, especially among members covered in the AlaskaCare retiree health plan. This is particularly challenging on the pharmacy side, as point-of-sale coordination requires a system that can perform this coordination when the member fills their medication. Additional challenges include those outlined in section 2.07(b).

Question 42: Please explain why the State of Alaska is soliciting proposals for a new pharmacy benefit manager.

Answer: The state is required to periodically issue a request for proposals (RFP) for third-party administrator (TPA) services for the AlaskaCare Employee Health Plan and Retiree Health Benefit Plan. The state has determined that allowing direct PBM service providers to propose on PBM services will benefit the state and plan members in the form of increased competition. Additionally, the state is highly motivated to implement an Medicare Enhanced EGWP effective January 1, 2019.

Question 43: Please provide information regarding the state's decision to solicit PBM services independent of the medical and dental programs.

Answer: See answer to question 23.

Question 44: Please confirm the date which all responses to all initial bidder questions will be answered and released.

Answer: Amendment #1 to the RFP, released on February 9, 2018, answered most of the initial offeror questions. This Amendment #2 addresses questions 20 – 67, and Amendment #3 will provide answers to the remaining questions received. If further questions are received, the date for those answers will depend on the date in which those questions are received. If an amendment is needed to answer questions or make any changes to the RFP less than 14 days from the deadline for receipt of proposals, the amendment will also extend the deadline to allow at least 14 days from the date of the amendment to the deadline.

Question 45: Bidder questions can be submitted up until 10 days prior to the deadline. Please confirm when the state will provide responses to questions asked through February 27 to ensure all information provided by the state is incorporated into the response. To ensure all bidders have the appropriate amount of time to contemplate the State of Alaska's responses provided to the bidder questions (due by Friday, 02/27/2018) into their proposal responses, please consider an extension of the proposal due date equal to the length of time (in days) the last responses to bidder questions are released.

Answer: Responses to offeror questions will be provided as quickly as possible. Any RFP amendment that answers questions or makes changes to the RFP less than 14 days from the deadline for receipt of proposals will extend the deadline to allow at least 14 days from the date of the amendment to the deadline.

Question 46: Please provide additional information on the current clinical programs including and not limited to, Prior Authorization Step Therapy, Age Gender, Age Gender and other edits.

Answer: Clinical Programs:

- No standard precertification or step therapy programs are in place currently.
 - National Precertification: Both the Active and Retiree Plans require Prior Authorization for specialty drugs. These are primarily injectable products. Please see specialty drug list attached. The drugs on the list with “PR” designation require Prior Authorization.
 - Safety Edits: Both the Active and Retiree Plans apply Prior Authorization and Quantity Limits to a limited list of drugs with the highest potential for abuse and harm. The goal is to ensure the prescribed drug will be used within the guidelines set by the Food and Drug Administration and current medical findings. Please refer to the Safety Edits drug list.
 - Rx Check: is a drug utilization review program in place for both the Active and Retiree Plans. It identifies drug-related opportunities to improve care, prevent misuse and reduce waste. It triggers targeted outreach to prescribers and sometimes members.
 - Targeted outreach to prescribers helps to:
 - Bring to light potential misuse
 - Spur direct and rapid involvement with the prescriber to improve member care
 - Reduce medicine errors
 - Some issues that Aetna Rx Check identifies include:
 - Simultaneous use of two drugs that serve the same purpose.
 - Severe drug-to-drug interactions.
 - Multiple prescriptions and/or prescribers for certain drugs with the potential for misuse.
 - Money-saving opportunities when generic equivalent drugs are available.
 - Prescriptions for a multiple daily dose of a proton pump inhibitor (PPI). A PPI reduces the production of acid by blocking the enzyme in the wall of the stomach that produces acid.
 - Controlled Substance Use & Misuse Waste and Abuse Program: In place for both Active and Retiree Plans, it identifies members exhibiting potential prescription drug misuse or abuse, notifies the members and their prescribing doctor(s) of the concern, and provides Behavioral Health resources to help them make changes. Top doctor-shopping cases are referred to the Aetna Special Investigations Unit (SIU) for fraud investigation.
-

Question 47: How does the state currently manage compound medications?

Answer:

Actives:

- Do not cover bulk chemical compounds
- Cover FDA approved ingredient compounds

Retirees:

- Cover bulk chemical compounds
- Cover FDA approved ingredient compounds

Compound Thresholds:

- Both Active and Retiree Plans follow standard compound policy for thresholds:

- ✓ Compound claim review process
- ✓ When the amount billed meets a certain threshold, Aetna prompts the dispensing pharmacist to call their Pharmacy Help Line for additional review.
- ✓ The applicable threshold is \$70 for a 30-day supply or less, \$75 for a 31-60 day supply and \$100 for a 61-90 day supply
- ✓ Upon calling, Aetna verifies that the claim is correct and valid, according to the NDCs provided for the compound
 - If the cost is under \$2,000 – Aetna enters an override for the prescription to be approved for payment
 - If the cost is over \$2,000 – Aetna sends notification to their compound team to review and approve the claim, if appropriate.

Question 48: Please provide additional information on the level and type of integration required for disease management, medical and/or data warehouse.

Answer: The state requires all of its vendors to share the information necessary for each vendor to properly serve the state. At a minimum the PBM will be required to share data with the medical claims administrator in order to properly administer benefit provisions that apply to both medical and pharmacy benefits (such as member out-of-pocket limits) and to support each vendor's health management and clinical programs. This data will include, but not be limited to full claims detail and key demographic and clinical information.

Question 49: Please define the current appeals process.

Answer: Please see the January 1, 2018 amendment at the front of the Defined Benefit Retiree Plan booklet available online at:

<http://doa.alaska.gov/drj/pdf/ghlb/retiree/RetireeInsuranceBooklet2003with2018amendment.pdf>

See section 9.14 of the Defined Contribution Retiree health plan booklet at:

<http://doa.alaska.gov/drj/pdf/ghlb/retiree/AlaskaDcrRetireeHealthPlan-Final-0118.pdf>

See section 8.14 of the AlaskaCare Employee plan booklet at:

<http://doa.alaska.gov/drj/pdf/ghlb/akcare/SelectBenefitsEmployeeBooklet2018.pdf>

Question 50: Is the plan subject to ERISA?

Answer: No.

Question 51: Submittal Form K, Definitions worksheet, row 21, cell B-21 – This worksheet is locked. Please provide the full text in cell B-21 so an appropriate response can be provided.

Answer: Submittal Form K has been updated to make this change and is posted on the state’s Online Public Notice system along with the RFP and this amendment.

Question 52: Submittal Forms B and F appear to be the only places where detailed requirements on capabilities are solicited, please confirm that is correct.

Answer: Submittal Form G also contains detailed requirements on capabilities. An offeror’s responses to Submittal Form G may be discussed in further detail during the Clarification Period. This also holds true for the GeoAccess and Network Disruption analyses.

Question 53: For the state’s RDS program, is the expectation that the state will submit the RDS file?

Answer: Yes.

Question 54: Please provide a list of pharmacies the state considers key Alaskan independent pharmacies. Or, please provide the criteria for which the state considers a pharmacy to be a be key Alaskan independent pharmacy.

Answer: It is important to the state that the pharmacy network include access for members in geographically isolated communities. Further, the state views favorable the participation of independent pharmacists in any given network. The claims file should have sufficient information for offerors to identify these areas.

Question 55: Can you please provide more detailed information regarding possible COB scenarios?

Answer: The Defined Benefit retiree plan and the Employee plan use traditional coordination of benefit rules (plans coordinate up to 100% of allowed). The Defined Contribution Retirement plan uses governmental carve out coordination where the secondary plan cost share provisions are applied to the portion of the claim not paid by the primary plan. Below are scenarios where each plan is an AlaskaCare plan unless otherwise indicated. PERS = Public Employees’ Retirement System, TRS = Teachers’ Retirement System.

- Retiree A has PERS retirement plan + Retiree A has TRS retirement plan.
- Retiree A has PERS retirement plan + own active plan.
- Retiree A has PERS retirement plan + covered as dependent under Retiree B’s PERS retirement plan.

- Retiree A has PERS retirement plan + Retiree A has TRS retirement plan + own active plan
- Retiree A has PERS retirement plan + Retiree A has TRS retirement plan + covered as dependent under Retiree B's PERS retirement plan.
- Retiree A has PERS retirement plan + Retiree A has TRS retirement plan + covered as dependent under Retiree B's PERS retirement plan + covered as dependent under Retiree B's TRS retirement plan.
- Retiree A has PERS retirement plan + Retiree A has an outside retirement plan.
- Retiree A has PERS retirement plan + Retiree A has an outside employee plan.
- Retiree A has PERS retirement plan + Retiree A has an outside employee plan + covered as dependent under Retiree B's TRS retirement.

This is not an exhaustive list, may be other combinations. Claims need to be reported to the state in a manner that the costs can be applied to the appropriate health trust, i.e. PERS, TRS, etc.

Question 56: Submittal Form G, Section 1, Question 3 – Does the state currently utilize a custom formulary or a PBM-developed formulary with exclusions? Please provide a copy of the current formulary (or formularies) including NDC codes.

Answer: The DCR and employee plans uses a PBM developed formulary with exclusions. The DB retiree plan uses a PBM developed formulary with no exclusions. The formulary is available at: http://doa.alaska.gov/drb/benefits/materials/2018_AetnaDrugGuide.pdf

The exclusion list is available at:

http://doa.alaska.gov/drb/benefits/materials/2018_ExclusionDrugList.pdf

These documents have also been provided as PDF attachments along with the other RFP documents posted on the state's Online Public Notice website.

Question 57: Submittal Form G, Section 1, Question 2/Section 5, question 4 & 5 – Is the 90-day network today targeted to one chain or a broad network? Are any custom networks in place today?

Answer: The 90-day network is a broad network. No custom network is in place today.

Question 58: Submittal Form G, Section 6, Question 5 – Please provide information on any pilot programs or other strategic state initiatives that have been started in the last four years.

Answer: The state has not deployed any pharmacy pilot programs in the AlaskaCare plans in the last 4 years. Strategic initiatives include the introduction of a 3-tier pharmacy benefit and exclusion list in the employee health plan, as well as restrictions in the employee plan around compound medications and over the counter equivalents.

Question 59: Submittal Form G, Section 10, Question 9 – Please provide any charges that the state would anticipate from the medical plan claims administrators for set-up, programming, etc.

Answer: This question refers to any charges from the PBM.

Question 60: Submittal Form G, Section 10, Question 11 – Please confirm the current FSA vendor.

Answer: The state contracts with Aetna who uses their subsidiary Payflex to administer the Health Flexible Savings Account.

Question 61: Submittal Form G, Section 12, Question 7 – Please indicate which systems are being referred to in this question.

Answer: This question refers to the PBM's claims adjudication system.

Question 62: Submittal Form G, Section 13, Question 1 – Please provide the list of data elements referenced in this question.

Answer: This section/question in Submittal Form G has been updated as follows: “The PBM will be expected to provide the reporting and data detail necessary for the state to manage the AlaskaCare program. Please confirm you are able to provide custom regular and as-needed ad-hoc reporting.”

As with any responses to Submittal Form G, if the offeror cannot firmly answer yes, the offeror should answer no and provide clarification (up to 250-word maximum) in the No Answers Clarification section at the end of Submittal Form G.

Question 63: Submittal Form G, Section 13, Question 3 – Please provide the state approved electronic format.

Answer: The electronic format can be created during the Clarification Period and may be modified throughout the life of the contract after discussions between the state and the contractor. As with any responses to Submittal Form G, if the offeror cannot firmly answer yes, the offeror should answer no and provide clarification (up to 250-word maximum) in the No Answers Clarification section at the end of Submittal Form G.

Question 64: Submittal Form G, Section 13, Question 8 – Please provide additional details around the state’s health reporting eligibility system and estimates on when it will be fully operational.

Answer: The current format of eligibility file transfer is the industry standard ANSI 834 EDI Enrollment Implementation Format sent via FTP transfer. A new 834 file will need to be created and tested for EGWP.

Question 65: Submittal Form G, Section 15, Question 10 – The yes/no check boxes are missing from the response column, please confirm PBM is able to duplicate the response style from the document and include it here to respond appropriately.

Answer: Submittal Form G has been updated to add these boxes and is posted on the state’s Online Public Notice system along with the RFP and this amendment.

Question 66: Submittal Form G, Section 18, Question 6 – Please confirm the requested GeoAccess report is equivalent to Submittal Form H – GeoAccess Analysis.

Answer: This section/question of Submittal Form G has been updated as follows: “Please confirm your EGWP network complies with all CMS requirements.”

Question 67: Some of our references already returned the "Submittal Form E – Performance Qualifications", prior to the title being renamed (i.e. "Past" being removed). Are we okay to use the original form, since it contains all the same fields?

Answer: Yes, this is acceptable.

End of Amendment #2

STATE OF ALASKA
Department of Administration
Division of Retirement and Benefits



PHARMACY BENEFIT MANAGEMENT (PBM) SERVICES

RFP 180000053

Amendment #4

March 6, 2018

This amendment is being issued to answer questions submitted by potential offerors. Offerors do not need to use Submittal For A – Offeror Information to acknowledge this amendment.

Please note that in order to ensure the project schedule and implementation remains on track, the questions period is closed and the deadline for receipt of proposals remains March 15, 2018, at 2:00 p.m. Alaska Time.

A handwritten signature in blue ink that reads "Jason Grove".

Jason Grove, CPPB

Contracting Officer

Phone: (907) 465-5679

Email: jason.grove@alaska.gov

Questions submitted by potential offerors and answers from the state:

(Note: the question numbering reflects a continuation from RFP Amendment #3)

Question 108: In section 3.01 the RFP states “The enhanced EGWP will be designed to ensure that from a member perspective, the Medicare eligible retiree benefits mirror those of the current commercial plan design”, but the response to Question 71 in Addendum #3 states “Currently 100% defined benefit retirees are in a 2 tier plan design with a fixed copay. With implementation of EGWP we intend to transition to 3 tiers with preferred/non-preferred brands having a copay differential of \geq \$15.” Will the state keep the current 2 tier pharmacy benefits in place for EGWP or will they move to the three tier model?

Answer: Proposals will be reviewed and analyzed based on the ability to replicate the current program(s) and the offeror’s ability to promote and support AlaskaCare as the program(s) evolve(s) over the course of the contract.

Question 109: Regarding Section 18, #8 of Form Submittal Form G – Contractual Requirements, is the state referring to the existing coverage gap discount program? Or is the state referring to new CMS proposed rule language that may require us to pass “rebates” through at point of sale?

Answer: The reference is to the existing coverage gap discount program.

Question 110: The answer to Question 81 says the OAH forms are attached but we do not see the attachment(s).

Answer: The forms are now attached on the Online Public Notice website, titled ben049 Alaska Care Retiree Health Plan Notice of OAH Appeal, and ben043 OAH PHI.

Question 111: We respectfully request that the state please reconsider our request regarding the formulary disruption.

The claim data provided includes a formulary indicator (F/NF) along with NDC but it, nor the Aetna PDL, include tier placement which is required in order to accurately complete the formulary disruption tabs within Submittal Form K. In order to provide the requested formulary disruption information relative to the current and proposed formularies, by tier, please provide either an updated claims file that includes the tier indicator (1, 2, 3) or the full formulary extract in excel that includes the NDC and tier of each formulary product. If the current tier information is not able to be provided, please provide instructions on how to complete the formulary disruption tabs within Submittal Form K.

Here is a more detailed description of the issue:

Based on the data provided with the RFP, the new worksheets (Formulary Disruption – Commercial and Formulary Disruption – EGWP) in Submittal Form K – Fee Scheduled provided with Amendment 3 cannot be populated.

The 2018 AetnaDrugGuide aka Preferred Drug List (PDL) provided with Amendment 2 does not contain NDC detail. NDC detail is required to crosswalk between drugs in the PDL and the state of Alaska’s claims data file. The PDL file is also in PDF format which is very challenging to work with to perform this type of comparison.

The PDL describes/defines drugs as:

CE = Copay Exception: Available to some members at no cost with a prescription from your provider when obtained at an in-network pharmacy. Certain limitations may apply.

G = Generic

NPB = Non-Preferred Brand
NPSP = Non-Preferred Specialty
PB = Preferred Brand
PSP = Preferred Specialty

Can you please translate what the Tier level (1, 2, or 3) is for each of the above? The worksheets require us to identify which drugs move from Tier 1, Tier 2, 3 and Tier 1,2,3 however the drugs are not classified this way on the PDL.

Additionally, the worksheets require us to identify the “Number of Rxs – column D” and “% of Total RXs – column E” affected by any change. In order to perform these analyses we need to use the claims file provided earlier in the RFP process. The claims file does not include the drug tier level or drug name. It only includes NDC. The PDL only includes drug name not NDC.

In order to provide the requested information we need either the formulary including NDC in Excel or an updated claims file with the drug tier data files added. The F=Formulary and NF=Non-Formulary indicators do not provide the tier level information being requested for the worksheets.

Answer:

Please utilize the RFP claims file to complete the formulary disruption, which includes a formulary indicator for the analysis:

F=Formulary; NF=Non-Formulary.

Please note that formulary disruption analysis is not necessarily the same as tier disruption analysis.

Question 112: Please clarify what is requested by Submittal Form G, Section 15, #9. The first sentence states that rebates will be paid upon signature of one of three types of documents. However, the second sentence states that past-earned rebates will not be withheld even if no document is signed.

Answer:

Per the first sentence, please confirm that “Rebates will be paid upon signature of: 1) the Letter of Agreement/Intent, OR 2) Pricing Implementation Document, OR 3) contract.”

To address instances in which bidders will not confirm the first sentence/request, the second sentence requests confirmation that “Past-earned rebates will not be withheld if there is no signed agreement documentation.”

End of Amendment #4

STATE OF ALASKA
Department of Administration
Division of Retirement and Benefits



PHARMACY BENEFIT MANAGEMENT (PBM) SERVICES

RFP 180000053

Amendment #3

March 1, 2018

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

A handwritten signature in blue ink that reads "Jason Grove".

Jason Grove, CPPB

Contracting Officer

Phone: (907) 465-5679

Email: jason.grove@alaska.gov

Questions submitted by potential offerors and answers from the state:

(Note: the question numbering reflects a continuation from RFP Amendment #2)

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

Retirees AB

Retirees Non AB

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

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

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

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

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

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

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

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

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

<http://doa.alaska.gov/drb/pdf/ghlb/akcare/SelectBenefitsEmployeeBooklet2018.pdf>

Coinsurance and copay differentials are outlined in the AlaskaCare Retiree Benefit Plan for DCR Plan Retirees booklet available at:

<http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaDcrRetireeHealthPlan-Final-0118.pdf>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Question 77: Provide list of formulary excluded products.

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

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

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

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

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

1. In the case of a biosimilar release where the cost of the biosimilar isn't providing an overall lower net cost.
 2. In the case of a “market exclusive generic” where the branded product maintains a lower overall net cost. Again, the generic is generally treated as non-preferred vs not covered and each instance is specifically evaluated on a case-by-case basis.
-

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC 7.02 STADARD CONTRACT PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

End of Amendment #3

STATE OF ALASKA
Department of Administration
Division of Retirement and Benefits



PHARMACY BENEFIT MANAGEMENT (PBM) SERVICES

RFP 180000053

Amendment #5

March 22, 2018

This amendment is being issued to revise the deadline for receipt of proposals to **March 23, 2018**, at **2:00 p.m. Alaska Time**.

It is the offeror's responsibility to contact doa.dgs.info@alaska.gov or (907) 465-2250 to confirm that the proposal has been received. To provide further instruction on proposal submission via email, the state recommends that the proposal be submitted well in advance of the deadline to account for any delays in delivery of the email to the above email inbox.

Offerors do not need to use Submittal For A – Offeror Information to acknowledge this amendment.

A handwritten signature in blue ink that reads "Jason Grove".

Jason Grove, CPPB
Contracting Officer
Phone: (907) 465-5679
Email: jason.grove@alaska.gov



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Freedom of Information Act

The following Freedom of Information Act exemption language applies to OptumRx proposal submissions:

- Protected from Disclosure Under Federal [and State] Law.
- Exempt from the Freedom of Information Act. See 5 U.S.C. §552(b).
- Contains Confidential Commercial/Financial and Other Protected Information.

The information contained in this proposal submission includes trade secrets, is confidential and proprietary. As such, this information is valuable to OptumRx, and OptumRx would be harmed if the information was obtained by competitors and other entities with which it negotiates. Public release of any information contained within this proposal is restricted to non-confidential, non-proprietary items and can only occur with advance written notice that allows OptumRx with the opportunity to take appropriate steps to prevent disclosure, obtain a protective order, or provide a redacted version.



1600 McConnor Parkway
Schaumburg, IL 60173

www.optum.com

March 14, 2018

State of Alaska
C/O Jason Grove, Contracting Officer
333 Willoughby Ave.
Juneau, AK 99801-1770

CONFIDENTIAL
Contains Confidential, Proprietary, and Trade Secret Information

Re: Confidential, Proprietary, and Trade Secret Information of OptumRx, Inc. contained in Optum's Proposal (the "Proposal") in response to Pharmacy Benefit Management (PBM) Services RFP # 180000053 ("RFP").

To whom it may concern:

OptumRx, Inc. has identified certain portions of its Proposal as containing Confidential, Proprietary, and Trade Secret information ("Optum Trade Secrets"). In compliance with the instructions of the RFP, Optum is specifically identifying the information that Optum believes should be kept confidential and has provided the attached Exhibit A, which includes the specific section of the information we consider to be confidential and our rationale for each designation. Optum hereby requests that the State of Alaska specifically except the portions of the proposal identified as confidential from public disclosure, on the grounds that such sections contain trade secret, commercial, or financial information which are proprietary, privileged or otherwise confidential. Disclosure of the trade secrets or confidential information may cause competitive harm as such information is sufficiently secret to derive economic value, actual or potential, from not being generally known. Optum makes significant efforts to maintain the secrecy and confidentiality of this information. Optum does not consent to disclosure of any information unless required to do so by law. In addition to these specific required and permissive exemptions, Optum asserts any other exemption allowed under applicable State or Federal law and does not limit its protections to those sections mentioned below.

If the State of Alaska receives a request for a copy of the Proposal, including Optum Trade Secrets, Optum requests that the State provide written notice of such request prior to making the material public so that Optum may provide justification in support of its assertion that such information is exempt from disclosure under the Alaska Public Records Act pursuant to Alaska Stat. § 40.25.120, and any other applicable law. Such written notice should be provided to: Optum, Attn: General Counsel, 1600 McConnor Parkway, Schaumburg, IL 60173. Please feel free to contact me should you have any questions regarding this letter at 224-231-1704 or Marissa.Watt@Optum.com.

Regards,

A handwritten signature in cursive script that reads "Marissa Watt".

Marissa Watt
Legal Counsel



1600 McConnor Parkway
Schaumburg, IL 60173

www.optum.com

Exhibit A

OptumRx – State of Alaska Pharmacy Benefit Management (PBM) Services RFP # 180000053 Exceptions to Public Disclosure Requirements

The information listed in the table below has been identified as proprietary and confidential within our proposal.

Section	Reason for Confidential Treatment*
Section II: Proposal Response, Submittal Form E (Performance Qualifications)	References/Customer Information
Section II: Proposal Response, Submittal Form H (GeoAccess Analysis)	Operational Information
Section II: Proposal Response, Submittal Form I (Network Disruption Analysis)	Operational Information
Section II: Proposal Response, Submittal Form K (Fee Schedule)** **OptumRx was unable to mark Submittal Form K as proprietary due to the protective restrictions the State has placed on the document. However, this designation shall serve as notice by Optum that it considers Submittal Form K to be proprietary and confidential.	Pricing Information
Section III: Supporting Attachments, OptumRx Specialty Drug List	Pricing Information
Section III: Supporting Attachments, OptumRx Formulary Disruption	Operational Information

*The items marked above are exempt from public disclosure under the Alaska Public Records Act for the following reasons corresponding to the categories noted above:

Pricing Information:

Optum provided detailed pricing in its proposal. In these areas, knowledge of our pricing would allow competitors to undercut us and to know exactly what they need to bid to be competitive with us. As with other PBMs, Optum's pricing information includes pricing discounts for specific drug prices, rebate amounts, performance guarantee penalty amounts and pricing for other services that are provided as part of the proposal. All the individual pricing elements together form the basis of Optum's overall proposal pricing. Disclosure of individual elements of our pricing, such as pricing for ad hoc reporting or plan set up would reveal our underlying pricing strategy and should be excluded from disclosure the same as any other pricing component. All pricing information related to the Proposal reflects pricing methodologies that are trade secrets and/or confidential commercial and financial information of Optum

Operational Information:



1600 McConnor Parkway
Schaumburg, IL 60173

www.optum.com

In general, Optum regards the information related to detailed business processes and development methodologies to be confidential and trade secret expressions of Optum's methodologies for performing its business. Specifically, disclosure of Optum's proprietary processes and methodologies would give an unfair advantage to Optum's competitors if it were to be released. The way in which Optum uses data analytics methodologies coupled with its clinical programs to drive value to our clients represents a proprietary trade secret business process. Optum believes it would be substantially harmed if competitors knew these operational details of Optum's commercial activities. This would allow competitors to unfairly compare their programs to Optum in bidding situations, as well as to determine where their operations may be lacking competitively so that they can attempt to imitate Optum's operational capabilities.

References/Customer Information:

Optum provided the State with contact information for other clients of Optum for reference purposes. The names and contact information relating to Optum's other clients constitutes a partial customer list of Optum, which is a trade secret of Optum. Disclosure of Optum's customers list would unfairly benefit Optum's competitors by allowing those competitors to target offers specifically Optum's customers without undertaking the efforts and related costs typically required to identify and market to potential customers.



REQUESTED CHANGES TO STANDARD AGREEMENT FORM FOR PROFESSIONAL SERVICES CONTRACTS

Per the instructions of section 7.02, OptumRx requests changes to language in State of Alaska's Standard Agreement Form for Professional Services Contracts (form 02-093/Appendix A), as provided below.

SEC. 7.02 STANDARD CONTRACT PROVISIONS

The contractor will be required to sign the state's Standard Agreement Form for Professional Services Contracts (form 02-093/Appendix A). This form is attached with the RFP for your review. The contractor must comply with the contract provisions set out in this attachment. No alteration of these provisions will be permitted without prior written approval from the Department of Law, and the state reserves the right to reject a proposal that is noncompliant or takes exception with the contract terms and conditions stated in the Agreement. Any requests to change language in this document (adjust, modify, add, delete, etc.), must be made in writing to the contracting officer no later than 10 days before the deadline for receipt of proposals. Please include the following information with any change/exception that you are proposing:

1. Identify the provision that the offeror takes exception with.

Article 10 (Ownership of Documents).

2. Identify why the provision is unjust, unreasonable, etc.

The work for hire principles would apply to those materials specifically developed for State of Alaska under a separate written agreement, such as a Statement of Work. OptumRx needs to retain ownership interests its systems and operational data in order to remain in compliance with pharmacy law and other rules and regulations applicable to pharmacy benefit managers. OptumRx also needs to maintain ownership over its operational data in order to conduct audits of the pharmacies in our network and to evaluate certain book of business measures.

3. Identify exactly what suggested changes should be made

OptumRx proposes the following redline changes to State of Alaska's contract language:

All designs, drawings, specifications, notes, artwork, and other work specifically developed for State of Alaska under a separate written agreement, such as a Statement of Work are produced for hire and remain the sole property of State of Alaska and may be used by State for any other purpose without additional compensation to the contractor. The contractor agrees not to assert any rights and not to establish any claim under the design patent or copyright laws with respect to work produced for hire. Nevertheless, if the contractor does mark such documents with a statement suggesting they are trademarked, copyrighted, or otherwise protected against State of Alaska's unencumbered use or distribution, the contractor agrees that this paragraph supersedes any such statement and renders it void. The contractor, for a period of three years after final payment under this contract, agrees to furnish and provide access to all retained materials at the request of the Project Director. Unless otherwise directed by the Project Director, the contractor may retain copies of all the materials. OptumRx retains all ownership interest in its systems, including any enhancements thereto, as well as operational data.

SUBMITTAL FORM A – Offeror Information

PROJECT INFORMATION

RFP NUMBER: 180000053
 PROJECT NAME: Pharmacy Benefit Management (PBM) Services

OFFEROR INFORMATION

Company Name: OptumRx, Inc.
 Address: 1600 McConnor Parkway, Schaumburg, IL 60173
 Tax ID: 33-0441200
 Alaska Business License #: 969517

CONTACT INFORMATION

Provide contact information for the individual that can be contacted for clarification regarding this proposal:

Name Colby Heiner
 Title Area Vice President, Sales, Public Sector
 Address 1600 McConnor Parkway, Schaumburg, IL 60173
 Email Colby.Heiner@optum.com
 Telephone 480-319-4364

CRITICAL TEAM MEMBERS

Provide the names of all critical team members that will be assigned to this contract. Note: These individuals cannot be removed or replaced from this project, or their positions, unless approved in writing the project director or contracting officer.

Name of Account Manager Christopher Ring, MBA
 Name of Implementation Manager Briana Hoepfner
 Name of Clinical Pharmacist Amy Speakman, PharmD
 Name of Member Services Manager Angela M. Smith

ADDENDA ACKNOWLEDGEMENT

The offeror acknowledges receipt of the following addenda and has incorporated the requirements of such addenda into their proposal. Failure to identify and sign for all addendum may subject the offeror to disqualification. The offeror must list all addenda's (by number), then initial and date to confirm that you have received and incorporated them into your proposal. *The offeror may add more rows as necessary*

Number	Initials & Date	Number	Initials & Date	Number	Initials & Date
1	SH 3-14-18	45	SH 3-14-18		
2	SH 3-14-18				
3	SH 3-14-18				

CERTIFICATIONS

No	Criteria	Response*
1	The offeror is presently engaged in the business of providing the services & work required in this RFP.	<input type="checkbox"/> True <input type="checkbox"/> False
2	The offeror confirms that it has the financial strength to perform and maintain the services required under this RFP.	<input type="checkbox"/> True <input type="checkbox"/> False
3	The offeror accepts the terms and conditions set out in the RFP (including the Standard Agreement Form – Appendix A) and agrees not to restrict the rights of the state.	<input type="checkbox"/> True <input type="checkbox"/> False
4	The offeror confirms that they can obtain and maintain all necessary insurance as required on this project.	<input type="checkbox"/> True <input type="checkbox"/> False
5	The offeror certifies that all services provided under this contract by the contractor and all subcontractors shall be performed in the United States.	<input type="checkbox"/> True <input type="checkbox"/> False
6	The offeror is not established and headquartered or incorporated and headquartered, in a country recognized as Tier 3 in the most recent United States Department of State's Trafficking in Persons Report.	<input type="checkbox"/> True <input type="checkbox"/> False
7	Offeror complies with the American with Disabilities Act of 1990 and the regulations issued thereunder by the federal government.	<input type="checkbox"/> True <input type="checkbox"/> False
8	The offeror certifies that programs, services, and activities provided to the general public under the resulting contract are in conformance with the Americans with Disabilities Act of 1990.	<input type="checkbox"/> True <input type="checkbox"/> False
9	Offeror complies with the Equal Employment Opportunity Act and the regulations issued thereunder by the federal government.	<input type="checkbox"/> True <input type="checkbox"/> False
10	Offeror complies with the applicable portion of the Federal Civil Rights Act of 1964.	<input type="checkbox"/> True <input type="checkbox"/> False
11	The offeror can provide (if requested) financial records for the organization for the past three years.	<input type="checkbox"/> True <input type="checkbox"/> False
12	The offeror has not had any contracts terminated by the State of Alaska (within the past five years).	<input type="checkbox"/> True <input type="checkbox"/> False
13	The offeror certifies that it is not currently debarred, suspended, proposed for debarment, or declared ineligible for award by any public or federal entity.	<input type="checkbox"/> True <input type="checkbox"/> False
14	The offeror certifies that they do not have any governmental or regulatory action against their organization that might have a bearing on their ability to provide services to the state.	<input type="checkbox"/> True <input type="checkbox"/> False
15	The offeror certifies, within the last five years, they have not been convicted or had judgment rendered against them for: fraud, embezzlement, theft, forgery, bribery, falsification or destruction of records, false statements, or tax evasion.	<input type="checkbox"/> True <input type="checkbox"/> False
16	The offeror does not have any judgments, claims, arbitrations or suits pending/outstanding against your company in which an adverse outcome would be material to the company.	<input type="checkbox"/> True <input type="checkbox"/> False
17	The offeror is not (now or in the past) been involved in bankruptcy or reorganized proceeding.	<input type="checkbox"/> True <input type="checkbox"/> False
18	Offeror certifies they comply with the laws of the State of Alaska.	<input type="checkbox"/> True <input type="checkbox"/> False
19	Offeror confirms their proposal will remain valid and open for at least 90 days.	<input type="checkbox"/> True <input type="checkbox"/> False

** Failure to answer or answering "False" may be grounds for disqualification. Please attach additional information on any subject where the Offeror responded "False" to a question above.*

CONFLICT OF INTEREST STATEMENT

Indicate below whether or not the firm or any individuals that will work on the contract has a possible conflict of interest (e.g., currently employed by the State of Alaska or formerly employed by the State of Alaska within the past two years) and, if so, the nature of that conflict. The Commissioner of the Department of Administration reserves the right to consider a proposal non-responsive and reject it or cancel the award if any interest disclosed from any source could either give the appearance of a conflict or cause speculation as to the objectivity services to be provided by the offeror. The Commissioner's determination regarding any questions of conflict of interest shall be final.

Does the offeror, or any individuals that will work on this contract, have a possible conflict of interest?

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
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** Failure to answer may be grounds for disqualification.*

If "Yes", please provide additional information regarding the nature of that conflict:

ALASKA PREFERENCES

Identify if your firm qualifies for any Alaska Preferences:

Alaska Bidder Preference: Do you believe that your firm qualifies for the Alaska Bidder Preference? Note: If you answer 'yes', please complete the additional information requested below.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
Alaska Veteran Preference: Do you believe that your firm qualifies for the Alaska Veteran Preference? Note: If you answer 'yes', please complete the additional information requested below.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
Please list any additional Alaska Preferences below that you believe your firm qualifies for.							
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 16.6%; border-bottom: 1px solid black;">1.</td> <td style="width: 16.6%; border-bottom: 1px solid black;">2.</td> <td style="width: 16.6%; border-bottom: 1px solid black;">3.</td> <td style="width: 16.6%; border-bottom: 1px solid black;">4.</td> <td style="width: 16.6%; border-bottom: 1px solid black;">5.</td> <td style="width: 16.6%; border-bottom: 1px solid black;">6.</td> </tr> </table>		1.	2.	3.	4.	5.	6.
1.	2.	3.	4.	5.	6.		

ALASKA BIDDER PREFERENCE

If you answered 'yes' to the Alaska Bidder Preference, complete the following information:

1	Does your firm hold a current Alaska business license prior to the deadline for receipt of proposals?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	Is your firm submitting a proposal for goods or services under the name appearing on the offeror's current Alaska business license?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	Has your firm maintained a place of business within the state staffed by the offeror, or an employee of the offeror, for a period of six months immediately preceding the date of the proposal? Note: 2 AAC 12.990(b)(3) defines a <i>place of business</i> as "that location at which normal business activities are conducted, services are rendered, or goods are made, stored, or processed; a post office box, mail drop, telephone, or answering service does not, by itself, constitute a place of business." 2 AAC 12.990(b)(7) also defines <i>staffed</i> as "the bidder or at least one employee of the bidder is resident of the state under AS 16.05.415(a)" (must be an Alaskan resident for at least a year with the intent to remain in Alaska indefinitely).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	Is your firm incorporated or qualified to do business under the laws of the state, is a sole proprietorship and the proprietor is a resident of the state, is a limited liability company (LLC) organized under AS 10.50 and all members are residents of the state, or is a partnership under AS 32.06 or AS 32.11 and all partners are residents of the State;	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	If your firm is a joint venture, is the joint venture composed entirely of ventures that qualify under (1)-(4) of this subsection.	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> Yes <input type="checkbox"/> No

ALASKA VETERAN PREFERENCE

If you answered 'yes' to the Alaska Veteran Preference, complete the following information:

Does your firm hold a current Alaska business license prior to the deadline for receipt of proposals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your firm qualify under AS 36.30.990(2) as an Alaska bidder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your firm a sole proprietorship owned by an Alaska veteran?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your firm a partnership under AS 32.06 or AS 32.11 if a majority of the partners are Alaska veterans?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your firm a limited liability company organized under AS 10.50 if a majority of the members are Alaska veterans?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your firm a corporation that is wholly owned by individuals, and a majority of the individuals are Alaska veterans?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SIGNATURE

This proposal must be signed by a company officer empowered to bind the company.

Printed Name Scott Neururer

Title Senior Vice President

Date March 14, 2018



SUBMITTAL FORM B – Service Approach

Part 1 – Network Plan (Commercial)

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposers cost/fee, and must not exceed four pages (reference RFP section 4.02).

We deliver comprehensive, specialized strategies to maximize the State of Alaska’s (the State) pharmacy benefit program through efficient retail, mail service and specialty pharmacy network services and operations.

RETAIL PHARMACY NETWORK

We offer a variety of flexible retail network solutions, enabling the State to select the option that best meets its and its members’ needs. We can discuss specific, required pharmacy network configurations and customization alternatives with the State during contract negotiation and plan implementation.

FACILITATING MEMBER ACCESS ACROSS THE STATE

We have developed a broad retail pharmacy network across the State of Alaska to enable access for all members including those in geographically isolated communities. For example, independent pharmacies such as Whale Tail Pharmacy in Craig, Cordova Drug in Cordova, Kana Pharmacy in Kodiak, and Petersburg Rexall Drugs in Petersburg, are all in our network. We also have independent pharmacies in our network in rural towns such as North Pole, Glennallen, Soldotna, Barrow, Unalakleet, Sitka, Haines Kotzebue, and others. We can expand the network with any additional independent pharmacies that may be of specific importance to the State.

NATIONAL NETWORK

Our National Network is our core network option and is comprised of more than 67,000 pharmacies, which equates to 93 percent of available retail pharmacies. This broad offering provides customers and their members with convenient access to thousands of chain and independent pharmacies throughout the United States (including Puerto Rico, Guam, and the Virgin Islands), for up to 90-day supplies of medications. Our National Network is extensive, established, and inclusive of all major pharmacy chains.

RETAIL90 NETWORK

Our Broad Retail90 network provides access to more than 90 percent of those pharmacies belonging to the National Network, including Walgreens, CVS, Rite-Aid, Walmart, Target, Costco and K-Mart. With more than 57,000 locations it provides deeper discounts for 90-day prescription fills.

WALGREENS90 NETWORK

Based on the RFP requirements, we have proposed our Broad Retail90 network. Per the request by the State, we have the ability to limit our Broad Retail90 network for additional savings. We can provide a 90-day network solution comprised of more than 8,200 locations that offer members the opportunity to select either mail service or a Walgreens retail pharmacy to fill their 90-day maintenance prescriptions. The State can choose either the Walgreens90 Saver (preferred) or Walgreens90 Saver Plus (mandatory) network options.

- **Walgreens90 Saver:** A preferred network with Walgreens as the preferred retail pharmacy and our mail service pharmacy as the preferred mail service pharmacy for 90-day fills (otherwise member pays a higher copayment)
- **Walgreens90 Saver Plus:** A mandatory network with Walgreens as the mandatory retail pharmacy and our mail service pharmacy as the mandatory mail service pharmacy for 90-day fills (otherwise member pays 100 percent out-of-pocket)

In either option, plan members are allowed two grace fills at the retail pharmacy before being formally directed to either Walgreens or our mail service pharmacy for their 90-day maintenance medications.

CVS90 NETWORK

Based on the RFP requirements, we have proposed our Broad Retail90 network. Per the request by the State, we have the ability to limit our Broad Retail90 network for additional savings. Through our CVS90 Network, we can offer effective and convenient delivery of medications to members and customers at affordable prices. Members have a

choice to fill 90-day prescriptions for maintenance medications at either their local CVS retail pharmacies or through our mail service pharmacy. The State benefits from the lower mail service discounts while members may fill their maintenance medications at approximately 9,600 CVS pharmacy locations.

The State can choose either the CVS90 Saver (preferred) or CVS90 Saver Plus (mandatory) network options.

- **CVS90 Saver:** A preferred network with CVS as the preferred retail pharmacy and our mail service pharmacy as the preferred mail service pharmacy for 90-day fills (otherwise member pays a higher copayment)
- **CVS90 Saver Plus:** A mandatory network with CVS as the mandatory retail pharmacy and our mail service pharmacy as the mandatory mail service pharmacy for 90-day fills (otherwise member pays 100 percent out-of-pocket)

In either option, plan members are allowed two grace fills at the retail pharmacy before being formally directed to either CVS or our mail service pharmacy for their 90-day maintenance medications.

The CVS90 Network offers a broader range of services in one platform, bringing together clinical capabilities and technology systems to build new combined pharmacy, health and wellness programs. The State may experience a reduction in pharmacy costs ranging from 1.5 up to 5 percent annually.

MAIL SERVICE PHARMACY

We own and operate four mail service pharmacy dispensing facilities that feature state-of-the-art automated fulfillment equipment, climate and access controlled production environments, and in-house pharmacists that provide hands-on verification of every order. We maintain efficient, technologically advanced procedures for dispensing mail service pharmacy prescriptions and safeguarding the security and integrity of all medications shipped from our facilities. Our processes assure accurate, efficient mail service pharmacy dispensing that combines the latest automation technologies with eyes-on inspection and verification at multiple checkpoints throughout the fulfillment process.

Our mail service philosophy is focused on the ways in which mail service—especially through savings and convenience for members—can support medication therapy adherence, which results in both improved member health and increased savings for the State. We strongly recommend the State implement benefit plans that give participants an incentive to use our mail service pharmacy program. Most customers define mail service benefits as ones that include a 90-day supply of maintenance medication for an amount equal to two (instead of three) one-month copayments.

We offer both preferred and mandatory mail benefit design options to increase mail service utilization through copayment or coinsurance differentiation. Increasing mail service enhances member convenience and reduces cost of care. We can customize both these benefit options to fit the State's specific needs. Additionally, based on our experience with other Alaska customers, we have found that the United States Postal Service is a reliable shipping option for mail and specialty medications as most other major carriers are not able to access the more remote locations as easily. As described in the specialty section below, we are also offering a concierge logistics service to the State at no additional cost to assist in delivering specialty medications to members in geographically isolated locations.

We work with the State to determine the most effective ways to communicate with members about the benefits of using our mail service pharmacy. Various promotional efforts available at no extra charge include targeted mailings to members, articles in employee newsletters and payroll stuffers.

SPECIALTY PHARMACY FULFILLMENT AND MANAGEMENT

Specialty pharmaceuticals continue to account for an ever-increasing percentage of pharmacy and medical costs. To address the unique needs of members who use specialty pharmaceuticals and the increasing costs and expanding indications of these medications, we offer our member-centric specialty pharmacy.

We own and operate a specialty pharmacy through which we provide access to biotech agents, injectable medication, and other high-cost specialty drugs. We offer significant savings and flexibility in delivering medications to members or to a physician's office for administration. We also offer high-touch care management services through this program. These services include proactive refill reminder assistance, case management, case review, disease

management counseling and support, and referral to external member-assistance programs.

Through our relationships with manufacturers and alternate vendors, such as limited distributors, we have access to all specialty medications.

SPECIALTY PHARMACY NETWORK

We have our own specialty pharmacy and have built a cost-effective, quality network of specialty pharmacy providers that comply with stringent participation requirements, including clinical programs, accreditation and robust reporting. We offer a specialty pharmacy network that provides members with convenient access to specialty medications and exceptional clinical services at the best possible price. Our specialty pharmacy network providers are contractually obligated to provide our high-touch clinical and cost-containment strategies. As such, utilization of our specialty pharmacy network has shown to drive better medication adherence and clinical management through interventional and educational programs, resulting in lower medical costs.

SUPPORTING THE STATE’S SPECIALTY MEDICATION MEMBERS

We provide a video consultation platform that allows the State’s members to have real-time, face-to-face consultations with a clinician who is an expert in their condition. We provide one-on-one support to help members take their medications and understand their treatment. Our functionality supports members through personal contact with our clinicians to provide education and promote adherence, teach members how to “unbox” the medication shipment and understand the items inside, help them inject their medication, give caregivers more information about member treatment and care, recommend ways to help manage any medication side effects. The personal and confidential appointment gives members as much time as they need to ask questions from the privacy of their own home. We can also record the session so members can review it later or share it with a caregiver.

Similarly, for members with specialty conditions such as cancer, hepatitis C, HIV, inflammatory conditions, multiple sclerosis and transplants, we offer an online community to make them feel connected to others with the same condition and present opportunities to learn about their condition. Members can access videos from others with their condition as well as videos with advice from experts and pharmacists with specialties in the condition. The videos help members understand their condition, specialty medications used to treat it, how to prevent and manage side effects from treatment, how diet and other lifestyle choices can help and other resources available for support during treatment. Members can access videos from their mobile phone, tablet or computer.

We also provide members with bundle kits filled with helpful items for specific conditions, such as ice packs, lotion, rubber grippers and water bottles. Calendars and journals are also included to help members take medications as prescribed, manage side effects and note any questions for doctors or caregivers.

Specialty pharmacists are available by phone 24 hours a day, seven days a week. We also give members access to a mobile app that they can use to request prescription refills, check order and shipping status, request an on-demand video consult, see specialty prescription history and find information about their condition and the medications to take to treat it.

FOCUSED ON THE NEEDS OF THE STATE

We are committed to meeting the specialty medication needs of the State and your members. We are finalizing plans for a new specialty pharmacy location in the Seattle, Washington area which, once complete, will serve as the primary specialty pharmacy for the State’s specialty and infusion needs. This new pharmacy is strategically located to provide the logistical flexibility to further help meet the specific geographic needs and provide the highest level of service for your valued members. We plan to begin staffing this new pharmacy operation in early 2019. In addition, we provide specialized expertise in delivering specialty medications to geographically isolated members. Delivery solutions use a combination of national, regional, and local carriers to facilitate on-time delivery and determine the method of delivery based on a member’s locations. Through a proprietary tracking system and access to specialized couriers, our enhanced concierge delivery service achieves on-time delivery of specialty medications using a broad range of delivery capabilities including private charter, boat, weather-adverse prepared couriers, dog sled and other methods. When an unexpected delay occurs, logistics specialists provide solutions to get the package delivered to members on the committed day and provides 24 hour a day, seven day a week customer support to keep the member informed.

SPECIALTY MEDICATION DELIVERY - MEMBER TESTIMONIALS:

"I am so thankful for your help. I didn't know my pharmacy offered this service, but I'm so happy they do!" – Patient

"Because of you I don't have to go through a night without my medication." - Patient

Beyond use of our specialty network, we have specific recommendations based on our strong relationships with pharmaceutical manufacturers and specialty expertise. Our specialty drug list strategically tiers medications based on clinical evidence to maximize pricing and rebate potential for the State.

SUBMITTAL FORM B – Service Approach

Part 1 – Network Plan (Enhanced EGWP)

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposer's cost/fee, and must not exceed four pages (reference RFP section 4.02).

Our CMS-compliant Medicare Part D network provides unrestricted, nationwide coverage in all 34 Medicare Part D regions (50 states) plus Puerto Rico and Guam. We provide members and customers a broad national network that enables them to receive convenient access to thousands of chain and independent pharmacies throughout the United States, where they can receive up to 90-day supplies of their medications. All major and local chains are included in our network. This Medicare network also includes access to long-term pharmacies and meets all CMS guidelines including access standards. Pharmacy limitations can be implemented as needed by State of Alaska (the State).

The proposed national retail network provides excellent geographic coverage for all out-of-state retirees, offering aggressive brand-name and generic discounts. Should the benefit allow, if a network pharmacy is not used, we have a direct member reimbursement (DMR) process for manual or paper claims.

In addition, the State's retirees can fill mail service prescriptions through our wholly-owned and operated mail service pharmacy, and specialty medications through our member-centric specialty pharmacy.

PHARMACY LOCATOR TOOL

The Pharmacy Locator Tool provides members with retail pharmacy information such as pharmacy name, address, phone number and network status. Medicare Part D members see additional information, including:

- Information about 24-hour and 90-day retail pharmacies nationwide and maps to these locations
- Identification of Indian Health Service, Tribe or Urban Indian Program pharmacies
- Identification of pharmacies with home infusion, long-term care and specialty services
- Network provider information
- Identification of pharmacies with e-prescribing capabilities
- Identification of pharmacies that offer vaccinations/immunizations

We can discuss expanding the capabilities of this tool to meet the State's needs.

MAIL SERVICE PHARMACY

We own and operate four mail service pharmacy dispensing facilities that feature state-of-the-art automated fulfillment equipment, climate and access controlled production environments, and in-house pharmacists that provide hands-on verification of every order. We maintain efficient, technologically advanced procedures for dispensing mail service pharmacy prescriptions and safeguarding the security and integrity of all medications shipped from our facilities. Our processes assure accurate, efficient mail service pharmacy dispensing that combines the latest automation technologies with eyes-on inspection and verification at multiple checkpoints throughout the fulfillment process.

SPECIALTY PHARMACY

Our specialty pharmacy network provides members with convenient access to specialty medications and exceptional clinical services at the best possible price.

Our objectives include comprehensive access to specialty medications, quality clinical services, competitive pricing and benchmarking to demonstrate value. When developing our specialty network, we do so purposefully, contracting specialty pharmacies based on:

- Clinical expertise
- Established product distribution
- Aggressive discounts

- Superior support, member education and customer service
- Established physician relationships
- Benchmarking capabilities

Specialty pharmacies in our network are held to high-quality standards with performance metrics reviewed on a quarterly basis to foster continuous improvement. Criteria include:

- Adherence rates
- Dose escalation and other clinical interventions on behalf of pharmacist
- Supply control
- Product market share

The combined therapeutic categories in our specialty network represent more than 95 percent of the total specialty pharmacy spend covered under the pharmacy benefit. Additionally, we continually monitor the drug pipeline and work with pharmaceutical manufacturers and our specialty pharmacies to determine pricing and optimal distribution methods to define clinical programs and expected service levels before new specialty products are introduced to the market. This proactive approach to managing specialty pharmaceuticals gives members timely access to the medications and support they need at the best possible price.

SUBMITTAL FORM B – Service Approach

Part 2 – Customer and Member Support

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the Proposers cost/fee/rates, and must not exceed four pages (reference RFP section 4.02).

We differentiate ourselves from our competitors by offering a streamlined consumer health care experience for the State of Alaska’s (the State) members. Traditional member service models ask members to navigate a fragmented health care system to manage their benefits across vendors. Our premiere service model simplifies the experience by offering a single point-of-contact for the State’s members. We work with the State’s vendors to provide members with data-driven support to help drive engagement, improve health outcomes and increase savings.

Through our premiere service model, the State has one team working on one system to provide the State’s members with a seamless support experience. Members have access to a special team of health care advisors (advocates), pharmacists, and registered nurses at the center of the member’s experience with a line of sight across the State’s health and wellness and pharmacy programs. Beyond providing traditional service, our advocates support the breadth of member needs for medical, behavioral, pharmacy and specialty benefits across multiple programs, vendors and carriers. From questions about benefits to concerns about symptoms, our team helps the State’s members become better stewards of their health.

Advocates have access to a member dashboard that displays information specific to each of the State’s members. In addition to supporting pharmacy benefit inquiries, advocates can help members find a physician, schedule appointments for call-backs with clinical pharmacists, enroll in programs or identify savings opportunities through incentives or lower-cost alternatives. If needed, advocates can connect members with nurses for symptom triage and decision support for over 250 treatments and procedures. Our skilled nurses also help members with chronic or complex conditions close gaps in care. Nurses and pharmacists are available 24 hours a day, seven days a week, to support members' clinical needs, working with members to establish care plans, close gaps in care and complete comprehensive medication reviews. This combination of experience, enhanced training and access to medical and pharmacy data, enables us to deliver the State’s members a superior service experience.

TEAM AVAILABILITY

One team of advocates handles the State’s commercial and EGWP plans, and is available to support benefit, eligibility, mail service and open enrollment inquiries from members, Monday through Friday from 7 a.m. to 10 p.m. CT. Outside of these hours, calls are supported by a designated team of advocates available 24 hours a day, seven days a week. To provide optimal service levels, we expand our call center staff during times of high call volume.

SERVICE FOR RETIREES

Advocates are provided the training and knowledge needed to support Medicare eligibility, enrollment, disenrollment and benefit inquiries, including drug coverage, Low Income Subsidy, pharmacy networks, copayment, TrOOP, complaints and grievances. Advocates can also assist with lower cost alternatives that a member can discuss with his/her doctor, and handle mail service prescription requests and orders.

Our call center operations have been in compliance with the Medicare Call Center reporting requirements since 2006 and continue to do so despite the suspension of Medicare Part D reporting requirements in 2007. Our call center continues to comply with the following Medicare call performance standards in effect prior to the suspension:

- 80 percent of incoming calls answered within 30 seconds.
- Abandonment rate for all incoming calls of less than 5 percent.
- Call center availability 24 hours a day, seven days a week.
- Call center support for non-English speaking and hearing-impaired members.

Our member service department is permanently staffed with bilingual advocates who can accommodate Spanish-speaking members. We also contract with LanguageLine Solutions®, a company that provides real-time translation for more than 240 languages. This language translation service is available around-the-clock.

SUPPORTING AN EXCEPTIONAL MEMBER EXPERIENCE

In addition to our advocates providing front-line customer service, we provide members with a digital consumer platform and mobile app to help them understand and manage their prescription benefit and be informed consumers of health care services. Our capabilities make it easy for members to access their profile and manage their prescription benefits on any device. Each member's real-time benefits information is presented on their personalized "My Medicine Cabinet" dashboard and we provide transparency and savings with accurate drug pricing and proactive messaging on cost savings for medications. Members can enroll in text message reminders for taking their medications as well as when they need to refill or renew prescriptions and when orders have shipped.

Similarly, with our mobile app, members have access to real-time benefits and drug coverage information and are able manage prescriptions, easily refill or renew home delivery prescriptions, or transfer retail prescriptions to mail service in a few easy steps. Members can also compare medication prices and save on lower cost options—all from a smartphone or tablet.

EMPOWERING PROVIDERS AT THE POINT OF MEMBER CARE

We have launched pioneering technology and analytics to more effectively connect with providers and evaluate their prescribing patterns. Innovative functionality enables us to provide physicians with patient-specific benefit, formulary and cost information, and the ability to clear a prior authorization, all within the physician's EMR workflow in real-time—*while the patient is in the doctor's office*. This capability removes barriers to accessing the most cost-effective and appropriate medication. Through this capability, we have observed a 25 percent increase in use of lower cost alternatives and 34 percent avoided or initiated prior authorizations. The functionality enhances the information available to providers at the point of prescribing to support the prescription decision-making process and enabling providers to focus on their patients' quality of care. Our tool also delivers alerts to keep the prescriber informed about critical medication issues related to adherence, dosage issues and drug interactions.

EXPERT RESOURCES TO MANAGE THE STATE'S PHARMACY BENEFIT

To help the State effectively manage its pharmacy benefits, we allocate expert resources from implementation, to account management, to enterprise government affairs that spans the entire health care spectrum. Our approach provides proactive support and assistance to improve member outcomes, control costs and keep the State up to date on impact analyses from key legislation. Our approach is focused on accountable performance for service excellence to the State and its members.

IMPLEMENTATION

We are dedicating an implementation manager to lead the State's implementation team. This individual has extensive experience implementing both commercial and EGWP plans and will manage and oversee all aspects of implementation to facilitate a successful launch on the January 1, 2019 effective date. In addition, specialized resources from our government services team are part of a defined implementation process to meet all aspects of the State's Medicare implementation requirements.

ACCOUNT MANAGEMENT

We provide the State with a comprehensive client management team led by a dedicated account executive with expertise managing commercial and EGWP accounts. The team will advance the State's pharmacy objectives and deliver results by using a total health care value approach to proactively manage the State's cost trends, delivering formulary management, utilization management, specialty pharmacy, home delivery, retail networks and effective clinical programs to contain costs and focus on performance.

The State's client management team includes leaders supporting the State's commercial and EGWP plans, providing comprehensive clinical program support and delivering advanced analytics and reporting.

Following are brief descriptions of key client management team member roles and how we collaborate with the State.

EXECUTIVE SPONSOR

The executive sponsor helps facilitate interaction with the State and drives timely and attentive problem resolution. In this role, the State's executive sponsor is:

- Present at business reviews and knowledgeable about the contract, the State's structure (including operations and needs), current performance metrics and opportunities for better achieving the State's goals
- Prepared to contact by phone the designated executive within the State at least monthly and meet face-to-face at least quarterly or as needed
- Available to the State through a personal cell phone number
- Familiar with all departments within our organization and can initiate remedial measures should they be needed
- Able to provide current information on legislative and regulatory activities in the area of pharmacy benefits that are likely to affect the State's constituency

ACCOUNT EXECUTIVE

Your dedicated account executive is the overall owner of our relationship with the State. The account executive has overall leadership of the assigned client management team's functions, and primary responsibility for our business relationship. The account executive serves as your strategic point of contact, tasked with achieving and maintaining your overall satisfaction with our services.

CLIENT RELATIONS MANAGER

The client relations manager is the State's primary liaison and manages daily operations, projects and reporting and strategic consultation. Additional functional roles provide analytical and data evaluation, trend forecasting, program counseling and outcome measurement. Your client relations manager is your day-to-day contact for all operational aspects, including maintaining critical documentation, coordinating the eligibility process and providing problem resolution for questions regarding claims, drug status and pricing.

CLINICAL CONSULTANT

Ongoing clinical management is vital to a successful prescription benefit program, and we assign a clinical consultant to act as a functional resource for defining and driving the State's clinical experience. Your clinical consultant is backed by the support of our clinical department, with responsibilities that include analyzing utilization trends to assist with identifying cost management strategies, providing forecast and trend information, and making recommendations on benefit program changes and enhancements.

CLIENT ADVOCATE

We provide a dedicated client advocate to serve as a customer service liaison with the State's client management team to handle all member escalations from the State. Working within our customer service department, the dedicated client advocate works closely with your implementation manager and client management team to facilitate service readiness for the State's new benefit implementation, and to resolve any member issues after implementation.

Service Readiness: From the onset of the relationship, the client advocate is assigned as part of the implementation team to confirm that the State's customer service team has the training and tools necessary to respond to and resolve frequently asked questions about new benefits. To support this, we validate that the benefit tools accurately reflect benefit design, formulary listings and pharmacy networks through extensive audits across member service touch-points. We also build and train teams for customer culture and benefit specifications.

Rapid Resolution: After implementation, the State's client advocate supports rapid resolution for escalated prescription or pharmacy service issues for members with the assistance of a dedicated research and resolution specialist. This second, dedicated individual from within our customer service department works closely with the client advocate to research and resolve complex member questions, such as benefit-related questions that may not be defined within existing benefit design documentation. Activities include tracking performance for service level agreements, monitoring recorded calls, conducting side by side's with the customer service team, and regular attendance of team meetings with the State's operations team. This approach proactively tracks and trends any State or member issue for remediation at the root cause, with the ultimate goal of delivering an exceptional member experience.

ONGOING SUPPORT

The West Coast based client management team meets regularly with the State to provide attentive and responsive account service. The client advocate may also participate in regular service meetings with account managers and the State, including performance reviews and remediation planning, if required.

We establish meeting requirements during the implementation stage, including meeting frequency, format, key personnel participation, and custom reports required. We facilitate a collaborative approach for providing the type of account service and reporting that best serves the desired outcomes, needs, and financial objectives of the State.

ENTERPRISE GOVERNMENT AFFAIRS

We have a dedicated Enterprise Government Affairs team that supports the State by tracking policy, providing federal legislation updates that may impact the State and members and advising the State on any adverse clinical, financial or feasibility impact related to key legislation. We leverage the significant scale of our organization to advocate on behalf of our customers, connecting policy insight and leadership to help drive total cost containment strategies that benefit the State. Our team educates and supports public officials, boards of pharmacy, state regulators, governor/executive team and legislative leaders and we provide advisory support to the State on pending legislation and policy initiatives at the state and federal level. Our unique approach informs and helps the State address impact from key legislation.

REBATE ROUNDTABLE – MANAGING CURRENT AND FUTURE TREND

We invite the State to participate and collaborate in a Rebate Roundtable, a research and discussion forum where our consulting group reviews the State’s plan designs, utilization and trend on a quarterly basis. We know that the rising cost of pharmaceutical drugs is a significant challenge for the AlaskaCare Plan and our team identifies opportunities for the State to mitigate current and future trend, improve clinical outcomes and generate enhanced savings through rebates and lower net cost alternatives. Our team works closely with the State to provide estimates for future rebates, which can include multiple scenarios that compare achieved savings along with the associated strategies and assumptions used to model each scenario across multiple therapeutic categories on a quarterly basis.

COMPREHENSIVE ONGOING SUPPORT FOR THE STATE

We provide the State with a highly competitive and differentiated pharmacy benefit management program that raises the bar on performance and accountability. Along with the comprehensive support from our implementation, account management, enterprise government affairs and rebate roundtable, we provide the State with regular reporting that puts actionable insights at your fingertips, including a dashboard to measure program performance and trends. We also provide the State with a secure client portal that gives access to eligibility and plan management, member utilization reporting tools, and drug information newsletters. Together, we work collaboratively with the State to set program goals, perform population analysis and benchmarking, and provide insights and recommendations to optimize the State’s program.

SUBMITTAL FORM B – Service Approach

Part 3 – Medicare Part D Enhanced EGWP

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the Proposers cost/fee/rates, and must not exceed four pages (reference RFP section 4.02).

We have held a Medicare Part D Employer Group Waiver Plan (EGWP) Prescription Drug Plan (PDP) contract with Centers for Medicare & Medicaid Services (CMS) since 2007. Our EGWP PDP has grown exponentially over the past several years. As of January 1, 2018, we manage a total of 23 employer groups with a combined membership of around 625,000 lives. We have several years of experience administering smaller regional employer groups as well as larger more complex state employer groups. Our experience encompasses all aspects of Medicare Part D, including CMS enrollment, member communications, claims adjudication, clinical programs, and compliance.

Some highlights of our EGWP PDP include:

- Streamlined single-plan/single-claim EGWP+WRAP approach enhances the administration of the plan and claim processing and improves the efficiency of the implementation and administration processes. In addition, we own the technology for our claim adjudication platform.
- A fully-customizable EGWP-plan design (provided the benefits are CMS compliant), formulary administration and set up, and most member communications within CMS guidelines, thus minimizing member disruption.
- Strong compliance track record with CMS: no sanctions, no significant audit findings.
- Dedicated Government Programs team focused on Medicare Part D including a separate group focused on EGWP Operations (for example, CMS enrollment, member communications, issue resolution, and client support). This service model can be implemented quickly and accurately and is adaptable to any size employer group. In addition, we also utilize a third party CMS enrollment vendor where all day-to-day management and oversight is performed by the EGWP Operations team.
- Consultative value-added approach in delivering EGWP PDP benefits in order to provide maximum value to our customers.
- Comprehensive EGWP customer implementation and ongoing account management models. In addition, within the EGWP Operations team, there are dedicated client account liaison staff who are assigned to work with client management to provide assistance with operational questions, project tracking, CMS guidance, and other activities to support customer expectations.

CMS ENGAGEMENT

We facilitate policy review and development through CMS engagement, including with our regional CMS office, to address day-to-day issues. These contacts prove valuable in securing support on routine issues and our CMS audits are opportunities to provide feedback to CMS. We also work with the Pharmaceutical Care Management Association industry group to provide feedback when CMS seeks industry comment on proposed guidance. For more advanced questions, on-site meetings with CMS can take place. These are performed by our compliance group and are typically discussions focused on topics of interest to all of our customers.

IMPLEMENTATION SUPPORT

We deploy a robust and comprehensive government services implementation process that validates that the following areas are addressed timely and accurately:

- Compliance requirements and adherence
- Member communications
- Data integrity through eligibility management, testing, and validation
- Benefit and formulary management
- Testing of benefit rules

Specialized resources from our government services team are part of the defined implementation process to validate that all aspects of the State's Medicare implementation meet requirements. In addition, a seasoned, experienced implementation manager with EGWP experience leads the State's implementation.

MEMBER ENROLLMENT AND COMMUNICATION

The State provides us with eligibility files for its EGWP population on a scheduled basis. We can accept EGWP eligibility based on the State's needs and requirements, as frequently as daily. We process files from customers to CMS on a daily basis, and we process response files received back from CMS on a daily basis. We do a monthly reconciliation to validate all systems are matching.

We process eligibility files, identify and prepare new enrollments, changes, and disenrollments for processing to CMS. CMS responses are received daily and processed by us, and we produce and mail resulting required participant correspondence. CMS response files are loaded to our adjudication system daily, and reports are provided to the State so you may update your records and files as applicable. The State must update its records and systems, based on this reporting provided, to confirm future eligibility files are accurate and up-to-date.

NOTICE OF ENROLLMENT

New enrollees into the State's EGWP plan are sent a Notice of Enrollment, also known as an opt-out letter, to notify them that they are being enrolled in the State's EGWP plan. The letter, which needs to be provided to an enrollee at least 21 days before the plan effective date, also informs new enrollees of their option to opt-out of the plan, and explains any the State-specific rules and information related to that choice. For example, as specified by the plan's specific requirements, enrollees who opt out may lose medical benefits, lose coverage for dependents, or lose the opportunity to re-enroll in the plan in the future. Plan opt-out rules are determined by the State prior to implementation.

Enrollees who chose to opt out are directed to contact us. A representative explains to the enrollee that it is the employer's Medicare Part D plan they are opting out of, and any ramifications of opting out are directed by the State. Enrollees that still want to opt-out at that point are processed in our system as a cancellation request, and a letter is triggered to mail to the enrollee acknowledging this request. We transmit files to CMS on a daily basis (including any requests received to opt-out).

DISENROLLMENTS

When we receive a disenrollment for an enrollee on the eligibility file, we trigger and mail an Acknowledgement of Disenrollment Request letter that provides the enrollee advanced notice of the disenrollment. We process files and disenrollments and cancelations (in addition to new enrollments and changes) and submit them to CMS on a daily basis. Tuesdays through Sundays, CMS processes these files and sends a response file back to us that confirms when the disenrollments request has been approved. Disenrollment confirmations from CMS can include both requests from the State, as well as disenrollments initiated by CMS (for example, disenrollment due to death, or disenrollment due to enrollment in another plan). Notification of disenrollment approvals are provided to programs in weekly reports. The responses from CMS are typically received and loaded to our adjudication system within two business days after the submission to CMS. When an approval of a disenrollment request is received from CMS, we also mail a CMS-required Disenrollment Confirmation letter to the enrollee confirming the disenrollment within seven days of receipt of the CMS approval.

MEMBER COMMUNICATIONS

We provide a Welcome Kit, mailed within 10 days of the CMS acceptance into the EGWP Plan. The kit includes an ID card, welcome letter, abridged formulary, geo-coded pharmacy directory, as well as the Evidence of Coverage. In addition, CMS-required enrollment and disenrollment letters, communications and mailings (for example, transition supply, formulary change notices) are included.

We use standard templates that follow CMS model documents, and provide some customization of certain CMS-required communications to meet the State's needs. Certain CMS dissemination requirements do not apply when an employer or union sponsor is subject to alternative disclosure requirements (for example, ERISA); we provide for adherence to these alternate dissemination requirements. In terms of introducing the EGWP plan to the enrollee, we can provide a simple introduction letter that is sent to the State's enrollees introducing us as the PBM, and what CMS-

required materials the enrollee can expect to see in the future as mentioned above.

We can support CMS required materials. Some materials are customizable in order to illustrate the State's benefit/plan design structure accurately. However, other materials are standard and not customizable. For our PDP EGWP, we work with the State to create accurate open enrollment marketing materials for its EGWP program.

Customizable documents to reflect plan design:

- Pre-notification/Introduction letter
- Annual Notice of Change
- Evidence of Coverage (EOC)
- Summary of Benefits
- Abridged Formulary
- ID Card (however, must comply with National Council of Prescription Drug Program requirements)

Non-customizable documents include:

- Geo-coded pharmacy directory
- Explanation of benefits (EOB)
- Transition Benefit letter
- CMS Exhibit/LIS/Late Enrollment Penalty (LEP) letters
- Clinical letters

Any other enrollment related support outside of those required by CMS shall be subject to mutual agreement.

FORMULARY MANAGEMENT

We offer a 4-tier closed formulary that is used primarily for Employer Group Waiver Plans. Utilization management guidelines are reviewed by our P&T Committee and approved by CMS.

Our EGWP Formulary includes:

- Tier 1: Most generic medications
- Tier 2: Preferred brand-name medications
- Tier 3: Non-preferred brand-name medications
- Tier 4: High cost, specialty brand-name and generic medications

Many customers like a Medicare Part D benefit with a broader coverage of drugs. Medications excluded from our Medicare Part D formularies may be provided as an enhanced benefit, or Other Health Insurance (OHI), with the base EGWP formulary. Customers using the standard EGWP formulary may select OHI coverage for their members.

We can implement an enhanced EGWP formulary that mirrors the State's commercial formulary to the extent possible; however, it must align with what we submit to CMS.

In addition, we can match the State's existing plan design, provided it meets CMS compliance requirements.

SUBMITTAL FORM C – Risk Assessment Plan

PART 1 – Assessment of Controllable Risks

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposers cost/fee, and must not exceed two pages (reference RFP section 4.02).

Risk 1: Implementation challenges that can compromise a timely and successful plan installation.

Description: A successful implementation is crucial to the overall success of the State’s plan. We offer a collaborative environment where the dedicated implementation manager works closely with the State to document operational and system requirements for all components of the program. Requirements are determined during detailed discovery sessions with the State. Because of this collaborative approach, we rarely encounter unanticipated difficulties during the implementation process.

Strategy: Quality and accuracy are critical components to administering the State’s benefits. The client management team, which includes a dedicated implementation manager, works with the State to collect business requirements, which are used to initiate a service request. The service request contains detailed specifications of the requested modification or enhancement. Our programming staff uses this request to make any applicable system changes. A key part of this process is obtaining the State sign off on the business requirements. Obtaining this sign off prior to any work being initiated allows both the State and us to have the same understanding of what the end results are expected to be. As a best practice for consistent project tracking, the State has access to our client portal. This tool supports tracking and management of all open items. Your client management team meets with the State on a weekly basis to provide comprehensive updates on the issues/project tracking log. In the event that a target date is missed or a challenge arises that directly impacts the critical path, the project plan is promptly addressed and reviewed to determine an action plan that is mutually agreed upon. We are prepared to establish workable and effective solutions and act quickly to resolution. We remain accountable to deliver a successful plan implementation. To identify issues quickly, determine magnitude and get speedy resolution, we assign a dedicated business analyst that monitors new installations hourly for a mutually agreeable period of time. This includes the review of paid and rejected claims to verify set up is accurate and claims are adjudicating as intended. This real time monitoring and comparison to plan intent results in minimal adverse impact to the plan and membership.

Risk 2: Natural and emergency disaster impact on mail service operations

Description: If any one of our mail service facilities becomes inoperable, we have policies and procedures in place to maintain continuity of service for our customers and their members.

Strategy: Our mail service facilities are positioned in geographically diverse locations and have complete integration and redundancy in terms of their operation. Should one facility be inoperable, orders may be routed directly to another facility. We may work with local contracted vendors and retail locations to provide timely delivery to State of Alaska’s (the State) members during critical weather conditions, disasters, or other circumstances that would otherwise disrupt our normal shipping process. We work closely with our members to keep them informed of the situation and their options as we monitor conditions so that we may best provide continuance of service. We are also in position to leverage our network of retail pharmacies to help the State’s members receive prescriptions in times of crisis or catastrophe when our mail service facilities may be offline or unable to dispense or send orders.

We take special care with members when areas are affected by natural disaster. When extraordinary circumstances such as a hurricane, blizzard, flood or another natural disaster occurs, many members lose their medications and need to refill them without being subject to the usual refill limitations, quantity limitations, or prior authorization requirements. We work with the State to create a regional disaster override table to provide direction on refill instructions for its members.

Risk 3: Security and protection of member and company data.

Description: Prevention of data being compromised or loss due to human error, hardware failure, natural disaster and/or theft.

Strategy: Our Information Security policies and standards have been developed on the ISO (International Organization for Standardization) framework. The Information Security Risk Management and Privacy Program protocols are based on industry practices (National Institute of Standards and Technology (NIST), ISO) and applicable regulatory obligations such as U.S. Department of Health and Human Services (HHS), Office of Civil Rights (OCR), Office of E-Health Standards & Services (OESS), Department of Insurance (DOI), Federal Trade Commission (FTC), State Attorney General's, International Implications (EU 95/46EC), Centers for Medicare & Medicaid Services (CMS), and other regulatory guidance.

We endorse the mission, charter, authority, and structure of the Information Risk Management organization. Our Information Risk Management team is charged with the responsibility for developing, maintaining, and communicating a comprehensive information security program to protect the confidentiality, integrity, and availability of information assets. These policies and standards apply to all employees, third parties, and subcontractors. Our Enterprise Information Security organization is responsible for developing and maintaining comprehensive Information Security policies and control standards. Information Security policies and standards are reviewed annually to confirm legal and regulatory compliance, proper governance, and alignment with the business objectives.

The mission of our Data Protection Governance organization is to protect the privacy of customers, members, employees, shareholders, and vendors by implementing and overseeing an enterprise-wide data risk management program. Through managed and repeatable processes, we confirm controls and security policies and standards are in place to protect sensitive data. For example, risk analysis is performed for the following:

- Information, data security, and privacy policies, and standards
- Payment Card Industry compliance (PCI)
- Health Insurance Portability & Accountability Act Security Rule (HIPAA)
- Gramm-Leach-Bliley Act compliance (GLBA)
- Social Security Number (SSN) use, handling, controls and standards
- Alliance Partner processes

Personnel are responsible for safeguarding communications to protect the confidentiality of information assets. Confidential and protected information is reviewed by information owners, resource administrators, and information users to determine if encryption is required when it is at rest or in transit. If encryption is required, only approved encryption tools may be used. Our personnel, third party consultants, contractors, and vendors may not implement encryption, digital signatures, digital certificates or key escrow tools without prior authorization from Information Risk Management. The selected algorithm used to encrypt data uses a tested and best practice standard.

SUBMITTAL FORM C – Risk Assessment Plan

PART 2 – Assessment of Non-Controllable Risks

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposers cost/fee, and must not exceed two pages (reference RFP section 4.02).

Risk 1: The inflation of drug pricing.

Description: We continually evaluate opportunities to help customers manage drug costs and proactively monitor and anticipate price increases. As more opportunities become available for managing price inflation, information is shared with customers.

Strategy: Our strong relationships with pharmaceutical manufacturers maximizes contracting and reimbursement opportunities. Our scope and size creates leverage to negotiate aggressive pricing to lower costs for the State and its members. We have relationships with every major specialty drug manufacturer and most specialty biotech and research and development manufacturers.

Along with negotiating aggressive pricing, and our single-source pharmacy model, we manage drug costs for the State through:

- Rewarding pharmaceutical manufacturers who keep costs down
- Using exclusions to block less effective products and drive lower cost alternatives
- Protecting the State from excessive price inflation through Price Protection and price surveillance

LOWEST NET COST APPROACH

We take the lowest net cost by therapeutic class approach to evaluate a drug’s value and determine its tier placement and management needs. We look at clinical efficacy, cost savings; member choice and disruption. When considering a drug’s formulary placement and management strategies, our Pharmacy & Therapeutics (P&T) Committee reviews products first for clinical efficacy and therapeutic equivalency. Only after the clinical review is complete do we begin to evaluate the financial impact of formulary decisions. We analyze the business impact each decision would make not only to OptumRx, but also to our customers. Unlike our competition, we try to align our decisions with our customers’ goals and consider the big picture before making any final decision that impacts our customers and members.

PRICE SURVEILLANCE

We use a proprietary Price Surveillance Tool to detect drugs with impactful price changes on a bi-weekly basis. The Price Surveillance Tool incorporates traditional and specialty drug utilization data and monitors the percentage price increases in wholesale acquisition cost (WAC)/trend impact for brand drugs on a week-to-week, month-to-month, and year-to-year basis. This report facilitates prompt identification of significant drug price increases and formulation of an action plan without delay. We conduct a daily review of industry publications, business news articles and press releases for drug price-related intelligence. Drugs identified through these methods undergo a rigorous review and assessment process and are evaluated for potential management strategies. These potential management strategies are reviewed by the P&T Committee for clinical appropriateness.

PRICE PROTECTION

We help the State mitigate the risk of increased drug costs by implementing a ceiling, or Maximum Allowable Price, on the majority of brand name, rebateable drugs. In fact, we have successfully negotiated Price Protection on nearly 99 percent of our rebated drugs.

- Our inflation cap payments or Price Protection is a guarantee by drug manufacturers that the wholesale price inflation of a drug does not exceed a certain level within a given

timeframe. If a drug's inflation does exceed the threshold within this timeframe, the manufacturer refunds the difference between the actual inflation and that threshold as a percent of WAC.

Risk 2:

Pharmacy fraud, waste and abuse that increases costs for customers and members.

Description:

Our Advanced Pharmacy Services offer a suite of additional, detailed options for preventing and identifying possible fraud, waste and abuse. Working in conjunction with our standard auditing programs, Advanced Pharmacy Audit Services provides the State a greater degree of insight and analytics which have been shown to increase recoveries while reducing drug spend.

Strategy:

Our Advanced Pharmacy Audit Services offer:

- Proactive monitoring and analyses of network pharmacies with highest billed claims or highest number of claims specific to your member utilization to determine potential for audit. This brings additional value as these audits/investigations allow for more in-depth review of pharmacy claim submissions.
 - Selective outreach to the State's members and their prescribers to validate receipt of medication by the member and treatment by prescriber.
 - State-specific weekly drug spikes reports which identify drugs that may be quickly increasing in volume and drug cost. The State is notified with recommendations to evaluate and potentially place edits, limits or other restrictions. For example, a Humalog drug report identifies spikes in billing and errors in quantity submitted. The average recovery for customers has been approximately \$140K per month.
 - Close monitoring of high cost claims on a daily basis to identify erroneous claims exceeding \$100K amount paid.
 - Review of member data including filling patterns, Geo-analysis and link analysis to identify members with potential drug-seeking behavior. This brings value from the health and safety perspective of the State's members. Any inconsistencies or concerns identified are referred to the customer for further review of their member.
 - Dedicated point of contact and subject matter expert for audit requests/referrals. Any requests are further analyzed by reviewing drug volume, pharmacy volume, medical claims data (if applicable), or reviewing for invalid or violation of pharmacy law.
-

SUBMITTAL FORM D – Value Opportunity Assessment

SPECIAL REQUIREMENTS: This Submittal Form must not contain any names that can be used to identify who the proposer is, must not identify the proposers cost/fee, and must not exceed two pages (reference RFP section 4.02).

Idea 1: **Enhanced customer service model that synchronizes and unites member health data to provide an exceptional member experience, drive better health care and lower costs.**

Description: We will deliver an enhanced customer service model that incorporates the State of Alaska’s (the State) medical claims into our advanced analytics to create a deeper understanding of member health needs across the health care spectrum. By analyzing both medical and pharmacy claims data, and combining it with analytics from other available sources, including behavioral and consumer data, we can generate a complete picture of member health—and act on the insight through our enhanced customer support model. The model includes health care advisors who answer member calls and have access to member benefit information as well as Next Best Actions analytics, which are personalized health recommendations based on individual member data. The analytics scores and prioritizes member health actions and displays the opportunities on a dashboard unique to each member. The result is a concierge model that helps your members navigate the health care system and connects them with the resources they need to improve health.

This enhanced service model can be scaled to meet the State’s unique needs. For example, we will add care management resources, such as condition management program nurses (covering five of the most prevalent disease conditions: diabetes, asthma, chronic obstructive pulmonary disease, coronary artery disease and heart failure) and connect members directly to nurses to help them manage conditions. Advisors and nurses have access to the same member dashboard, removing obstacles to engagement through immediate program referral and helping “take the member out of the middle.” On average, members engaged through our model have shown a 60 percent engagement in condition management programs when connected to the programs through our enhanced model and savings from our condition management program range from \$.90 to \$2.69 per member per month. Our approach uses one fully aligned team (that is, advisors, nurses and pharmacists), on one comprehensive care platform, to coordinate care specific to each member’s needs.

Idea 2: **Combating opioid use disorder through an innovative, integrated Opioid Risk Management program.**

Description: We are pioneering an innovative approach to address the opioid crisis through an integrated program that leverages pharmacy, our behavioral health program, our payment integrity program and advanced analytics. The approach engages clinicians/prescribers, members and pharmacists in education, prevention and intervention activities across the continuum of care. The program integrates pharmacy claims with medical claims and behavioral health data and uses advanced analytics to generate a view of opioid use and prescribing patterns across the State. Data analytics are captured in key performance indicator (KPI) dashboards for the State and guide targeted interventions with members and prescribers. Program components:

Pharmacy Benefit Management: Provides point-of-service safety edits, crucial proactive member education, and concurrent and retrospective DUR interventions targeted at prescribers to address dangerous combinations of drugs, excessive overuse of opioids, and facilitate intensive case management on those members who are highest risk for opioid use disorder.

Behavioral Health: Our innovative solution adds our behavioral health program, and Medication-Assisted Treatment network, to identify and manage high-risk, high-need members with opioid use disorder and medical/behavioral comorbidities. Integrating pharmacy, medical and behavioral claims enables us to intervene with members who are at risk for opioid misuse from their first fill.

Payment Integrity: Services include claims editing, prepay medical record review and postpay data mining. By aggregating medical and prescription claims together, the State benefits from

a more comprehensive picture of possible billing anomalies as well potential instances of fraudulent or abusive behavior.

Data & Analytics: Our analytics identify opioid misuse and help guide the intensity of care team outreach and interventions. Analytics are shared across the program to coordinate activities and we use analytic algorithms to evaluate the history of opioid prescribing across prescribers, or prescriber subsets, for opioid specific measures to target prescribers for education on appropriate prescribing. The program incorporates opioid KPI dashboards using a framework that includes prevention, pain management, opioid use disorder treatment, and maternal, infant and child health. Our KPI dashboard has the flexibility to generate a range of different views at the borough-level or deeper to help the program address trends and unique problem areas.

Some achievements of the pharmacy component of the opioid risk management program include: 21 percent reduction to CDC first-fill dosing guidelines of 50mg morphine equivalent dose (MED) per day for first-fill acute prescriptions resulting in 93 percent compliance to safe dosing; 5 percent decrease in current chronic opioid utilizers issues for >90mg MED resulting in 97 percent compliance to safe dosing; and, 14 percent reduction in average dose across all short-acting opioid prescriptions.

Idea 3: Advanced pharmacy audits using expert resources that dig deeper to prevent and detect fraud, waste and abuse and recover spent money.

Description: Our Advanced Pharmacy Audit Services program uses expert auditors, analysts and real-time audit management, plus proprietary algorithms and data mining tools, to catch and address questionable pharmacy activity. The team proactively monitors network pharmacies, analyzing claims to pinpoint even the most sophisticated instances of fraud, waste, abuse and error. The program examines high cost claims on a daily basis to identify erroneous claims exceeding \$100K amount paid. We have found that for every mis-paid claim identified, future overpayments are avoided on an estimated 3.4 refills. We also closely review member data, including filling patterns, perform Geo-analysis and link analysis to identify members with potential drug-seeking behavior and dig into your claims to look for any potential irregularities with your prescribers. The program adds value to the State through expert insight and analytics to increase recoveries while reducing drug spend. On average, customers experience a 3-to-1 return on investment with our Advanced Pharmacy Audit Services program.

Idea 4: Simplifying health care by consolidating member benefits information on a digital hub.

Description: A critical component for receiving the right care, and making the right care decision, is knowing what benefits and resources are available. On January 1, 2019, we are launching a digital platform that consolidates the full ecosystem of a customer’s benefits offering onto one member-friendly platform optimized across smartphones, tablets and computers. The platform creates a unified member experience helping members navigate health care by integrating benefits information from multiple vendors and personalizing each member’s interaction with the platform by incorporating member data and using it to drive engagement into programs available to them.

Idea 5: Lowering costs and expanding site of care options to include on-site clinics at retail pharmacies

Description: Our convenience care program allows members to receive medical care at a retail pharmacy and urgent care clinics at a flat bundled rate per visit, covering all available services provided by the clinics. These services are included as part of the pharmacy benefit and members do not pay anything at the point of care, but are notified by text or email the cost of the services prior to receiving a bill from the providers. Since the negotiated rate is less than the cost of seeing a primary care provider under medical plan benefits for the same services, the result is significant savings for the member (particularly members with high deductible health plans) and our customers. One customer experienced utilization of approximately 7,000 members with savings of greater than \$400,000 to the customer.

SUBMITTAL FORM E – Performance Qualifications

The State of Alaska (Division of Retirement and Benefits) is analyzing performance information on PBM providers and their critical personnel. The firm/individual listed below has identified you as a previous client. The State of Alaska greatly appreciates your time in completing this survey.

PART A – VENDOR NAME

Name of the PBM Firm: OptumRx, Inc.
 Name of the Account Manager: Sanya Blagojevic

PART B – PROJECT BACKGROUND

Client Name: Alaska Teamster-Employer Welfare Trust
 Business Type: Employee benefits
 Location (City/State): Anchorage, AK
 Start Date of Service: 2010 Number of Employee Participants: 2000
 End Date of Service: Present Number of Retiree Participants: 0
 Average Number of Claims Processed Per Month: 5800

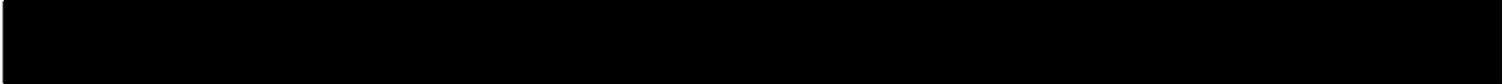
PART C – REFERENCE EVALUATION

Please rate your overall level of satisfaction on a scale of 1 to 10 (with 10 representing that you were very satisfied and 1 representing that you were very unsatisfied).

CRITERIA	UNIT	RATING
Ability to manage costs	(1-10)	10
Ability to manage schedule	(1-10)	10
Ability to meet quality expectations	(1-10)	10
Overall customer satisfaction	(1-10)	10

Please provide any additional information regarding the vendor and/or the project (consider: any significant accomplishments, anything you would do differently, challenges and risks, etc.)

Overall, the OptumRx team provides an outstanding job, both in terms of costs, programs and service.



Printed Name of Evaluator _____ Title _____ Phone Number _____ Signature _____

Thank you for your time and effort in assisting us in this important endeavor.
 Please return the completed survey to: jaclyn.frigaard@optum.com

CONTAINS HIGHLY SENSITIVE PROPRIETARY OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

SUBMITTAL FORM E – Performance Qualifications

The State of Alaska (Division of Retirement and Benefits) is analyzing performance information on PBM providers and their critical personnel. The firm/individual listed below has identified you as a client. The State of Alaska greatly appreciates your time in completing this survey.

PART A – VENDOR NAME

Name of the PBM Firm: OptumRx, Inc.

Name of the Account Manager: Christopher Ring

PART B – PROJECT BACKGROUND

Client Name: County of Orange

Business Type: Government Employer

Location (City/State): Santa Ana, CA

Start Date of Service: 1/1/13

Number of Employee Participants: 4,300

End Date of Service: _____

Number of Retiree Participants: 2,080

Average Number of Claims Processed Per Month: 9,700

PART C – REFERENCE EVALUATION

Please rate your overall level of satisfaction on a scale of 1 to 10 (with 10 representing that you were very satisfied and 1 representing that you were very unsatisfied).

CRITERIA	UNIT	RATING
Ability to manage costs	(1-10)	9
Ability to manage schedule	(1-10)	9
Ability to meet quality expectations	(1-10)	9
Overall customer satisfaction	(1-10)	9

Please provide any additional information regarding the vendor and/or the project (consider: any significant accomplishments, anything you would do differently, challenges and risks, etc.)

OptumRx has a comprehensive clinical document (CBDT) used to capture and document the clinical requirements of its new clients and ensure its Rx claims processing system is correctly configured to match the client specific health plan documents. The County of Orange, while not a new client, recently completed an update of this tool (primarily with the assistance of the OptumRx assigned clinical team and the County's consulting pharmacist). This was a very good process and will provide reasonable assurance of correct Rx claims processing for the County of Orange self-funded PPO plans. The process also identified some additional opportunities for cost/abuse controls available for implementation.

Printed Name of Evaluator

Title

Phone Number

Thank you for your time and effort in assisting us in this important endeavor.

Please return the completed survey to: jaclyn.frigaard@optum.com

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SUBMITTAL FORM F – Mandatory Requirements

Bid Qualifications

NO	CRITERIA	RESPONSE
1	Confirm your organization has at least ten years of experience in providing prescription drug benefit plan services, including claims administration and retail pharmacy network services, to at least one State Plan and to large group plans (more than 10,000 covered lives).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	Confirm your organization has at least five years of experience in providing enhanced EGWP services, including claims administration and retail pharmacy network services, to at least one 10,000-member group, with at least 500,000 members in your overall Book of Business (including PDP members).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	Confirm your organization is contracted directly with CMS to provide an enhanced EGWP and subcontractors will not be used to provide any enhanced EGWP services to the State.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	Confirm your organization has at least 3 million covered lives across your pharmacy benefit management book of business.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	The PBM acknowledges it is compliant with all state and federal applicable regulations and currently not restricted or prohibited from conducting business in all states where the State's participants reside or access care.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	Confirm your organization can provide data reporting and other support as needed for the Retirement Drug Subsidy filings.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

SUBMITTAL FORM G – Contractual Requirements

The following are contractual expectations. The offeror must confirm if they can or cannot meet each requirement. For all “No” responses, provide clarification (up to 250 word maximum) in the No Answers Clarification section at the end of this document.

The state seeks to replicate the current plan design for the Commercial benefit and to move retirees to an Enhanced EGWP Plan. Please confirm if you can replicate the following functions:

Section 1 - Match Current Plan

NO	CRITERIA	RESPONSE
1	All proposers are required, at a minimum, to duplicate the plan features presently offered by the state (for each plan: Commercial, Non-Medicare Retirees and Enhanced EGWP).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	All proposers are required, at a minimum, to duplicate the plan coverage presently offered by the state (for each plan: Commercial, Non-Medicare Retirees and Enhanced EGWP).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	Using the spreadsheet in Submittal Form K, PBM will provide listing of all products that will be negatively impacted, positively impacted (covered, non-preferred, non-covered/excluded) or remain unchanged in regard to formulary status.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	Confirm that the proposed retail 30 network will be a broad network, but retail 90 day can be a targeted network with at least one major retail pharmacy chain available.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	Can you provide an Open Specialty Arrangement that allows fills at any participating retail pharmacies?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	Can you provide a contract with pass through or traditional pricing terms with 100% rebate pass through?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	Confirm that your PBM systems have the capability to cover the Medicare retiree in the enhanced EGWP plan and the non-Medicare spouse in the commercial plan as well as families with mixed Medicare eligibility.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 2 - Legal Responsibilities

NO	CRITERIA	RESPONSE
1	The PBM acknowledges that it is compliant with the Electronic Data Interchange (“EDI”), Privacy and Security Rules of the Health Insurance Portability and Accountability Act (“HIPAA”), and will execute the appropriate Business Associate Addendum (“BAA”) as provided by the state.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	The PBM must agree that in the event of a dispute between the parties, about the payment or entitlement to receive payment, or any administrative fees hereunder, the PBM and the state shall endeavor to meet and negotiate a reasonable outcome of said dispute. In no event shall PBM undertake unilateral offset against any monies due and owed the state, whether from manufacturer rebates, credit adjustment or otherwise.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	The PBM will respond to and incorporate future Health Care Reform changes in full compliance with the law and at no additional cost to the state.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	The PBM is in compliance with and will administer the proposed benefit plan(s) in accordance with all applicable legal requirements, including HIPAA, COBRA, DOL, ERISA, and state and local mandates.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	The PBM is able to administer HIPAA creditable coverage notices.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Section 3 - Termination Requirements

NO	CRITERIA	RESPONSE
1	PBM agrees to a mid-contract term market check, that may start as soon as the second quarter of the second contract year to ensure the state is receiving appropriate current pricing terms competitive with the industry (as compared to other PBMs) based on its volume and membership and will improve pricing in the event that the state's contract terms are less than current. The state will have the right to terminate without penalty if the pricing terms are not industry competitive.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	All rebate revenue earned by the state will be paid regardless of its termination status as a client. All earned but lagged rebates will continue to be paid to the state after termination until 100% of earned rebates are paid.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	The PBM agrees to send all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for the plan participants to any successor PBM at no charge if the state terminates the contract with or without cause.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 4 - Brand and Minimum Generic Discount Guarantees

NO	CRITERIA	RESPONSE
1	The PBM agrees to provide upon request any proprietary algorithms, hierarchy or other logic employed to define a prescription drug as generic or brand.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	The PBM agrees, in accordance with DOL requirements, to disclose details of all programs and services generating direct or indirect compensation from outside entities that are based on the state's drug claim experience.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 5 - Retail Network Management

NO	CRITERIA	RESPONSE
1	The PBM agrees that it will not remove any participating network pharmacies that impact greater than 2% of the state's prescriptions without communicating to the state at least 90 days in advance of the scheduled change.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	If any change to the pharmacy network is not agreeable to the state, the state will have the right to terminate the agreement without penalty with 90 days advance notice.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	The PBM agrees to offer improved pricing terms to the state if greater than 2% of members are impacted by proposed changes to the participating pharmacy network.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	The PBM agrees to customize their networks based on the state's specifications and needs with no additional charge.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	The PBM agrees to customize their Retail 90 network based on the state's specifications and needs with no additional setup charge.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	Confirm you can provide a broad retail network that includes all major retail chains.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	Confirm you will cover claims processed outside of the enhanced EGWP network on a wrap-basis.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 6 - Miscellaneous Services

NO	CRITERIA	RESPONSE
1	PBM has real-time online edits for Drug Utilization Review.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	PBM offers medication adherence and patient support services to improve patient outcomes.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	PBM has edits or programs in place designed to detect and address potential drug fraud and/or abuse?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	PBM agrees to add pharmacies to the network to provide medication in bubble wrap/blister packaging to participants.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	PBM agrees to support pilot programs and other strategic state initiatives.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 7 - Audit Rights

NO	CRITERIA	RESPONSE
1	The state or its designee will have the right to audit annually, with an auditor of their choice, (for both claims and rebate audits), with full cooperation of the selected PBM, the claims, services and pricing and/or rebates, including the manufacturer rebate contracts held by the PBM, to verify compliance with all program requirements and contractual guarantees with no additional charge from the PBM.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	The state or its designee will have the right to audit up to 36 months of claims data at no additional charge from the PBM.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	The plan sponsor or its designee will have the right to conduct an audit at any time during the year, at any point during the contract term, and the selected PBM will provide all documentation necessary to perform the audit.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	The PBM will provide complete claim files and documentation (i.e., full claim files, financial reconciliation reports, inclusion files, and plan documentation) to the auditor within 30 days of receipt of the audit data request as long as a non-disclosure agreement is in place between the auditor and the PBM.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	The PBM agrees to a 30-day turnaround time to provide the full responses to all the sample claims and claims audit findings.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	The state or its designee will have the right to audit up to 12 pharmaceutical manufacturer contracts during an on-site rebate audit.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7	The audit provision shall survive the termination of the agreement between the parties for a period equivalent to the Initial Term of the contract.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	The state will not be held responsible for time or miscellaneous costs incurred by the PBM in association with any audit process including, all costs associated with provision of data, audit finding response reports, or systems access, provided to the state or their individual designees by the PBM during the life of the contract. Note: This includes any data required to transfer the business to another vendor and money collected from lawsuits and internal audits.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 8 - Formulary Management

NO	CRITERIA	RESPONSE
1	With the exception of FDA recalls or other safety issues, the PBM agrees not to remove any additional drug products, brand or generic, from the state's formulary or preferred drug listing without notification and prior approval from the state, no less than 180 days from the suggested effective date of the change.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2	The PBM agrees to notify the state or its designee in advance of 90 days when a formulary drug is targeted to be moved to or from the preferred drug list. The PBM must provide a detailed disruption and financial impact analysis at the same time. No greater than two percent (2%) of participants will be disrupted by any formulary deletions or all deletions in total, on an annual basis.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3	The PBM agrees to remove drugs from coverage or the formulary at most one-time per year and no greater than two percent (2%) of participants will be disrupted by any formulary deletions or all deletions in total, on an annual basis.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4	The PBM agrees to implement and maintain all existing utilization management/clinical edits at no additional charge to the state.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	Confirm a member is able to obtain an excluded prescription through a Prior Authorization without impact on guaranteed rebates.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	The PBM agrees to grandfather the state's current formulary for up to 90 days following the contract effective date, without impact on guaranteed rebates.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	The PBM agrees to offer a formulary specific to Seniors that would be appropriate for the current RDS program or enhanced EGWP.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	The PBM agrees to implement an enhanced EGWP formulary that mirrors the Commercial formulary.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 9 - Appeals

NO	CRITERIA	RESPONSE
1	PBM will follow the state's current appeals process for certification review, claim review and/or billing appropriateness for commercial plan.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	PBM has multi-level appeals process for administrative and clinical denials.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	PBM uses staff medical professionals and/or outside consultants to review disputed claims for medical necessity and billing appropriateness.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	PBM will be able to provide copies of all claim and appeal documents to the state for appeals that reach the state's level.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	The PBM will agree to defend claims litigation based on its decisions to deny coverage for clinical reasons.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6	The PBM will agree to handle claims/appeals processing in accordance with the minimum requirements of ERISA as amended by the Patient Protection and Affordable Act (PPACA).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	The PBM will agree to be responsible for selecting and contracting the external review organizations sufficient to allow the state to comply with ERISA as amended by the PPACA.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	PBM agrees the state reserves the right to review, edit, or customize appeal templates from the PBM to state's membership to ensure compliance with state law and due process requirements.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9	Do you have a dedicated appeals staff?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10	Confirm the state will have a single point of contact for appeals related inquiries.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 10 - Implementation

NO	CRITERIA	RESPONSE
1	The PBM agrees to provide a one-time Implementation Credit to the state on a per member basis.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	The PBM agrees to provide a Pre-Implementation Audit allowance to be conducted at least 60 days prior to the start of claims adjudication. The PBM will work with the auditor to run test claims in a test environment utilizing the state's actual plan parameters.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	Does the test environment mirror the live environment?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	The PBM agrees to provide a procurement allotment in the amount of \$175,000.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5	The PBM will provide draft SPD language for any clinical programs that are to be implemented.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	The PBM agrees to load all current prior authorizations, open mail order refills, specialty transfer files, claims history files and accumulator files that exist for current members from the existing PBM at NO charge to the state (with no charges being deducted from the implementation allowance for file loading or IT).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	The PBM agrees to send at least 12 months of claims history data, all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for the state's members to the next/successor PBM at NO charge if the state terminates the contract <u>with or without cause</u> .	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	The PBM agrees to provide weekly and/or monthly data transmissions (may include feeds to data warehouses) to any qualified health data analytics vendors at no charge and two full, annual electronic claims files, in NCPDP format, at no charge as needed. PBM will also interact/exchange data with all vendors as needed at no additional charge.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9	The PBM agrees to waive any charges to the state or the state's medical plan claims administrators such as a set-up fee, a programming fee or a monthly fee, for establishing a connection with a Third Party Administrator/Claims processor for real-time, bidirectional data integration, including non-standard data integration formats.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10	The PBM agrees to absorb any programming or other administrative costs to meet any existing or future requirements of the Affordable Care Act.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

11	The PBM is capable of designing exports to the FSA vendor to process FSA claims based off medical claim data files.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
12	The PBM agrees to coordinate clinical management with the medical administrator, wellness and disease management vendor, and any other vendor or administrator the state contracts with to provide services for its members' health administration and management services.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 11 - Specialty Drug Management

NO	CRITERIA	RESPONSE
1	PBM agrees to notify the state and its members at least 60 days prior to the addition of a drug to the specialty drug list and at least 90 days prior to a deletion of a drug from the specialty drug list.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2	The state and/or its members reserve the right to approve any addition to the specialty drug list.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	The PBM agrees to provide separate minimum ingredient cost discount guarantees and rebate guarantees for specialty drugs (vs non-specialty drugs).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	Specialty Pharmacy pricing, including guaranteed discounts, dispensing fees and rebate guarantees, apply to all specialty pharmacy claims, regardless of the number of supply days.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	The PBM agrees that the state will not be responsible for any member contributions (e.g., deductible, coinsurance, copays) owed to the PBM through the specialty pharmacy. Collecting such fees will be the sole responsibility of the PBM.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	The PBM agrees to allow the state to limit specialty pharmacy claims to a 30-day supply (including those dispensed by your specialty pharmacy), with no modifications to the pricing terms you are proposing for specialty medications in this RFP.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	PBM confirms that members will continue to be able to receive specialty drugs dispensed at retail pharmacies, and that these prescriptions will be included in retail guarantees.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8	PBM guarantees access/delivery of fragile specialty medications to participants in rural/remote areas, at no additional charge to the state.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 12 - Member and Account Service

NO	CRITERIA	RESPONSE
1	The PBM agrees to provide designated/dedicated account resources including, but not limited to, an implementation manager, strategic account executive, clinical director - pharmacist, account manager, claims advocate and an underwriter/financial analyst, with a separate team for the enhanced EGWP.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	The PBM agrees to obtain the state's approval for all member communication materials before distribution to members. The PBM will not automatically enroll the state in any programs that involve any type of communications with members or alterations of members' medications, without express written consent from the state.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3	The state reserves the right to review, edit, or customize any communication from the PBM to its membership, including the AlaskaCare logo as the prominent feature.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4	All member service call recordings and notes between the PBM and the state's members will be the state's property.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5	The PBM agrees to document 100% of the state's member service calls through call recordings and call notes. PBM will forward written transcripts of applicable calls at the state's request within two business days of the request being made.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	The state reserves the right to access all call recordings or call notes from member service calls with its members. PBM agrees to allow the state the right to request call recordings and/or notes at any time. PBM agrees to allow the state to listen to any recorded calls with its members within two business days of the state's request.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

7	The PBM will have system access security process with members, providers and the state.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	The PBM agrees to allow the state access to its member website with a dummy login prior to the go-live date.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9	The PBM will provide the state with a virtual tour of its CSR system and any custom messaging system.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10	The PBM agrees to, ad-hoc calls with the state to review member service issues. The PBM agrees to allow the state to review member service quality issues to the resolution endpoint. In addition, the PBM agrees to, at a minimum, quarterly in-person meetings with the account team, to review overall performance and trends.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
11	The PBM agrees to a minimum of one annual meeting with call center executives to discuss services regarding enrollment and member issues.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
12	The PBM agrees to provide online, real-time, claim system access to the State or its designee, including access, to historical claims data and eligibility data for up to three (3) years following termination of the agreement.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
13	The PBM agrees that all future edits required because of plan design changes implemented by the state shall be completed, after testing, by the PBM within 30 days of receiving notice unless agreed to by the state at no additional charge.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
14	The PBM agrees that that they will use call centers located within the United States (no outsourcing to non-U.S. based locations) for all the state's members.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
15	PBM call center can be configured to provide service based on Alaska Standard Time.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
16	The PBM agrees to allow the state to override their individual plan rules (e.g. brand/generic/mail copayments, emergency prescriptions).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
17	The PBM agrees to allow the state to be given access for at least 5 of the state's staff members to enter Prior Authorizations for non-covered drugs approved for medical necessity.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
18	PBM can assure the plan any major changes to organizational structure or outstanding legal action against the PBM and/or owners, if any, will not disrupt business operations.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 13 - Information Technology

NO	CRITERIA	RESPONSE
1	The PBM shall maintain the identified state's list of data elements necessary to meet the state's claims review and reporting requirements.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	The PBM shall provide all necessary data for the state to comply with or participate in programs (whether optional or mandated) implemented as part of any local, state or federal government health care reform legislation. Required data shall be provided at no additional cost to the state. This includes future program options such as enhanced EGWP or wrap plans that the state determines are advantageous to the state, if benefit plan and/or membership decide to participate.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	The PBM must make all data available in a state approved electronic format. In addition, all schemata and file definitions must be made available to the state upon request.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	PBM will release detailed claims data to state's data warehouse.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	Upon determination and identification of system problems, programming problems, or transfer problems, the PBM shall notify the state immediately upon identification of issue. The PBM shall also make every effort necessary to correct such problem immediately or as soon as possible, including but not limited to: working nights; weekends; and holidays, to minimize any negative impact to employees, retirees, or dependents and to maintain continual operations of the program.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	PBM has a Computer Disaster Recovery Plan and can provide their most recent outside assessment of readiness.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

7	The PBM must accept data transmissions from designated state vendors and agree there will be no additional fees, unless outlined in the Administrative Fee table in the cost proposal, to establish the interface and/or any other IT services in the initial set-up or to accept changes to the file layout during the term(s) identified as part of the award. PBM must reconcile each data feed and work with the appropriate vendors to keep the data accurate and consistent among all parties at no additional cost to the state and will work with the state and its respective vendors to identify opportunities to improve data transmission requirements that will result in improved operational efficiencies and program effectiveness.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	Does your automated data processing capability include the ability to interface with the state's health reporting eligibility system when fully operational?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9	Does the online system allow the state to assign different levels of access internally?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 14 - Coordination of Benefits

NO	CRITERIA	RESPONSE
1	The PBM will coordinate COB information electronically with other vendors such as the medical provider, dental network, and health management provider, for their use in coordinating benefits.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	Confirm that the PBM is able to handle internal coordination when a claimant is covered under more than one state benefit plan such as being covered as the member and also as a dependent.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	Is COB history stored online?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	PBM has COB administrative procedures to ensure all claims are paid consistently with the correct order of benefit determination.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	PBM has annual validation process to identify other health insurance coverage requirements.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	PBM has edits in system to identify potential COB cases on a continual basis.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	PBM has computer edit checks or triggers to initiate COB.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	Medicare COB: The PBM has an electronic system currently in place to allow Medicare Part B claims filed with the Medicare carrier to automatically coordinate (crossover) with the retiree plans so that retirees are not required to submit secondary Part B claims to this plan.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 15 - Financial

NO	CRITERIA	RESPONSE
1	Each distinct pricing guarantee (including rebates) will be measured and reconciled on a component (e.g. retail 30 brand, retail 30 generic, retail 90 brand, retail 90 generic, mail order brand, mail order generic, specialty drugs at participating retail pharmacies) basis only and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls paid to the state. Surpluses in one component may not be utilized to offset deficits in another component.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2	The PBM will provide a financial reconciliation report to the state within 60 days after the end of each contractual year, and the report will include the contractual and actual discounts and dispensing fees for each component (e.g., retail brands, retail generics, mail brands, mail generics, specialty drugs via Participating Retail Pharmacies).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	The PBM agrees that any shortfall between the actual result and the guarantee will be paid, dollar-for-dollar, to the state within 90 days of the end of the measurement period.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	All pricing submitted will NOT be contingent on participation in any proposed clinical management programs, group medical or behavioral health programs proposed by you or any other vendor other than programs that are requested by the state. Further, the pricing guaranteed in the Financial Section of this RFP reflects a) the PBM's broadest national network and b) the PBM's broadest formulary or preferred drug listing (for both Commercial and EGWP), without any drug coverage exclusions unless otherwise authorized or requested by the state.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	Confirm the PBM will, at a minimum, duplicate the plan features and levels of coverage	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

	presently offered by the state to its members, without impacting the proposed pricing.	
6	Mail order pricing and rebates will apply to all claims that adjudicate at mail regardless of days' supply.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	Guaranteed rebates per prescription will be based on all brand prescriptions dispensed, not on formulary prescriptions dispensed.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	Rebates are guaranteed on a minimum (i.e., not fixed) basis, and the PBM will pass through 100% of the rebates to the state.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9	Rebates will be paid upon signature of: 1) the Letter of Agreement/Intent, OR 2) Pricing Implementation Document, OR 3) contract. Past-earned rebates will not be withheld if there is no signed agreement documentation.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10	Is your PBM responsible for rebate contracting?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
11	The PBM will reconcile rebate guarantees to verify that the state is receiving the guaranteed rebates and provide rebate payments and reports listing detailed rebate utilization and calculations to the state quarterly, within sixty (60) days of the quarter's close, without a request being made by the state.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
12	The PBM will provide the annual rebate report within 90 days of the end of each contract year. Confirm any shortfall between the actual result and the minimum rebate guarantees will be paid, dollar-for-dollar, to the state within 90 days of the end of the contract year. Please confirm that lag rebates will continue to be paid to the state until 100% of earned rebates are paid.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
13	The PBM will guarantee Retail/Mail Order unit cost equalization meaning that Mail Order unit costs prior to member cost sharing, dispensing fees, and sales taxes charged will be no greater than the unit cost for the same NDC-11 at Retail for each matching mail order generic prescriptions, adjusted for quantity and day supply.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
14	The PBM agrees to produce a date-sensitive comparison report showing unit costs charged to the state at a GCN-level, and reimburse the state on a dollar-for-dollar basis for all instances where mail order unit costs exceed retail unit's costs. Report and reconciliation will be provided on an annual basis, without a request being made by the state.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
15	The state will be notified of any switch to the source of the aggregate AWP with at least a 180-day notice. In the event that a switch is made, it must be price neutral to the state. In the event a switch is made that is not price neutral, the state will have the right to terminate the contract with no penalty.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
16	The PBM will be responsible for collecting any outstanding member cost shares for prescriptions dispensed through the mail order facility. The PBM will not invoice the state for any uncollected member cost shares even if there is a debit threshold in place.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
17	Confirm that if the state disputes all or a portion of any invoice, the state will pay the undisputed amount in a timely manner and notify the PBM in writing, of the specific reason and amount of any dispute before the due date of the invoice. The PBM and the state will work together, in good faith, to resolve any dispute. Upon resolution, the state or the PBM will remit the amount owed to the other party as the parties agree based on the resolution.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
18	The PBM will credit the state 100% of any audit recoveries of the contracted pharmacy network including mail order and specialty pharmacies. Any recoveries will be disclosed and credited to the state no less than annually.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
19	If an enhanced EGWP is not implemented by the state in 2019, the PBM agrees to extend the Commercial pricing terms and guarantees to the entire membership (Commercial and Retirees) for the contract term.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 16 - Contractual Financial Expectations

NO	CRITERIA	RESPONSE
1	There are no additional fees (beyond those outlined in Submittal Form K – Fee Schedule required to administer the services outlined in this RFP.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

2	Any mandatory fees, including clinical and formulary program fees, must be clearly outlined in Submittal Form K – Fee Schedule	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	All applicable fees include the cost of claims incurred/filled during the effective dates of this contract regardless of when they are actually processed and paid (run-out).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	The PBM will provide run-out claims processing for the state after contract termination.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	The PBM agrees to apply network discounts to newly introduced generic drugs as soon as the new product is publicly available.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	The PBM agrees to adjudicate prescription claims for compound medications with the same dispensing fees and pricing logic associated with each component drug that comprises the compound claim.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	The PBM agrees to no additional charges for any retroactive claims reprocessing and member reimbursements due to retroactive plan design adjustments.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	All pricing will be effective and guaranteed for the term of the agreement and will not include adjustments for claims volume shifts amongst the various provider channels (e.g., mail utilization rates decline or 90-day retail utilization increases).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9	Confirm all pricing will be effective and guaranteed for the term of the agreement and will not be modified or amended if the state implements or adds a 100% member paid plan design such as a high deductible health plan/consumer-driven health plan option.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10	Confirm all pricing will be effective and guaranteed for the term of the agreement and will not be modified or amended if the state's membership decreases by 30% or less.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
11	Confirm all pricing will be effective and guaranteed for the term of the agreement and will not be modified or amended if the state adds new classes of eligible members. .	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
12	The state will have the ability to annually renegotiate and/or “carve-out” specialty drug pricing and service terms without penalty or changes to all existing financial guarantees.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
13	The PBM mail order service must notify the individual member or the state prior to substituting products that will result in higher member co-pay.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
14	The PBM will NOT implement, administer, or allow any program that results in the conversion from lower discounted ingredient cost drug products to higher ingredient cost drug products or increases member's cost share without the prior written consent of the state.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
15	All applicable administrative fees will be on a per paid claim basis as defined in "Definitions".	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
16	Confirm that postage is included in all mail order prescriptions and any mailings.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
17	Confirm that quoted fees include postage paid mail order envelopes for member prescription submission.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
18	Confirm there are no charges associated with your organizations fraud and/or abuse programs or edits.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
19	Confirm that mail order and specialty drug dispensing fees will remain constant throughout the contract term and will not be increased for any increases in postage charges.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
20	PBM understands the state is requesting competitive pricing for both enhanced EGWP and Commercial programs.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
21	PBM understands the state is looking for flat dollar (\$) performance guarantee amount and the ability for the state to select the weighting for each metric.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
22	PBM will provide other guarantees designed to differentiate their program from other PBMs.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
23	PBM agrees performance guarantee will not be the sole and exclusive remedy available to the state for failure of the PBM to properly administer claims and PBM will pay any amount owed to the state if the PBM fails to properly administer claims.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 17 - Banking

NO	CRITERIA	RESPONSE
1	Confirm you will establish a separate bank account on the state's behalf.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2	Confirm that you will set up the state's account structure based upon their requirements.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3	Confirm you will process claims and issue checks from the bank account you established on	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

	the state's behalf.	
4	Confirm you will request an electronic transfer of funds from the state at regular intervals on a "checks cleared" basis and that the request will be by active employee claims and retiree claims; retiree claims will be split by medical and DVA expenses as well as by retirement system.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5	Confirm you will provide the state with a monthly report reconciling the account balance, claims drafts and electronic transfers.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6	For self-funded plans, confirm that no imprest balance is required.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Section 18 - Medicare Part D- Enhanced Employer Group Waiver Plan (EGWP)

NO	CRITERIA	RESPONSE
1	Confirm you maintain a Center for Medicare and Medicaid Services (CMS) approved prescription drug Medicare Part D plan in the form of an enhanced EGWP.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	Confirm that you will provide all CMS required filings (including filings related to formulary, medication therapy management (MTM), and other clinical programs on a timely basis).	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3	Confirm that you will provide all CMS required filings related to certification of compliance to all waste, fraud, and abuse requirements.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4	PBM can match the existing plan design to minimize disruption to the current drug formulary and pharmacy network.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5	PBM can accommodate a separate copay structure in the wrap plan for dual covered retirees.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
6	Confirm you provide a pharmacy network per CMS requirements by providing a GeoAccess report.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	Confirm you are able to administer a Medicare B vs. D program at point of sale, at no additional cost to the state.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	Confirm you will coordinate benefits with Medicare at point-of-sale to ensure members receive benefits seamlessly, including the routing of Part B drugs through the medical plan to CMS for Part B reimbursement, at no additional cost to the state.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9	Confirm you will apply the required brand and generic Pharma discounts for Part D applicable drugs at point-of-sale.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10	Confirm that you will provide all CMS-required member communications and that this is included in your base administrative fee.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
11	Confirm that the state will have the ability to customize member communications at no additional charge when permitted by CMS.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
12	Confirm that you will provide separate reporting and billing for the enhanced EGWP group.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
13	Confirm you will process low-income premium subsidy refunds to members and the state as well as low-income cost sharing refund requests to the members.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
14	Verify that your P&T Committee meets CMS' requirements for objectivity and validity.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

No Answers Clarification (add rows as necessary)

Section	NO	Clarification
1	#6	OptumRx is offering State of Alaska (the State) a traditional pricing arrangement with 100 percent pass-through of rebates. However, OptumRx retains manufacturer administrative fees for the commercial line of business.
2	#5	We do not perform creditable coverage determinations or mailings for EGWP members. This responsibility falls to the customer. We assist in helping the State to provide a global attestation for an EGWP or RDS plan. Individual attestations are assessed through post enrollment Late Enrollment Penalty (LEP) letters.
7	#6	We agree; however, the auditor will be mutually agreed upon between the parties.
8	#1	The State's client management team communicates updates within 90 days of negative

		changes. Communication includes a summary of customer-specific member disruption. With respect to tier changes, down-tiers may occur monthly. Up-tiers are limited to twice a year, January 1 and July 1, unless due to new generic availability. Our Clinical Services department promptly assesses formulary impact, based on new developments. We follow the same Pharmacy & Therapeutics Committee review and approval processes, as we do for new medications, to recommend the appropriate course of action. The Pharmacy & Therapeutics Committee may recommend to add or to remove drugs, due to safety and efficacy concerns or if clinically similar, more cost-effective drugs are on the formulary.
8	#2	With respect to tier changes, down-tiers may occur monthly. Up-tiers are limited to twice a year, January 1 and July 1, unless due to new generic availability. The State's client management team communicates updates within 90 days of negative changes. Communication includes a summary of customer-specific member disruption. The State's client management team will notify the State of estimated percentage of participants disrupted by formulary deletions.
8	#3	With respect to tier changes, down-tiers may occur monthly. Up-tiers are limited to twice a year, January 1 and July 1, unless due to new generic availability. The State's client management team communicates updates within 90 days of negative changes. Communication includes a summary of customer-specific member disruption. The State's client management team will notify the State of estimated percentage of participants disrupted by formulary deletions.
9	#5	We agree to defend claims litigation based on decisions to deny coverage for clinical reasons to the extent that any coverage decisions are inconsistent with the State's benefit plan.
9	#8	We agree for the State to review, edit or customize appeal templates for its commercial members. We do not customize appeal letters for EGWP members.
10	#4	OptumRx is offering the State a Pharmacy Management Allowance (PMA) credit of up to \$5 per member in years two and three, which must be utilized within the applicable year and will not carry over to the following year. The PMA credit is to be used by the State to offset the cost of actions intended to maximize the value of the pharmacy program. Funds may be used for items including, but not restricted to, programming for customization, design and implementation of clinical or other programs, communications, documented expenses related to staff education and industry conference attendance, auditing, data integration and analytics, consulting fees, and engagement of relevant vendors that impact the pharmacy program strategy and results. The State is required to submit documentation to support the expenses for which it seeks reimbursement. The parties acknowledge that the credit provided by OptumRx for such services represent fair market value. If the State terminates this agreement in breach before the end of the Initial Term, the State shall refund to OptumRx within 30 days after the effective date of such termination the full PMA credit applicable to the year of termination. It is the intention of the parties that, for the purposes of the Federal Anti-Kickback Statute, this PMA credit shall constitute and shall be treated as a discount against the price of drugs within the meaning of 42 U.S.C. 1320a-7b(b)(3)(A).
11	#1	Customers are notified of additions to the specialty drug list once pricing is established and have 30 days to decline inclusion. However, we can agree to notify customers at least 90 days prior to a deletion of a drug from our specialty drug list.
11	#7	Specialty drugs dispensed at retail network pharmacies are included in the annual aggregate specialty guarantee.
12	#2	Yes, for commercial members. For EGWP members, during implementation, we discuss

		<p>with the State the approximately 150 different types of communications that could be sent to a member, depending on their scenario.</p> <p>The State must review and approve any material for open enrollment, specifically tailored to the State’s benefit design set up (ANOC, EOC, Summary of Benefits, formulary).</p> <p>There are approximately 100 post-enrollment letters which are required and triggered by CMS. We follow model, but have tailored those toward EGWP and to be more member friendly. The State can review these letters, but these letters are standard and follow guidance. We also have several clinical letters (prior authorization, grievance, coverage determinations, appeals) which follow CMS model documents and are not customizable due to programming and systems that send those. We are happy to share all of these for the State to reference, which are standard and required. Timeline restrictions do not allow for us to get review/approval every time we need to mail out a required letter.</p> <p>We also have optional programs, such as hassle-free fill programs, that the State may opt into. Again, those are standard templates, and cannot be customized due to programming and system set up, but we are happy to share them with the State beforehand.</p>
12	#3	<p>Yes, for commercial members. For EGWP members, we can support all CMS-required materials. Some materials are customizable in order to illustrate State of Alaska’s benefit/plan design structure accurately. However, other materials are standard and not customizable. For our OptumRx PDP EGWP, we work with the State to create accurate open enrollment marketing materials for its EGWP program.</p> <p>Customizable documents to reflect plan design include:</p> <ul style="list-style-type: none"> • Pre-notification/Introduction letter • Annual Notice of Change • Evidence of Coverage (EOC) • Summary of Benefits • Formulary Drug Listing • ID Card (however, must comply with NCPDP requirements) <p>Any letters not required by CMS incur additional costs for printing and mailing</p> <p>Non-customizable documents include:</p> <ul style="list-style-type: none"> • Geo-Coded Pharmacy directory • Explanation of benefits (EOB) • Transition Benefit letter • CMS Exhibit/LIS/Late Enrollment Penalty (LEP) letters • Clinical letters
12	#4	<p>Recorded calls and member record notes will remain property of OptumRx due to HIPAA, PCI Compliance and other regulations. However, OptumRx will make available recorded calls and or member transcripts to the State within two business days of the request, including regularly scheduled reviews of recorded calls.</p>
12	#6	<p>We can share files of recorded member calls, call notes or call logs after we have reviewed and removed PHI and other confidential data discussed with members during business hours. We can provide redacted materials within five business days. This timeframe enables us to review and exclude any member information “protected for privacy” by federal and state laws.</p> <p>We cannot provide the State with access to call recordings or call notes at its discretion.</p>
15	#1	<p>Rebates are measured in aggregate.</p>

15	#11	We agree to provide within 90 days of the quarter's close.
15	#14	We agree, with the exception that the report will be GPI based, not GCN based.
16	#7	OptumRx may charge a fee, depending on the extent of the changes.
16	#9	OptumRx reserves the right to modify or amend the financial provisions of this document upon prior notice to the State in the event of implementation or addition of 100 percent member-paid plans.
16	#10	OptumRx reserves the right to modify or amend the financial provisions of this document upon prior notice to the State in the event of a reduction of greater than 10 percent in the total number of members from the number provided to OptumRx during pricing negotiations, upon which the financial provisions included in this document are based.
16	#11	We are unable to agree to this requirement as written, without knowledge of what additional new classes of eligible members will be added (for example, worker's compensation, discount cards, etc.). We cannot support these classes under the proposed pricing.
16	#12	OptumRx's offer assumes specialty will be carved out. OptumRx is willing to discuss and update financial offer if the State is interested in carving out specialty.
16	#16	Postage, shipping and handling are included in the pricing for mail service and BrivoRx dispensed claims. Postage for mailings requested by the State will be passed through.
16	#17	We do not provide postage paid envelopes for mailing prescriptions. However, we do provide pre-addressed envelopes to members in their initial Home Delivery Pharmacy enrollment kits and with each shipped Home Delivery Pharmacy order. We also include information and instructions on using our interactive voice response (IVR) system and website to place refill orders.
17	#1	We agree to the alternative billing/banking arrangement described by the State's answer to Question 88 of Amendment #3. OptumRx will use its own funds to reimburse the pharmacies, and will separately bill and collect amounts from the State to cover those claims reimbursements to pharmacies.
17	#2	Not applicable.
17	#3	We agree to the alternative billing/banking arrangement described by the State's answer to Question 88 of Amendment #3. OptumRx will use its own funds to reimburse the pharmacies, and will separately bill and collect amounts from the State to cover those claims reimbursements to pharmacies.
17	#4	We will request funds on a claims submitted basis.
17	#5	We do not use employer-specific reimbursement accounts. Rather, we use OptumRx funds. Customers may make payments by Automated Clearing House (ACH), automatic withdrawal, wire transfer or check. ACH is preferred, but not required. Once payment is received, OptumRx makes payments to network pharmacies.
18	#11	Production costs, plus postage, shipping, and handling are passed through for custom communications.

SUBMITTAL FORM H – GeoAccess Analysis

State of Alaska

GeoAccess: (GeoAccess Report based on Member Zip Codes in Census File)

We would like the following standards to be evaluated for the proposed Retail Network using a GeoAccess analysis:

Urban

2 Retail Pharmacies within 3 miles

Suburban

1 Retail Pharmacy within 5 miles

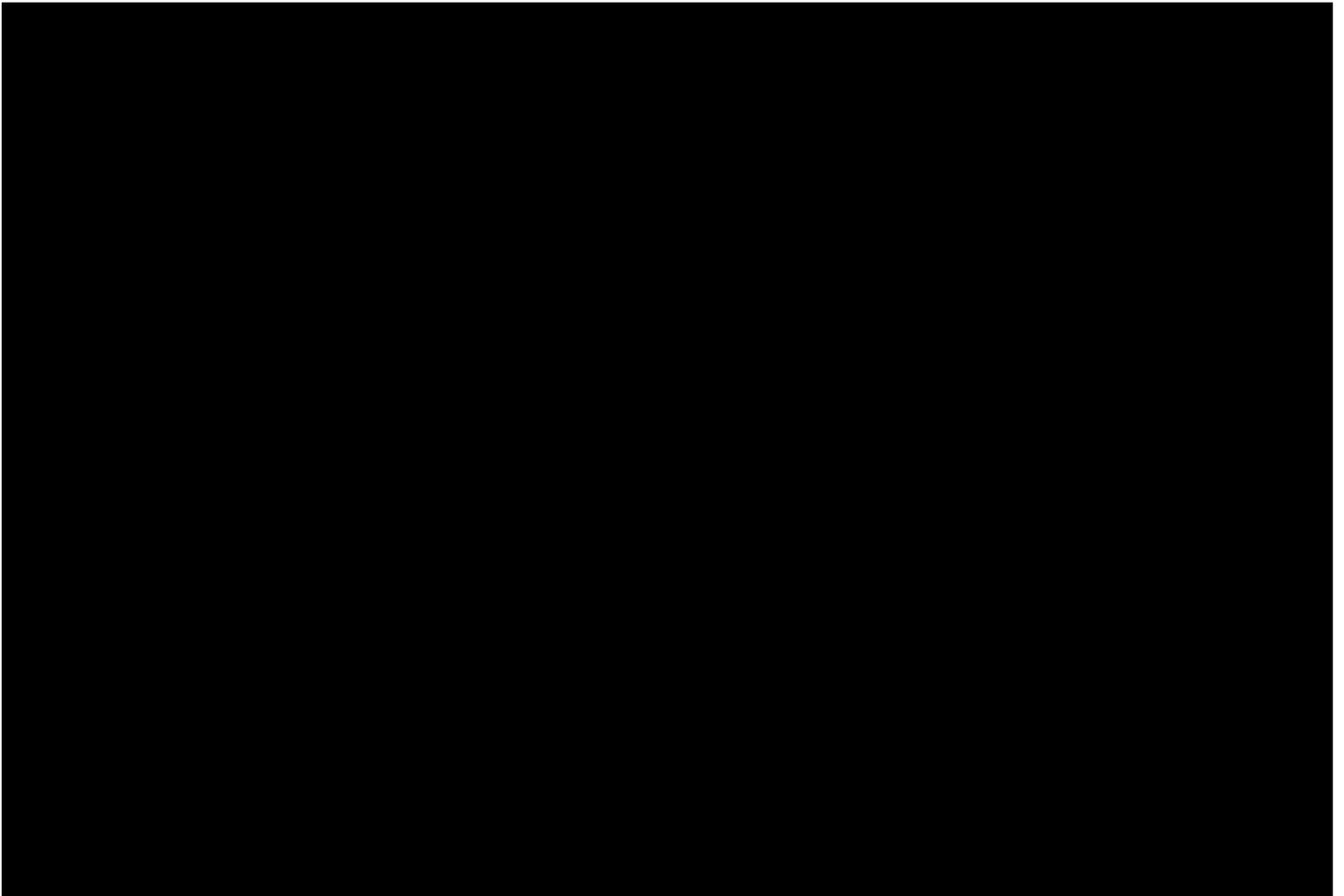
Rural

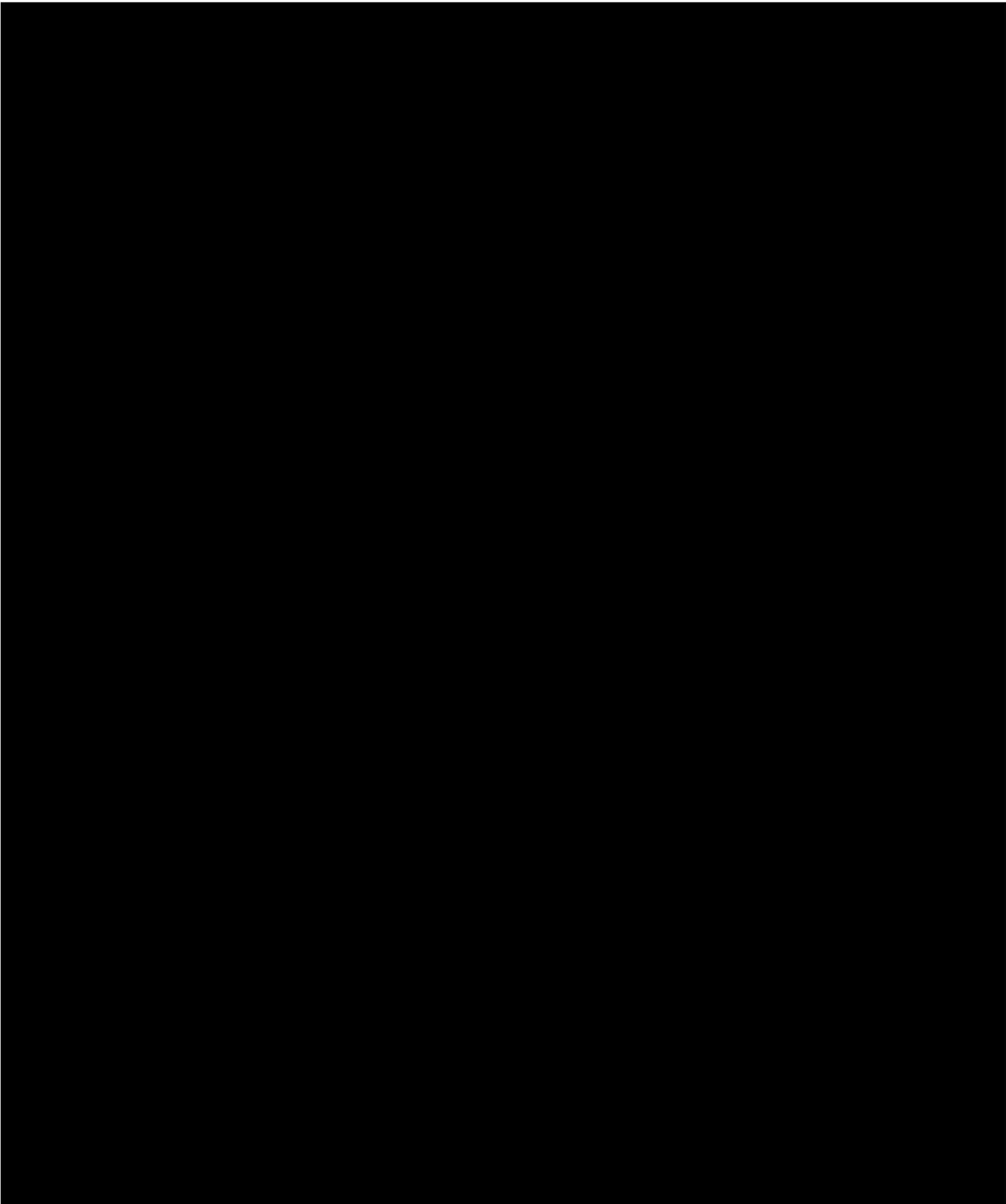
1 Retail Pharmacy within 12 miles

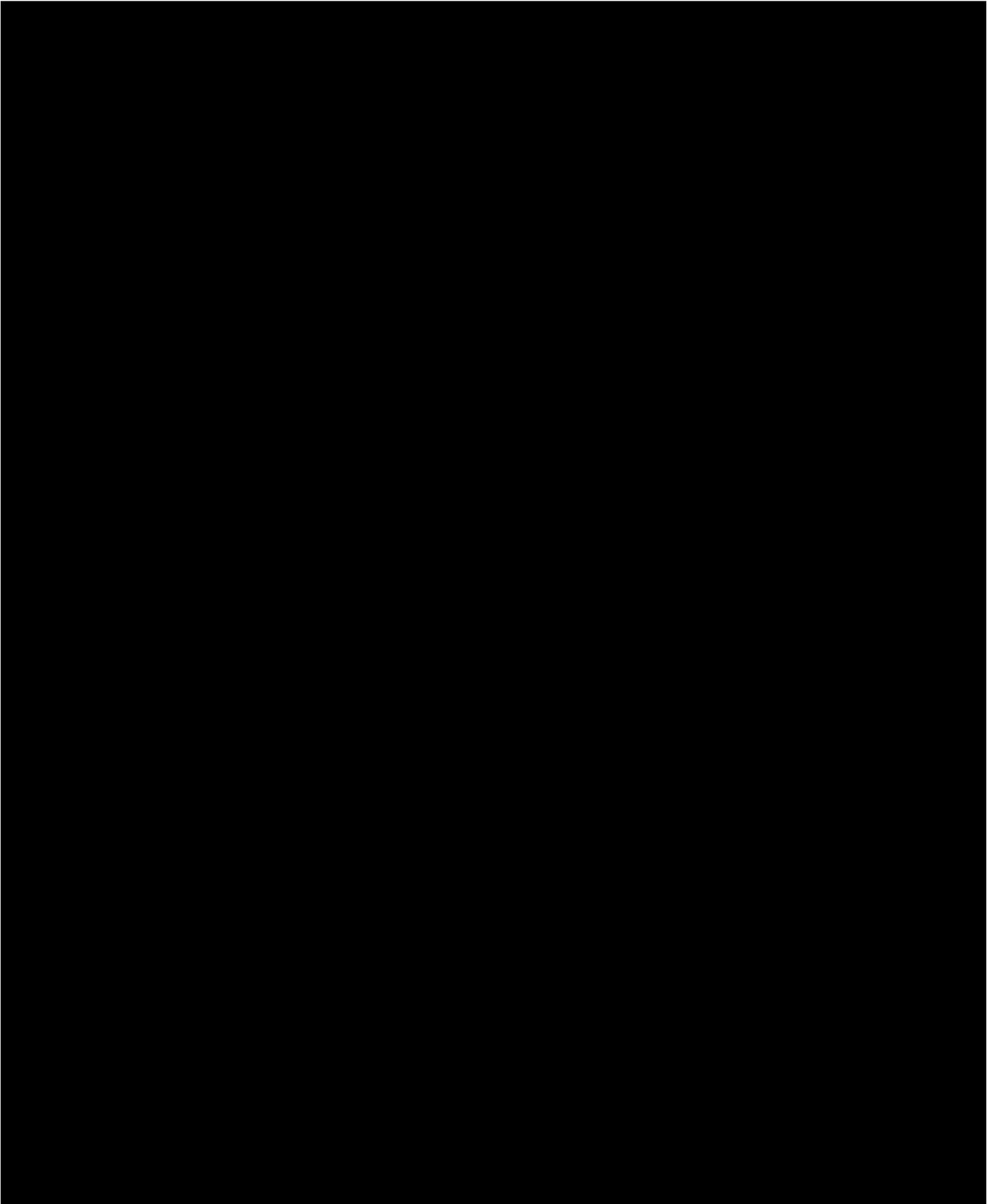
Provide GeoAccess reports that indicate the number of members that are within and without the desired access. For those that are without the desired access, you must provide the number of miles to the nearest in-network retail pharmacy. Please provide summaries of your retail GeoAccess analysis using the tables below as templates:

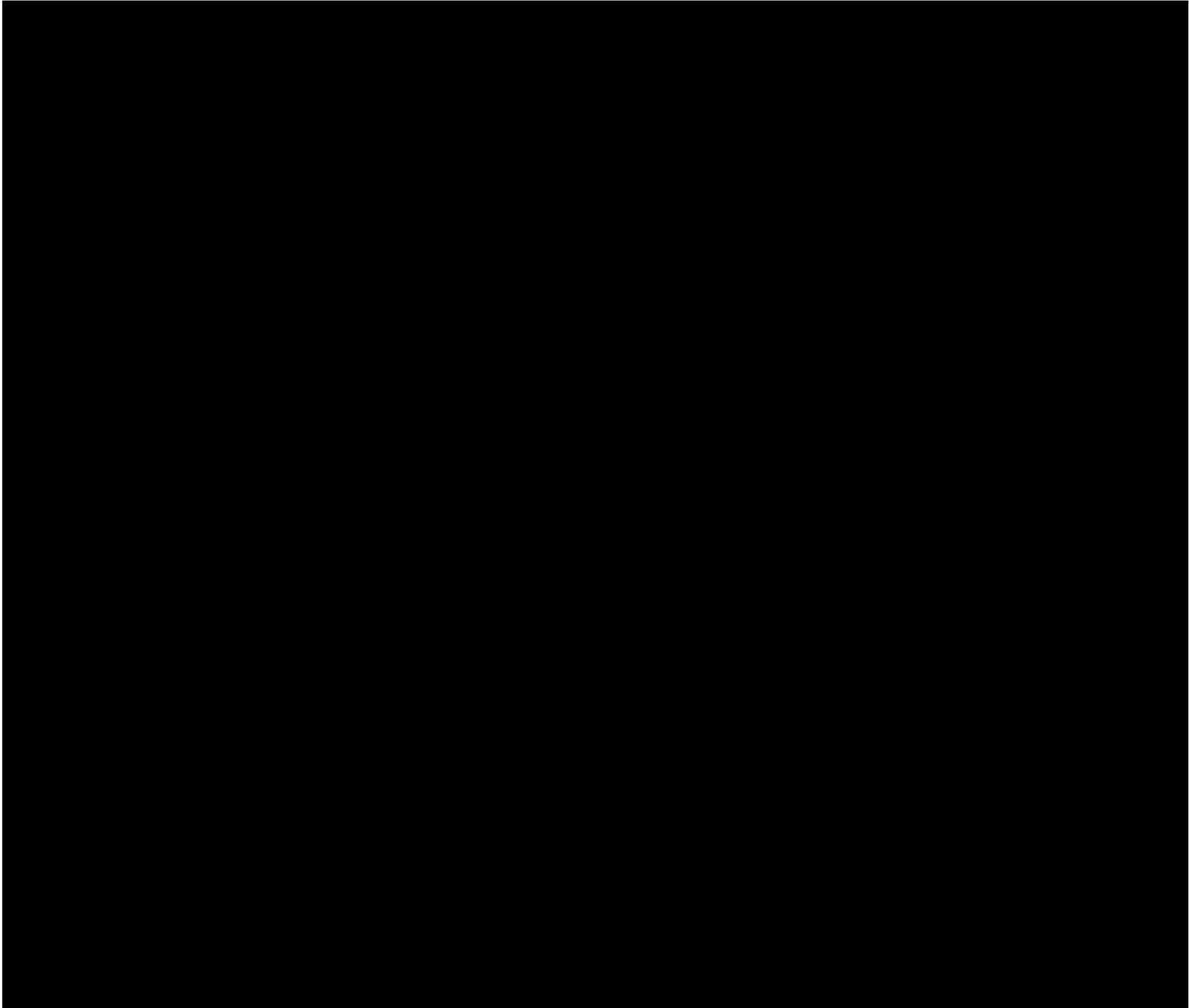
A) **Commercial:**

CONTAINS HIGHLY SENSITIVE PROPRIETARY OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.



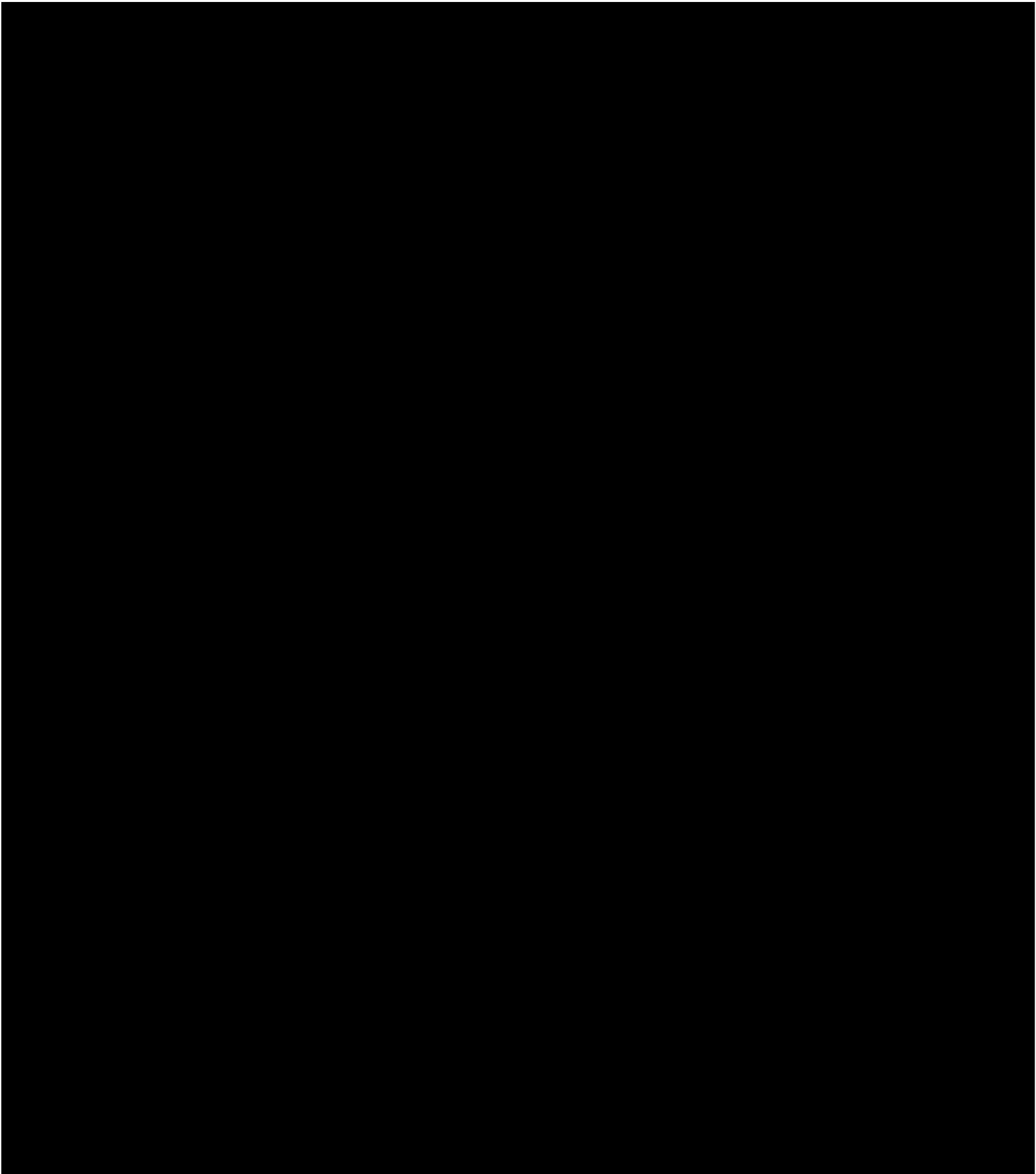


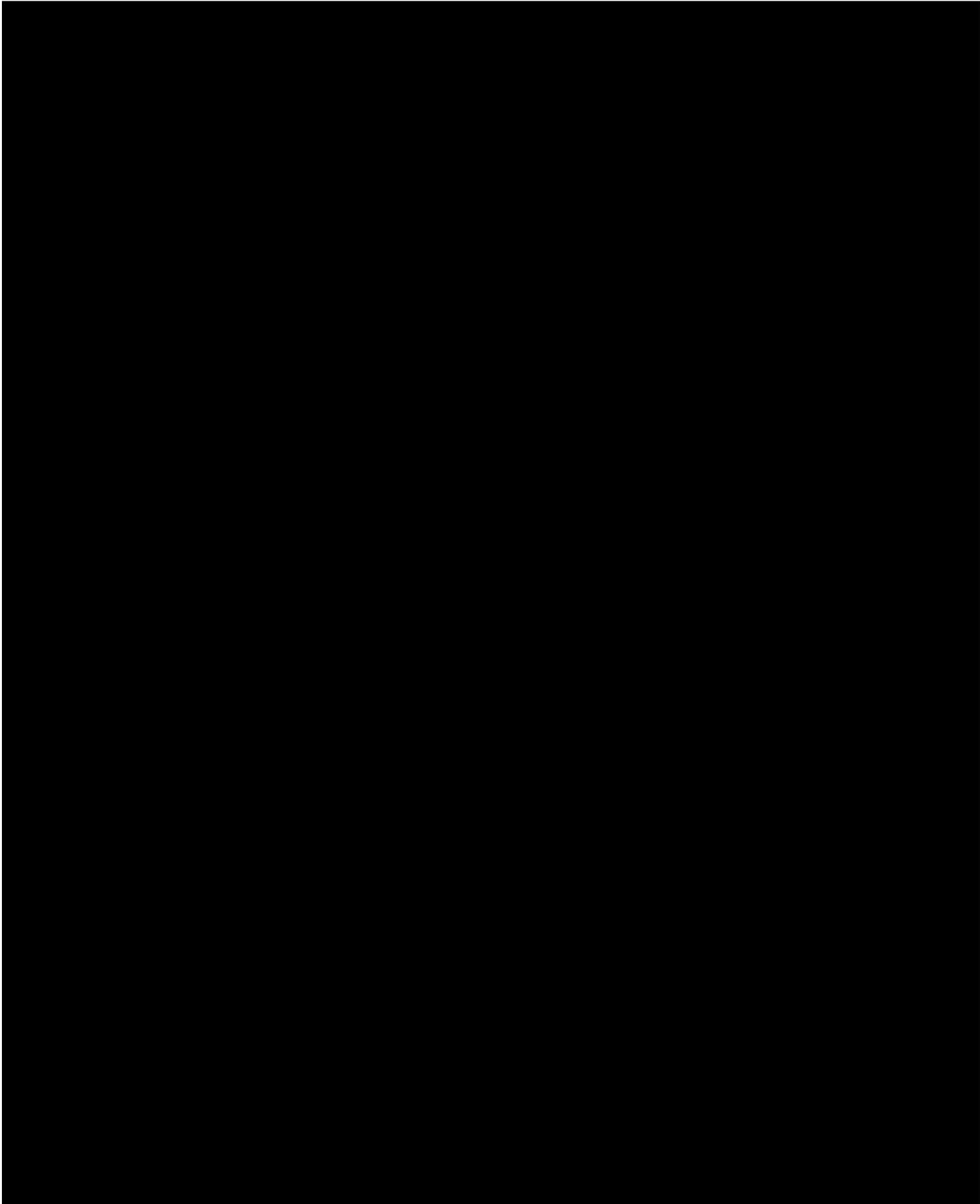


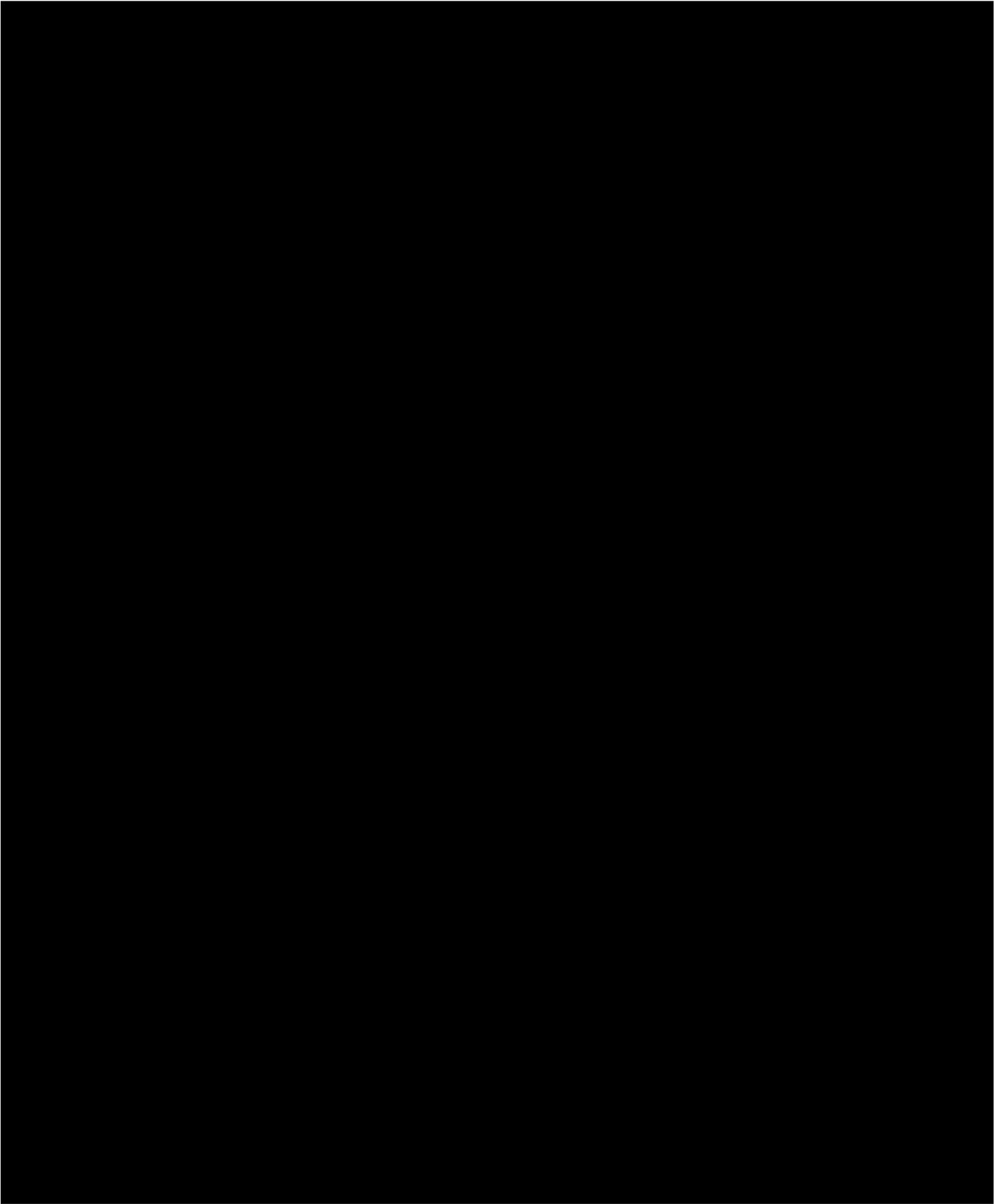


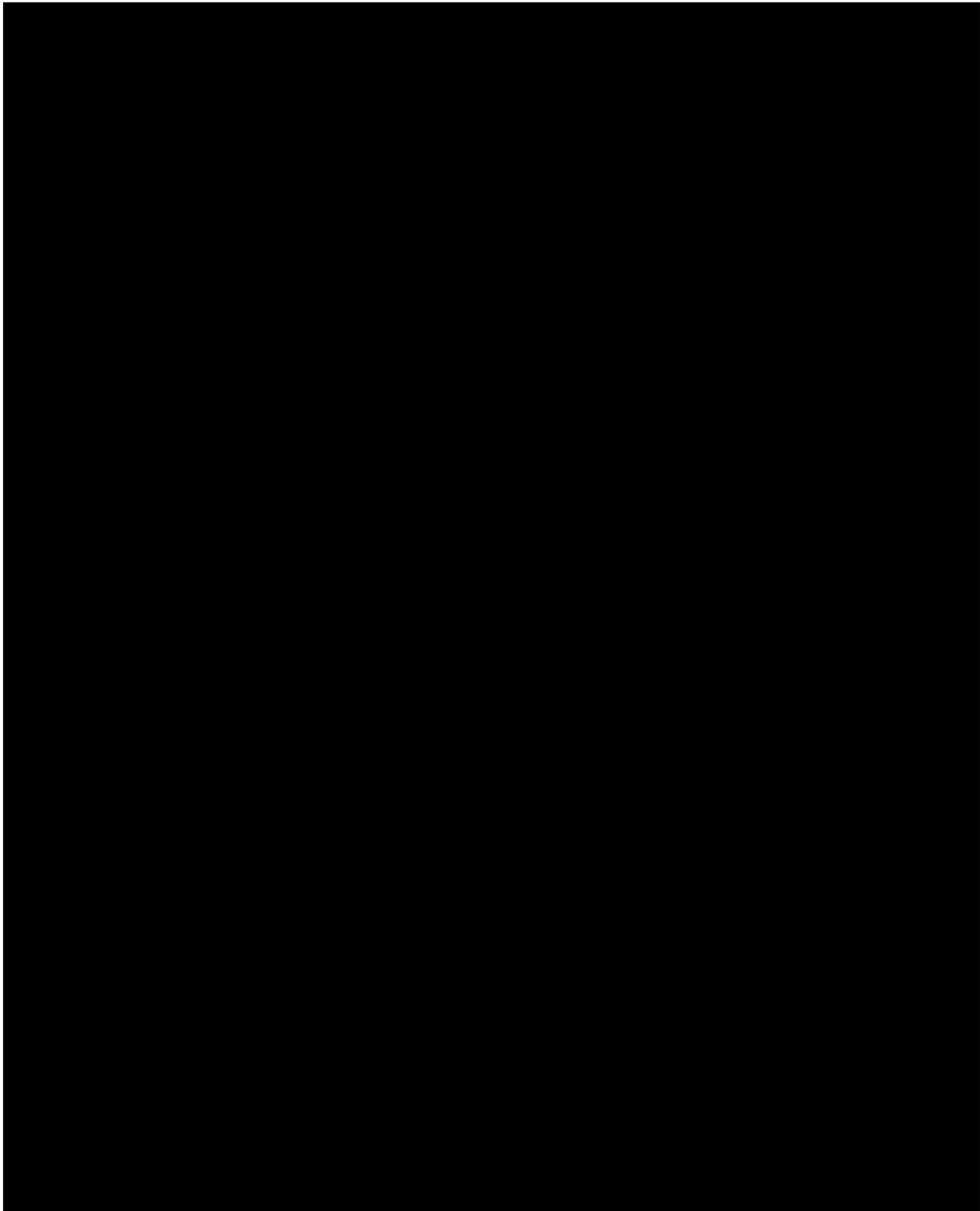
B) Enhanced **EGWP**:

CONTAINS HIGHLY SENSITIVE PROPRIETARY OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE









SUBMITTAL FORM I – Network Disruption Analysis

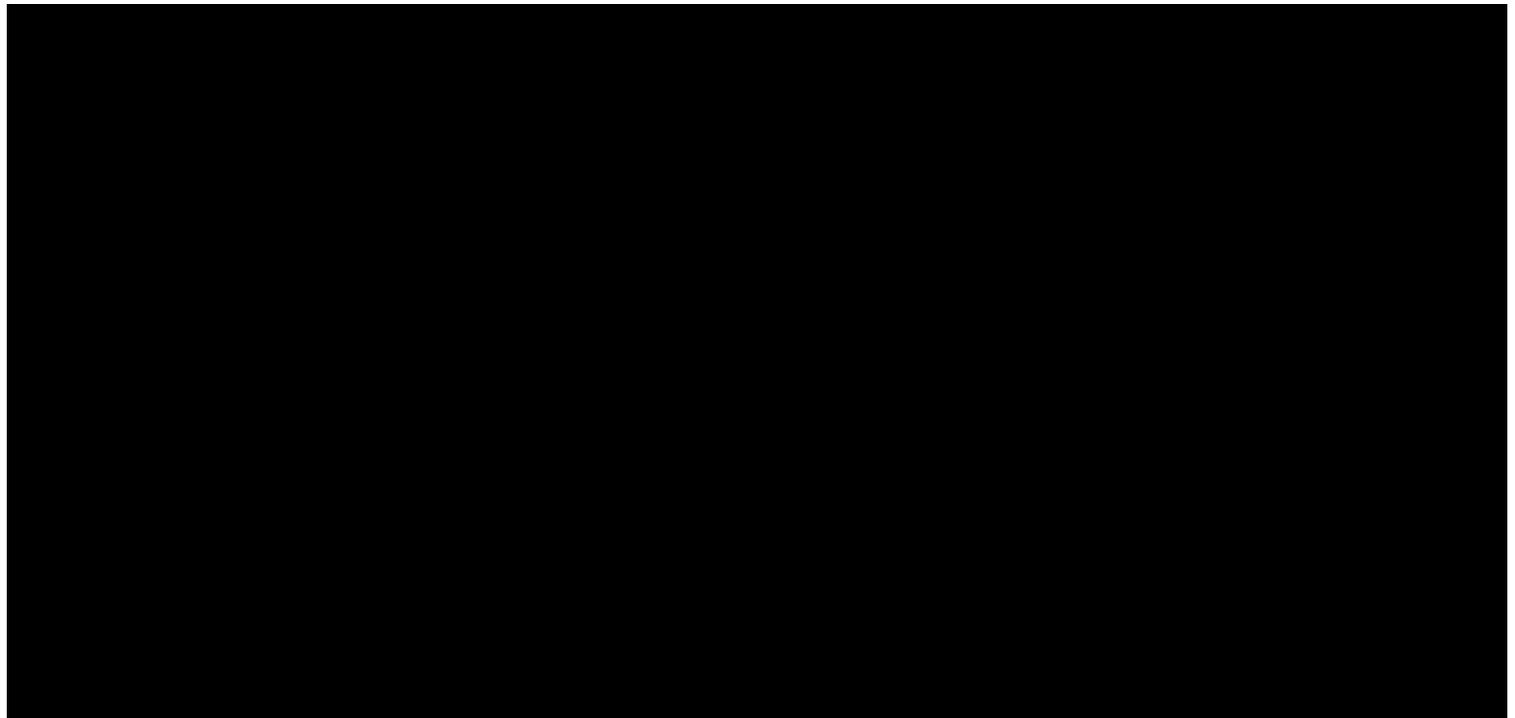
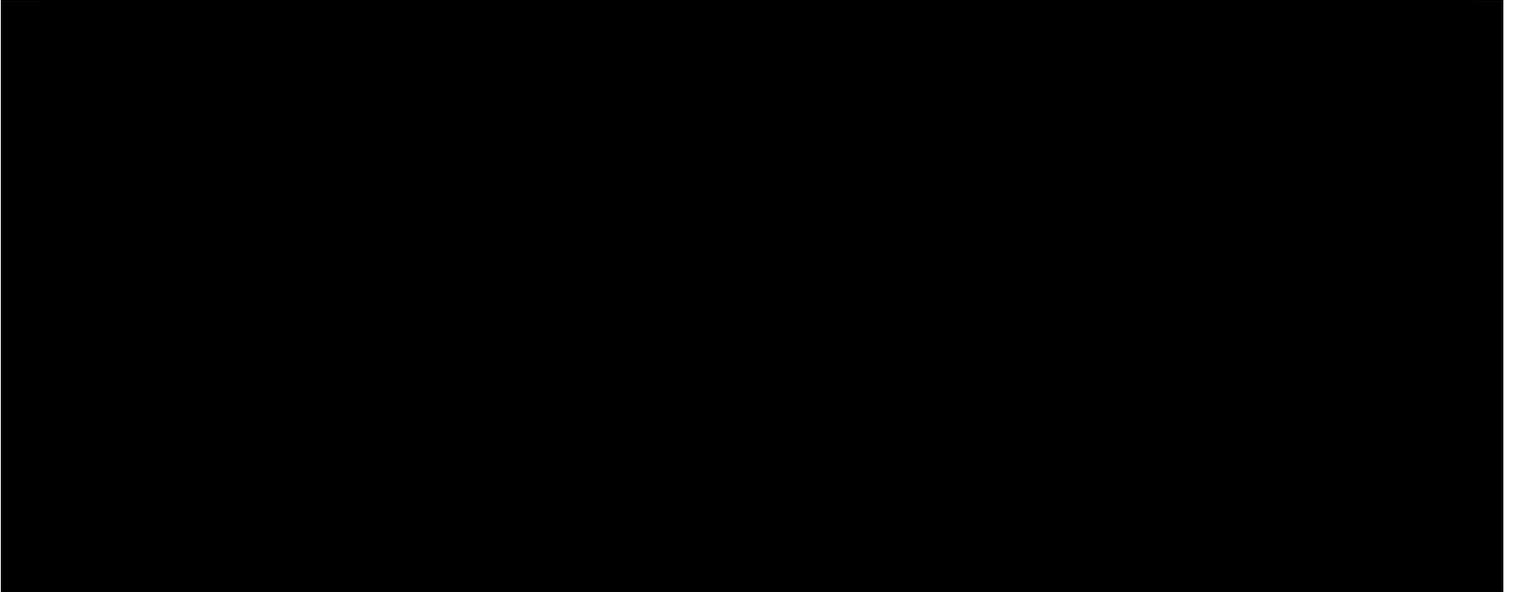
State of Alaska

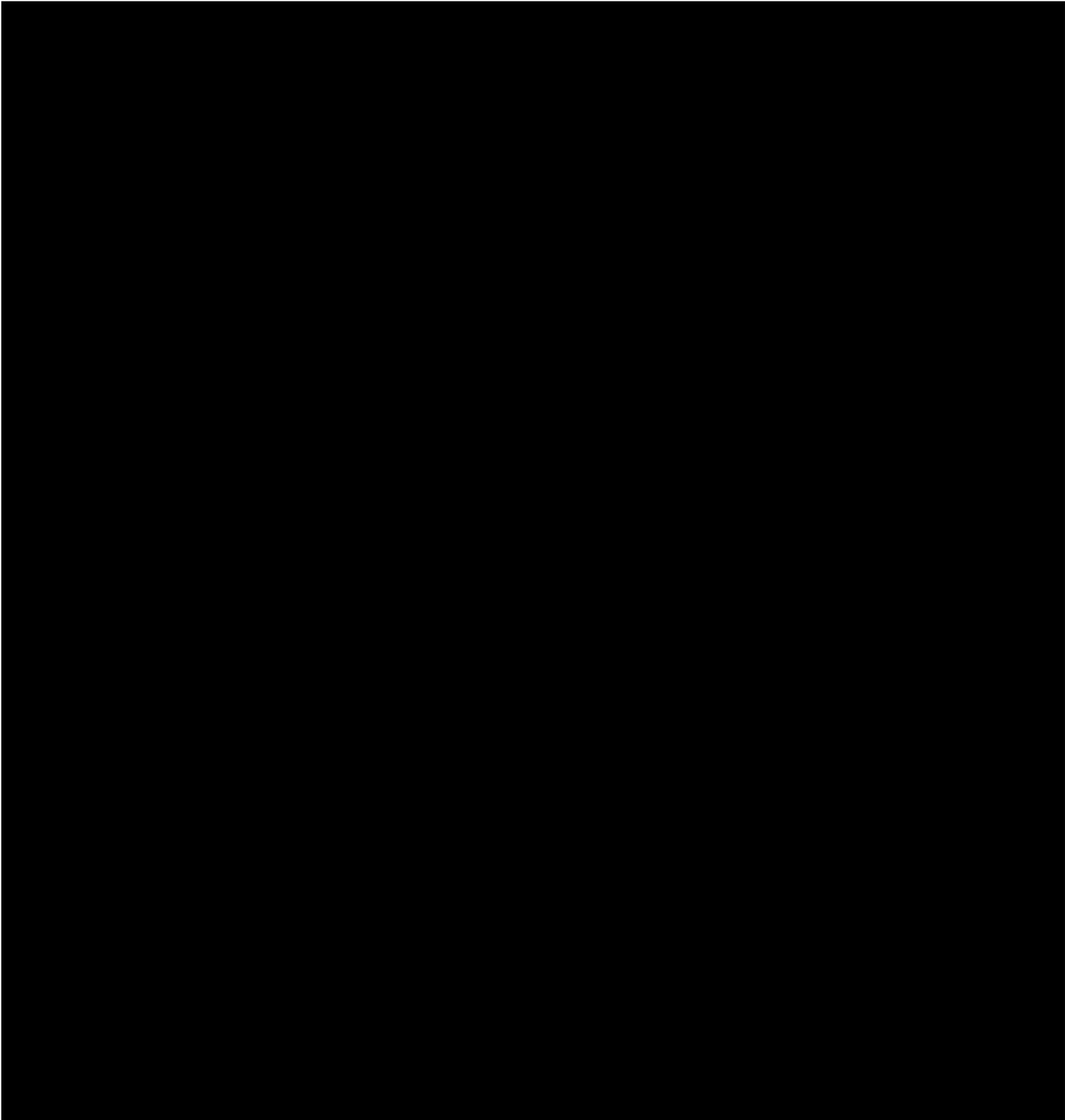
Network Disruption:

Provide separate network disruption analyses for Commercial and enhanced EGWP members. You must indicate numbers and percentages of pharmacies, members and prescriptions disrupted in the tables below. In addition, provide the names of pharmacies eligible for solicitation into the network.

CONTAINS HIGHLY SENSITIVE PROPRIETARY OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

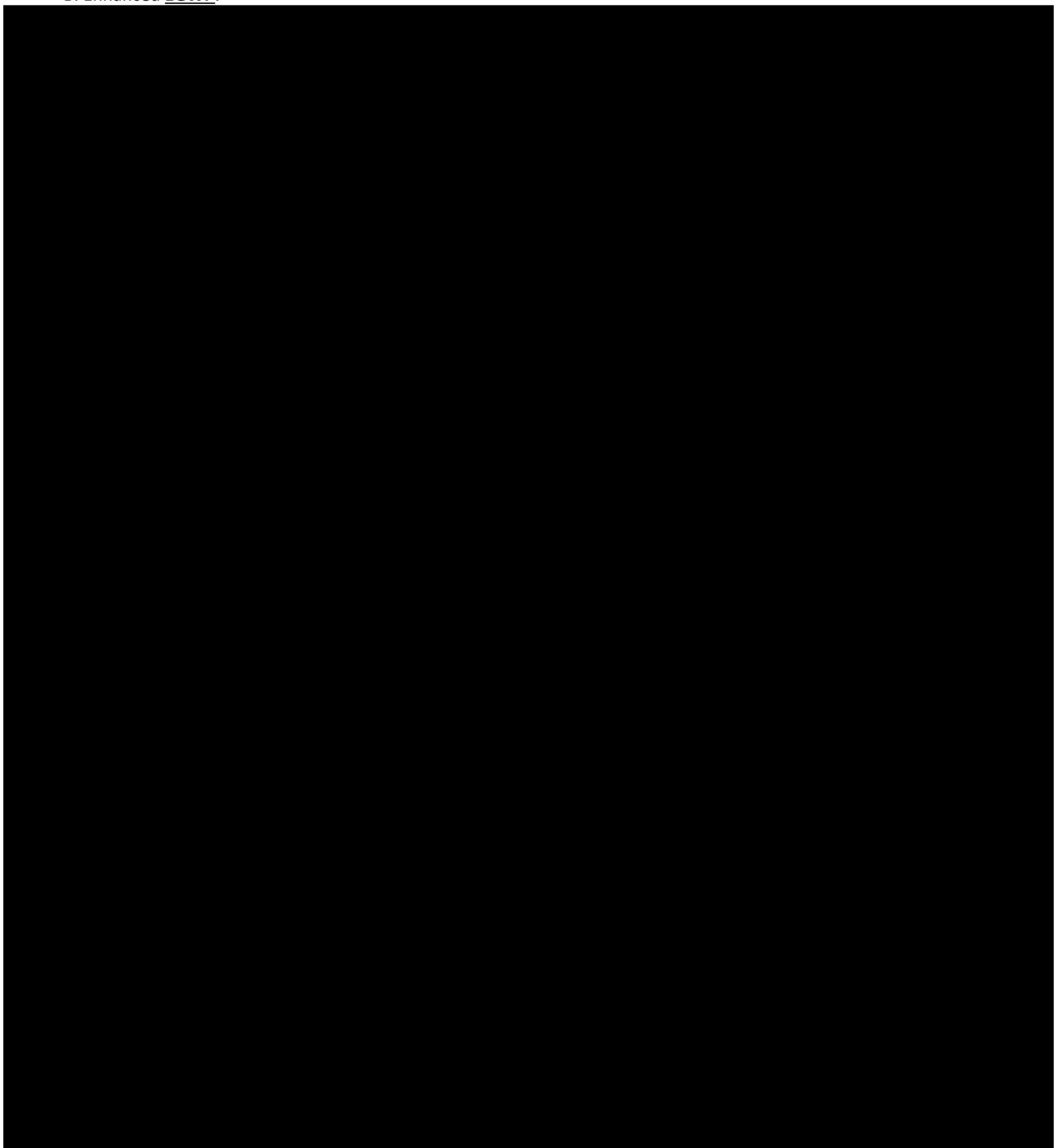
A. Commercial:

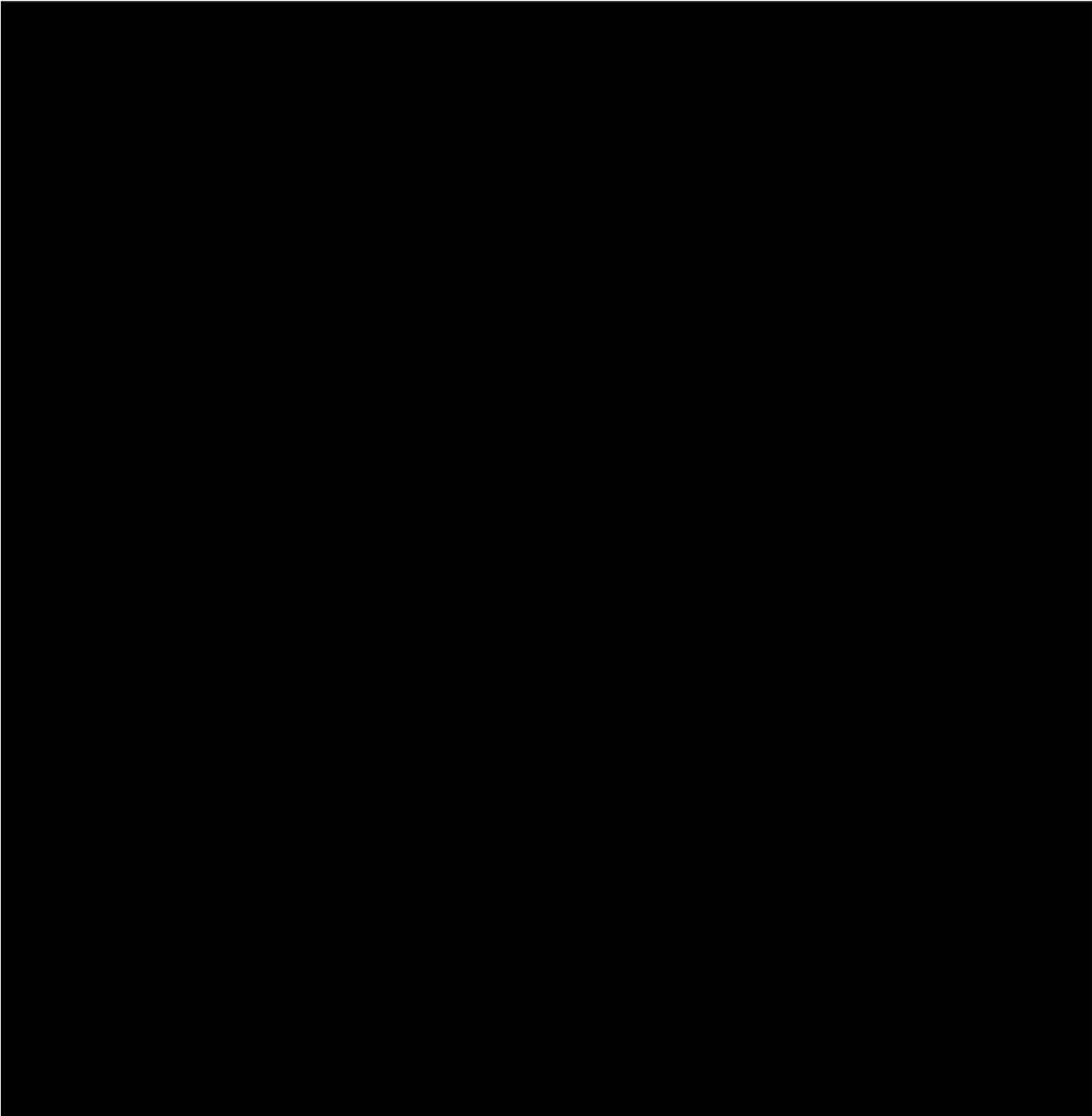




CONTAINS HIGHLY SENSITIVE PROPRIETARY OR TRADE SECRET INFORMATION; PUBLIC DISCLOSURE WILL CAUSE SIGNIFICANT COMPETITIVE INJURY AND DISRUPTION.

B. Enhanced EGWP:





SUBMITTAL FORM J – Subcontractors

Please complete the below form if using subcontractors. During the Clarification Period (RFP Section 5.20), the state will require a signed written statement from each subcontractor that clearly verifies the subcontractor is committed to performing the services required by the contract. Prior to contract award, the state will also require evidence that each subcontractor possesses a valid Alaska business license.

	Subcontractor Name	Address	% of Work Performing	Alaska Business License #
Claims Processing System	Not applicable.	Not applicable.	Not applicable.	Not applicable.
Formulary Management	Not applicable.	Not applicable.	Not applicable.	Not applicable.
Appeals	Not applicable.	Not applicable.	Not applicable.	Not applicable.
Clinical Programs	Not applicable.	Not applicable.	Not applicable.	Not applicable.
Pharmacy and Therapeutics Committee	Not applicable.	Not applicable.	Not applicable.	Not applicable.
Customer Service	Not applicable.	Not applicable.	Not applicable.	Not applicable.
Rebate Contracting	Not applicable.	Not applicable.	Not applicable.	Not applicable.
Network Contracting	Not applicable.	Not applicable.	Not applicable.	Not applicable.
Mail Order	Not applicable.	Not applicable.	Not applicable.	Not applicable.
Specialty Pharmacy	Not applicable.	Not applicable.	Not applicable.	Not applicable.
Data Reporting	Not applicable.	Not applicable.	Not applicable.	Not applicable.

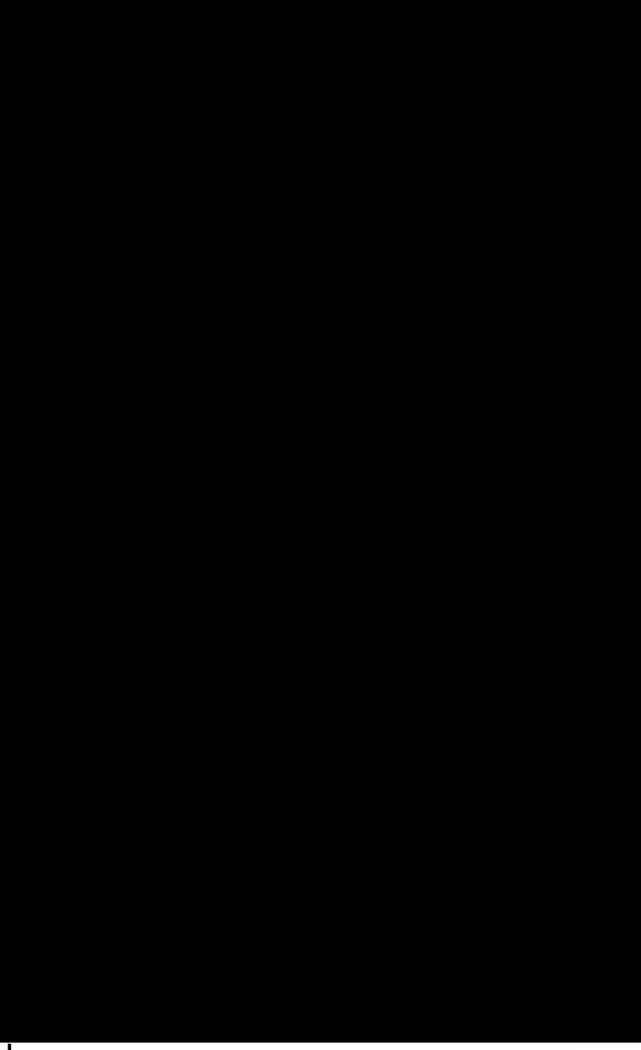
Definitions: Confirm you agree to the following contract definitions:		Response: YES or NO	Details (for "NO" responses only)
1	"Pass Through Formulary Drug Rebates" - The PBM agrees to pass through 100% of ALL rebate revenue earned and will not charge an administrative fee for this arrangement.	NO	[REDACTED]
2	"Rebates" - Compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer attributable to the purchase or utilization of covered drugs by eligible persons, including, but not limited to, incentive rebates categorized as mail order purchase discounts; credits; rebates, regardless of how categorized; market share incentives; promotional allowances; commissions; educational grants; market share of utilization; drug pull-through programs; implementation allowances; clinical detailing; rebate submission fees; and administrative or management fees. Rebates also include any fees that PBM receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access.	NO	[REDACTED]
3	AWP (Average Wholesale Price) is based on date sensitive, 11-digit NDC as supplied by a nationally-recognized pricing source (i.e., Medi-Span) for retail, mail order, and specialty adjudicated claims.	YES	
4	Member Copay - Members will pay the lowest of the following: plan copay/coinsurance, plan-negotiated discounted price plus dispensing fee, usual and customary (U&C), MAC (maximum allowable cost) or retail cash price.	YES	
5	Client eligibility and claim data - All eligibility and claims records are the sole property of and must be made available upon request to the state and its representatives. Selling or providing of the state's data to ANY outside entities is not permitted under any circumstances.	YES	
6	Paid Claims - Defined as all transactions made on eligible members that result in a payment to pharmacies or members from the state or the state's member copays. (Does not include reversals, rejected claims and adjustments.) Each unique prescription that results in payment shall be calculated separately as a paid claim.	YES	
7	Members - All eligible participants and their eligible dependents enrolled under the state's prescription benefit program.	YES	

Brand and Minimum Generic Discount Guarantees: Brand and Minimum Generic Discount Guarantees for both mail and retail shall be defined as follows: (1-Aggregate Ingredient Cost/Aggregate AWP), where a through k are defined as:		Response: YES or NO	Details (for "NO" responses only)
a	Aggregate Ingredient Cost prior to application of plan specific participant co-payments, excess copays or deductibles.	YES	
b	Aggregate AWP will be from a single, nationally recognized price source for all claims.	YES	
c	Dispensing Fees are not included in the Aggregate Ingredient Cost.	YES	
d	All guarantee measurements shall be calculated prior to the copayment being applied.	YES	
e	Both the Aggregate Ingredient Cost and Aggregate AWP from the actual date of claim adjudication will be used.	YES	
f	Aggregate AWP will be the date sensitive, 11-digit NDC of the actual product dispensed.	YES	
g	Both non-MAC, MAC, single-source and multiple source generic products are to be included in the generic guarantee measurement.	YES	
h	Compounds, OTC claims, and claims with ancillary product or service charges will be excluded from the guarantee measurements for retail and mail order components.	YES	
i	The guarantee measurement must exclude the savings impact from DUR programs, formulary programs, utilization management programs, and/or other therapeutic interventions.	YES	
j	Measurement will be performed annually by PBM and subject to independent audit utilizing date-sensitive AWP derived from a single, nationally recognized price source for all claims.	YES	
k	Zero balance due claims or zero plan paid amount claims will be included in the guaranteed measurement for AWP, ingredient cost, achieved discounts or dispensing fee calculations at the discounted cost before member copay.	YES	

Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.1 Administrative Fees: Commercial

Bidder Name				
	Traditional with 100% Pass Through Rebates or Transparent with 100% Pass Through Rebates PROPOSAL ADMINISTRATIVE SERVICES	1/1/2019-12/31/2019	1/1/2020-12/31/2020	1/1/2021-12/31/2021
	Indicate which of these services are included for no additional cost: Note traditional or retail pass through pricing	Traditional: Base Admin Fee: \$0.00 per net paid claim (PNPC)	Traditional: Base Admin Fee: \$0.00 PNPC	Traditional: Base Admin Fee: \$0.00 PNPC
	Toll Free Phone Lines			
	Bi-weekly or Monthly Data Feeds to the State or its Designee(s)			
	Prospective /Concurrent/Retro DUR			
	Standard Reports			
	Ad Hoc Reports			
	COB Program			
	Mandatory Mail Program			
	Dose Optimization Program			
	Prior Authorization Program			
	Step Therapy Program			
	Quantity Limitations			
	Custom System Overrides			
	Annual EOB Statements			
	Retro Termination Letters			
	Group Coding			
	Drug Notification Letters			
	Formulary Administration/Management			
	ID Cards			
	Pharmacy Directories and other member materials			
	Standard 1st level appeals processing			
	Standard 2nd level appeals processing			
	Urgent appeals processing			
	Overrides			
	Audit Recovery Fees			
	Compound Drug Management			
	RDS Services: PBM submits all required reporting to CMS			
	Services above that have additional costs (i.e., services marked "N" above) (show fees separately):	Please see details section below	Please see details section below	Please see details section below
	.			

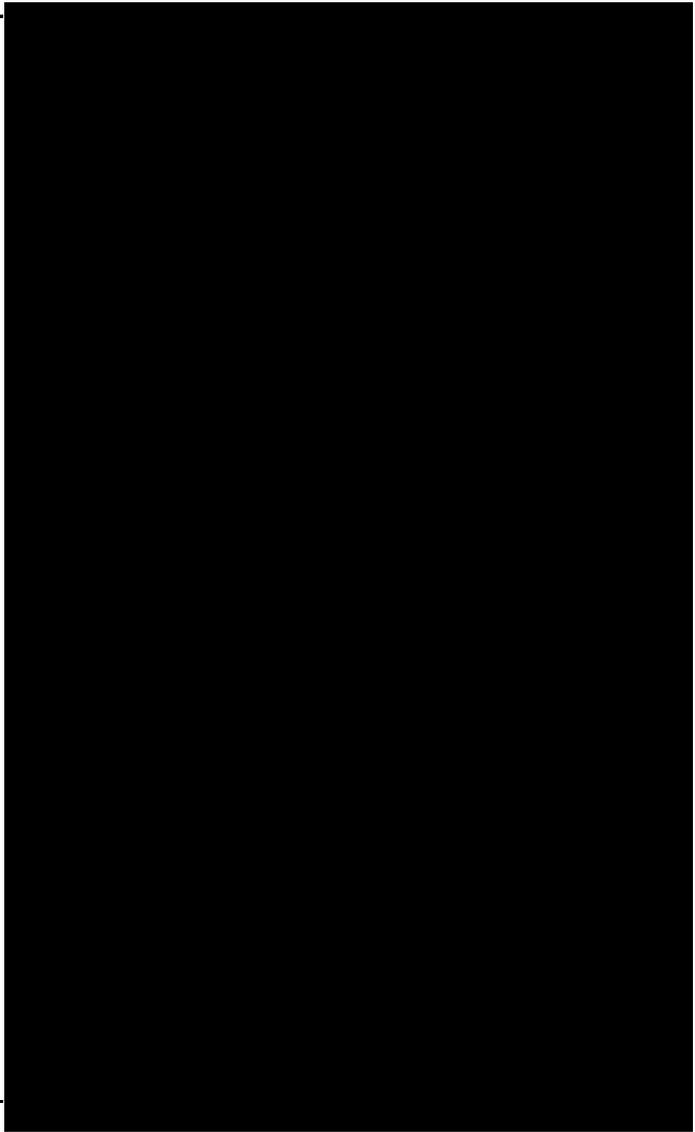
Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.1 Administrative Fees: Commercial

Bidder Name			
Traditional with 100% Pass Through Rebates or Transparent with 100% Pass Through Rebates PROPOSAL ADMINISTRATIVE SERVICES	1/1/2019-12/31/2019	1/1/2020-12/31/2020	1/1/2021-12/31/2021
Details			

Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.1 Administrative Fees: EGWP

Bidder Name			
Traditional with 100% Pass Through Rebates or Transparent with 100% Pass Through Rebates PROPOSAL ADMINISTRATIVE SERVICES	1/1/2019-12/31/2019	1/1/2020-12/31/2020	1/1/2021-12/31/2021
Indicate which of these services are included for no additional cost: Note traditional or retail pass through pricing			
Toll Free Phone Lines			
Bi-weekly or Monthly Data Feeds to the State or its Designee(s)			
Prospective /Concurrent/Retro DUR			
Standard Reports			
Ad Hoc Reports			
COB Program			
Mandatory Mail Program			
Dose Optimization Program			
Prior Authorization Program			
Step Therapy Program			
Quantity Limitations			
Custom System Overrides			
Annual EOB Statements			
Retro Termination Letters			
Group Coding			
Drug Notification Letters			
Formulary Administration/Management			
ID Cards			
Pharmacy Directories and other member materials			
Standard 1st level appeals processing			
Standard 2nd level appeals processing			
Urgent appeals processing			
Overrides			
Audit Recovery Fees			
Compound Drug Management			
Services above that have additional costs (i.e., services marked "N" above) (show fees separately):	Please see details section below	Please see details section below	Please see details section below
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.			

	Details
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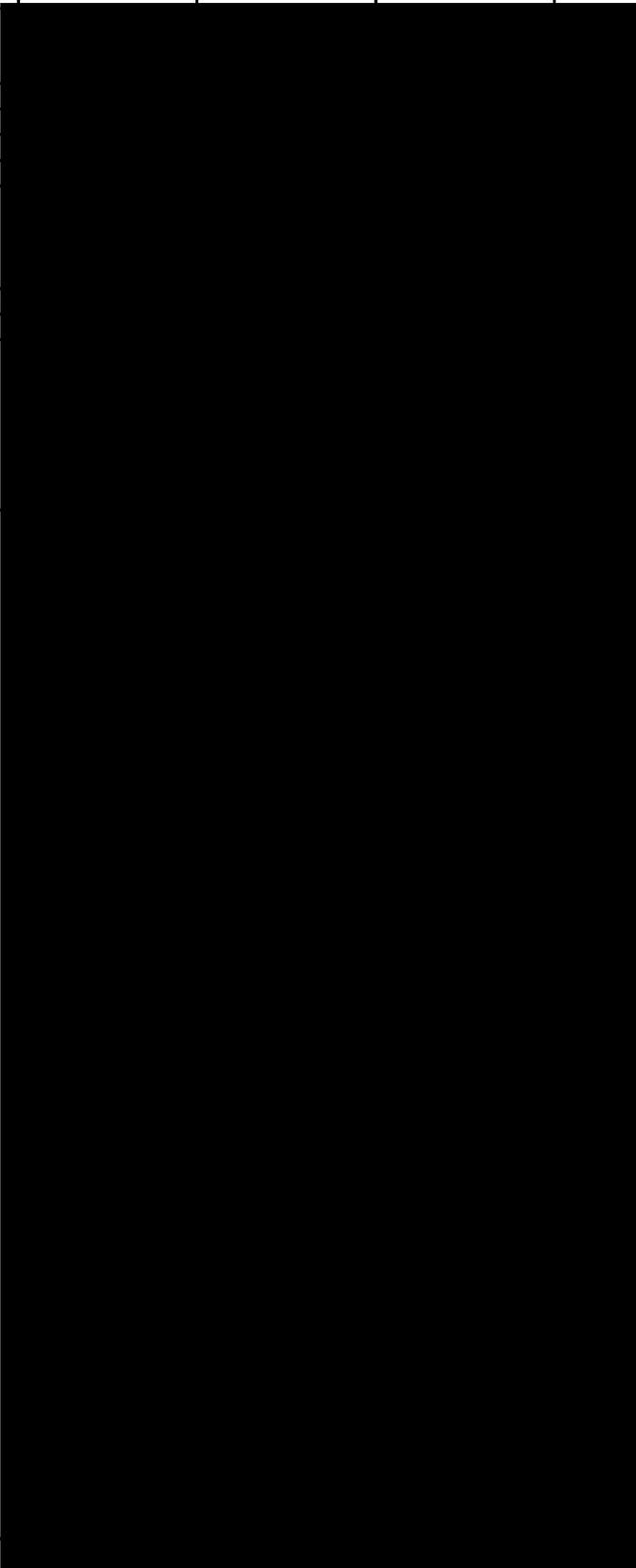
Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.2A Prescription Drug Pricing: Commercial

Year 1 Commercial

B	
	Broadest Retail Network (List any Major Retail Chains Excluded)
	Brand Drugs
	Discount from AWP for all brands
	Dispensing Fee Per Brand Rx
	Generic Drugs
	Discount from AWP for all generics (composite discount of MAC and Non-MA prices, discounted AWP, or usual and customary retail price)
	Dispensing Fee Per Generic Rx
	Rebates
	Three Tier Plan – Per Brand Rx
	Details

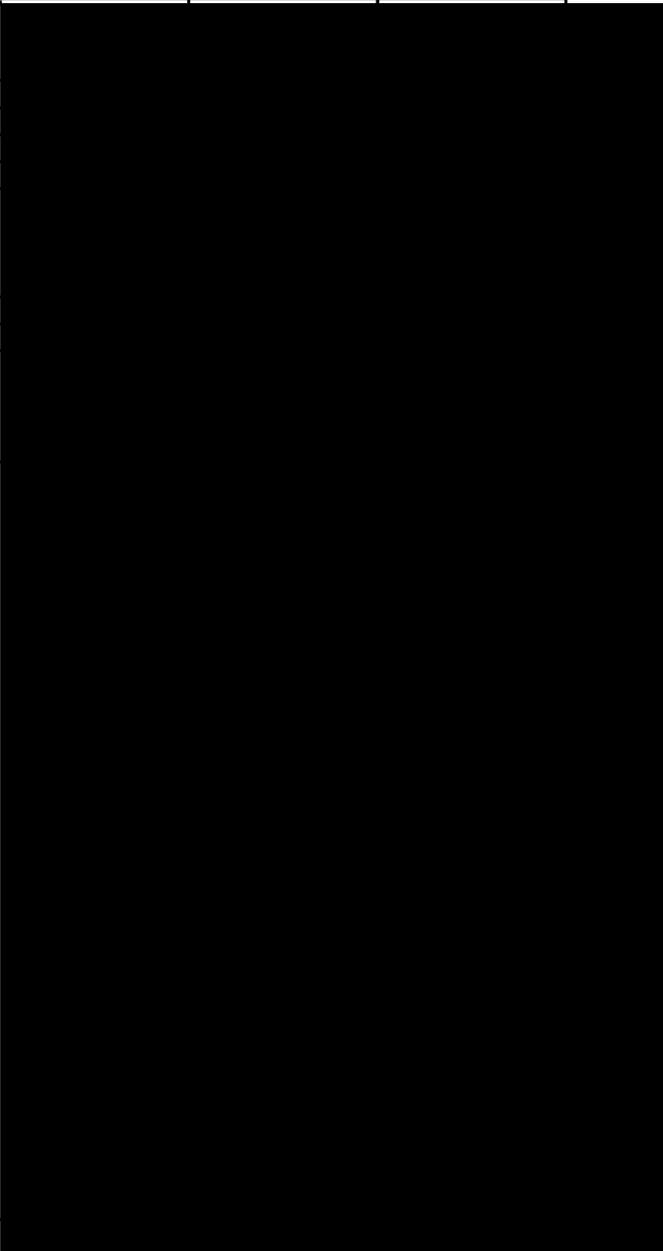
Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.2A Prescription Drug Pricing: Commercial

Year 2 Commercial

		Bidder Name
	Broadest Retail Network (List any Major Retail Chains Excluded)	
	Brand Drugs	
	Discount from AWP for all brands	
	Dispensing Fee Per Brand Rx	
	Generic Drugs	
	Discount from AWP for all generics (composite discount of MAC and Non-MA prices, discounted AWP, or usual and customary retail price)	
	Dispensing Fee Per Generic Rx	
	Rebates	
	Three Tier Plan – Per Brand Rx	
	Details	

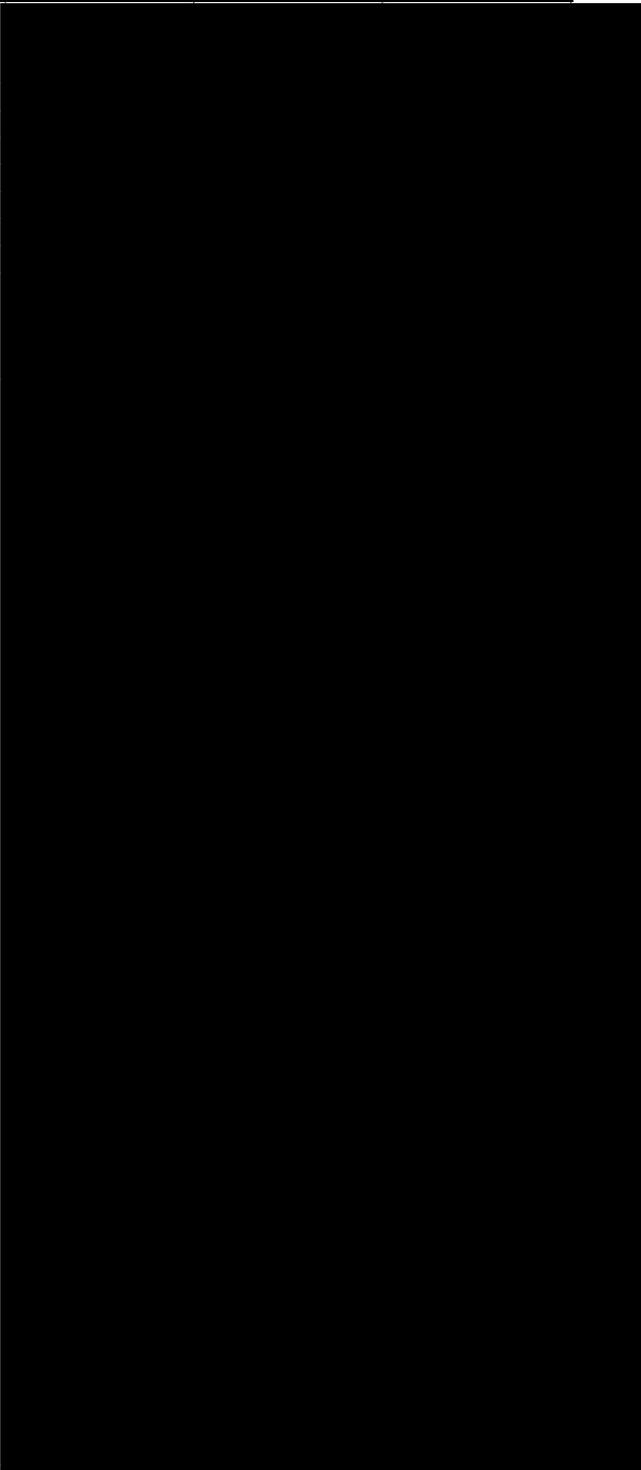
Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.2A Prescription Drug Pricing: Commercial

Year 3 Commercial

		Bidder Name
	Broadest Retail Network (List any Major Retail Chains Excluded)	
	Brand Drugs	
	Discount from AWP for all brands	
	Dispensing Fee Per Brand Rx	
	Generic Drugs	
	Discount from AWP for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	
	Dispensing Fee Per Generic Rx	
	Rebates	
	Three Tier Plan – Per Brand Rx	
	Details	

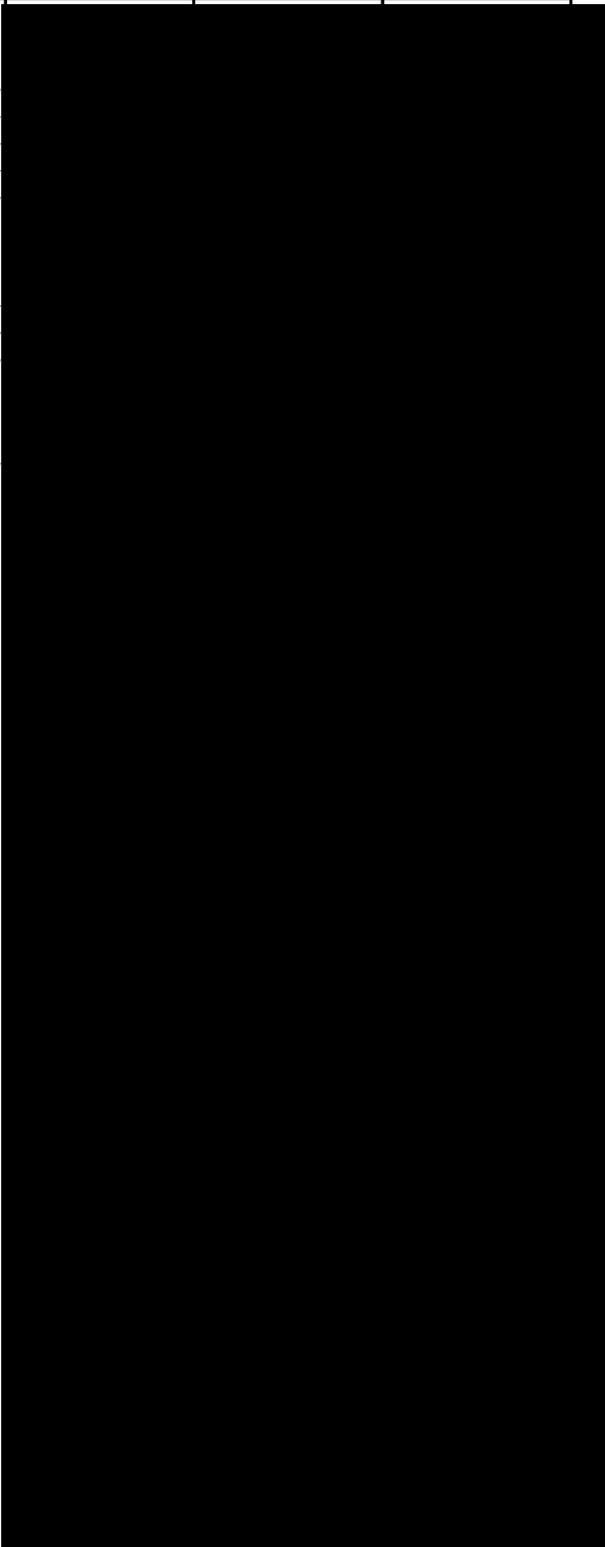
Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.2B Prescription Drug Pricing: EGWP

Year 1 EGWP

		Bidder Name
	Broadest Retail Network (List any Major Retail Chains Excluded)	
	Brand Drugs	
	Discount from AWP for all brands	
	Dispensing Fee Per Brand Rx	
	Generic Drugs	
	Discount from AWP for all generics	
	Dispensing Fee Per Generic Rx	
	Rebates	
	Two Tier Plan – Per Brand Rx	
	Details	

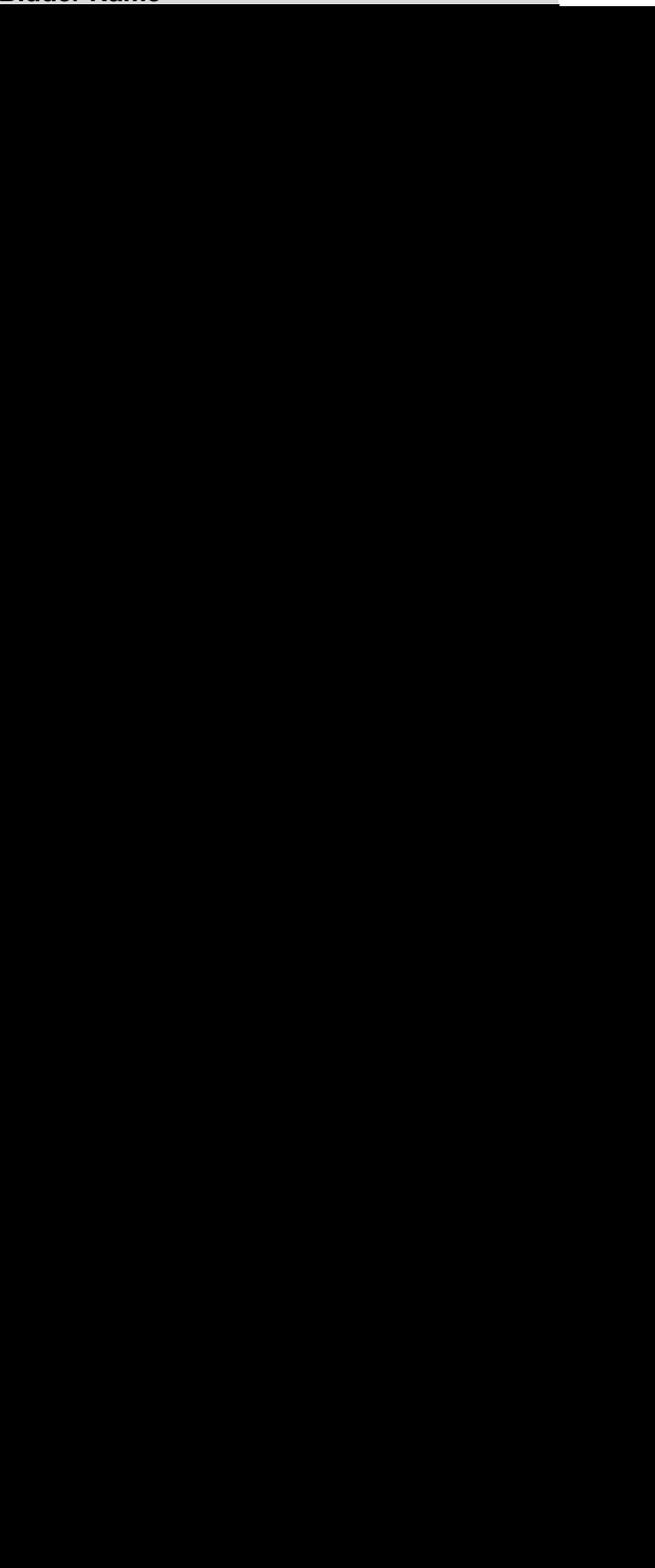
Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.2B Prescription Drug Pricing: EGWP

Year 2 EGWP

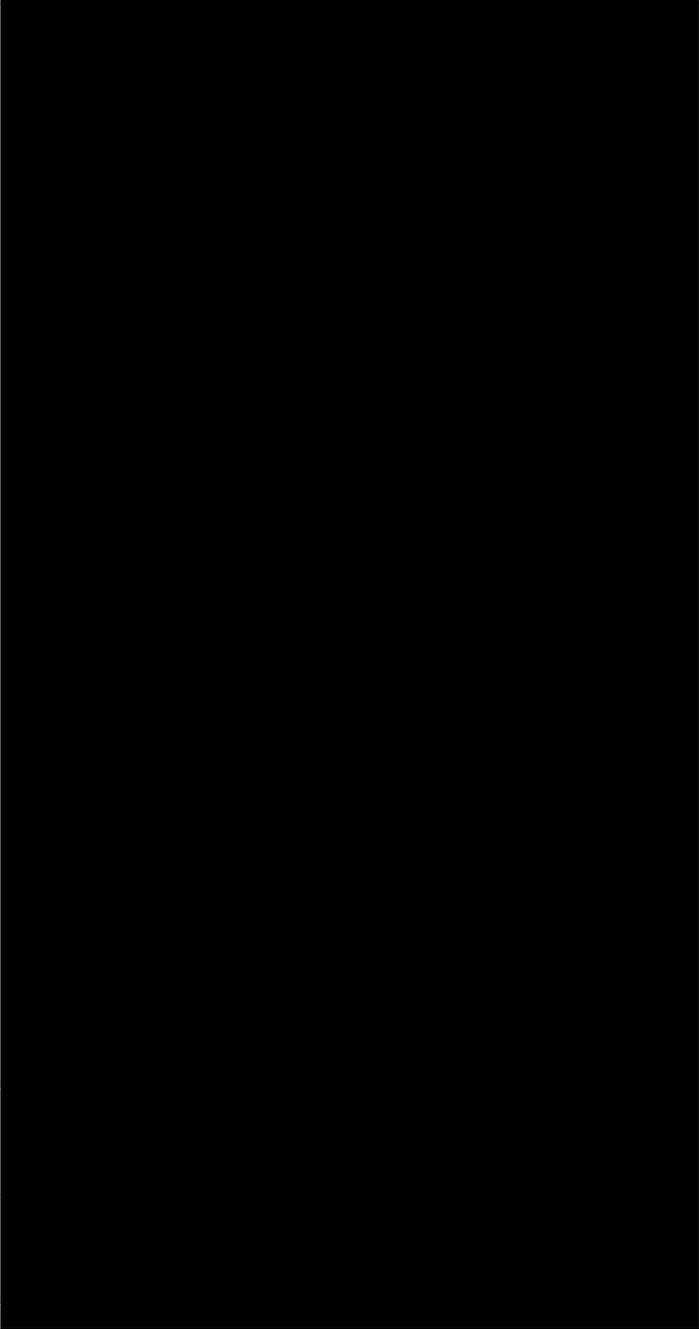
		Bidder Name
	Broadest Retail Network (List any Major Retail Chains Excluded)	
	Brand Drugs	
	Discount from AWP for all brands	
	Dispensing Fee Per Brand Rx	
	Generic Drugs	
	Discount from AWP for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	
	Dispensing Fee Per Generic Rx	
	Rebates	
	Two Tier Plan – Per Brand Rx	
	Details	

Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.2B Prescription Drug Pricing: EGWP

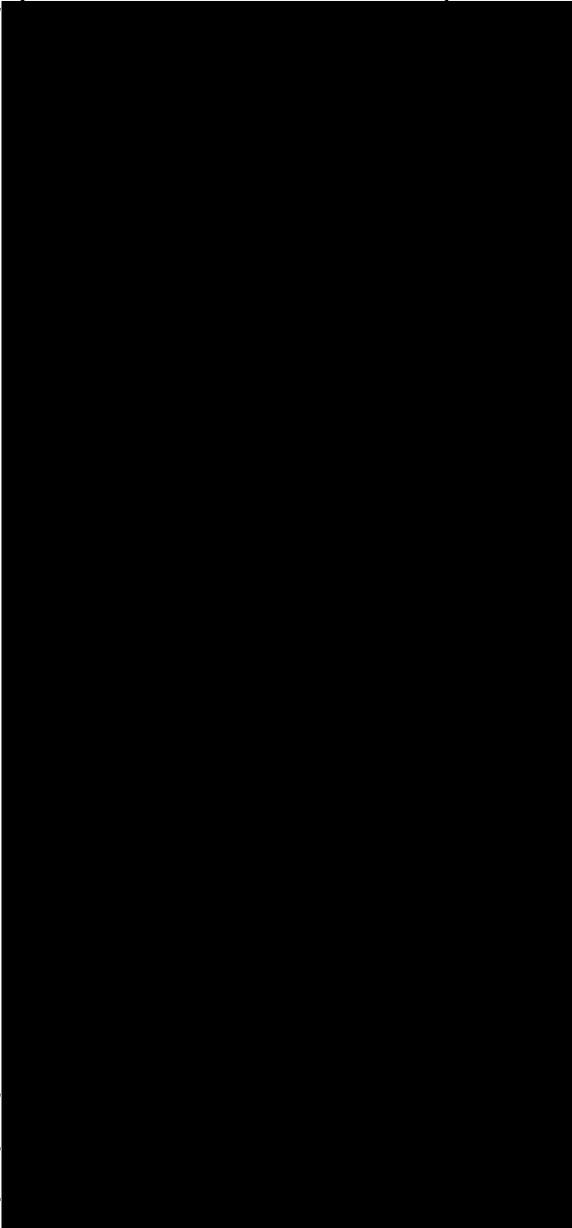
Year 3 EGWP

		Bidder Name
	Broadest Retail Network (List any Major Retail Chains Excluded)	
	Brand Drugs	
	Discount from AWP for all brands	
	Dispensing Fee Per Brand Rx	
	Generic Drugs	
	Discount from AWP for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	
	Dispensing Fee Per Generic Rx	
	Rebates	
	Two Tier Plan – Per Brand Rx	
	Details	

Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.3 Allowances

Bidder Name		
Allowance	Description	Response
Implementation		
Pre-Implementation Audit		
Audit		

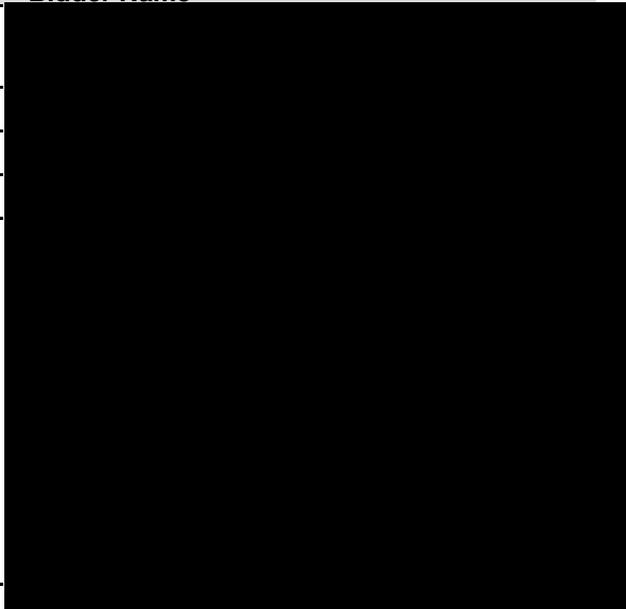
Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.3 Allowances

Bidder Name		
Allowance	Description	Response
Annual Allowance		
General Pharmacy Program Management	Not applicable.	
Details		

Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.4 Generic Drugs - Dispensing Rate Guarantees

Bidder Name	
Guaranteed GDR	
1/1/2019-12/31/2019	
1/1/2020-12/31/2020	
1/1/2021-12/31/2021	
Details	

Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.5 Price Inflation Guarantees

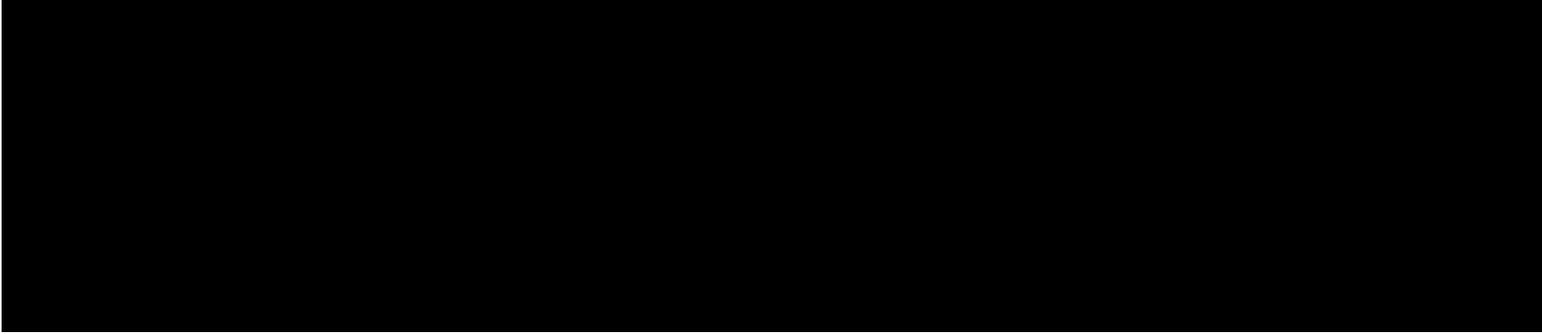
		Bidder Name
	Guaranteed Price Inflation Max	
	1/01/2020 – 12/31/2020	
	1/01/2021 – 12/31/2021	
	1/01/2022 – 12/31/2022	
	Details	

Event Name: State of AK PBM RFP
Report Aspect: 8 Financial Section
Report Option: 8.6 Specialty Pharmacy Program Pricing: Commercial

Bidder Name

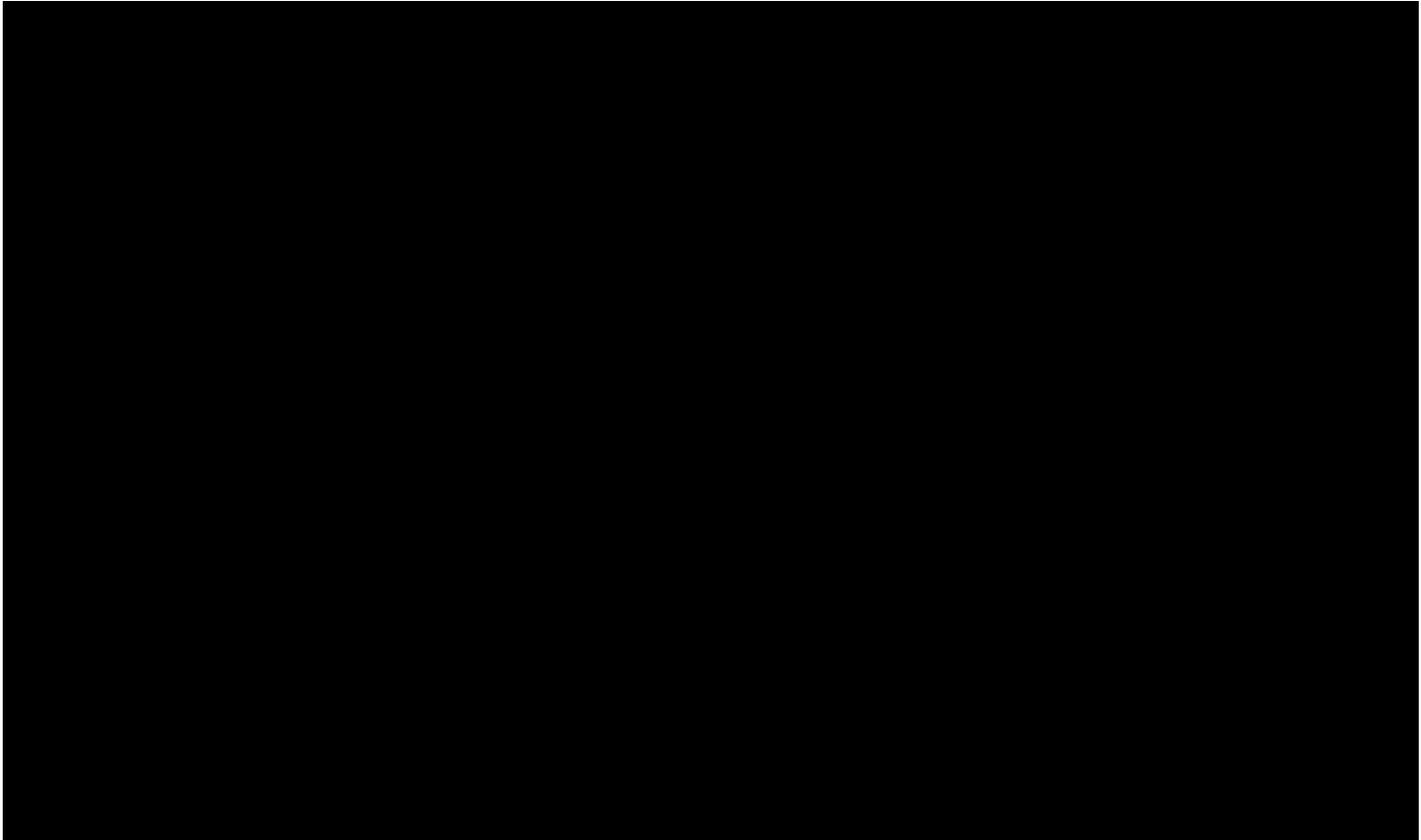


Current Tier	Proposed Tier	Type of Change	Number of Rxs	% of Total Rxs
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Current Tier	Proposed Tier	Type of Change	Number of Rxs	% of Total Rxs
[Redacted Content]				

State of Alaska



State of Alaska

Claims Period: Oct 16 - Sep 17



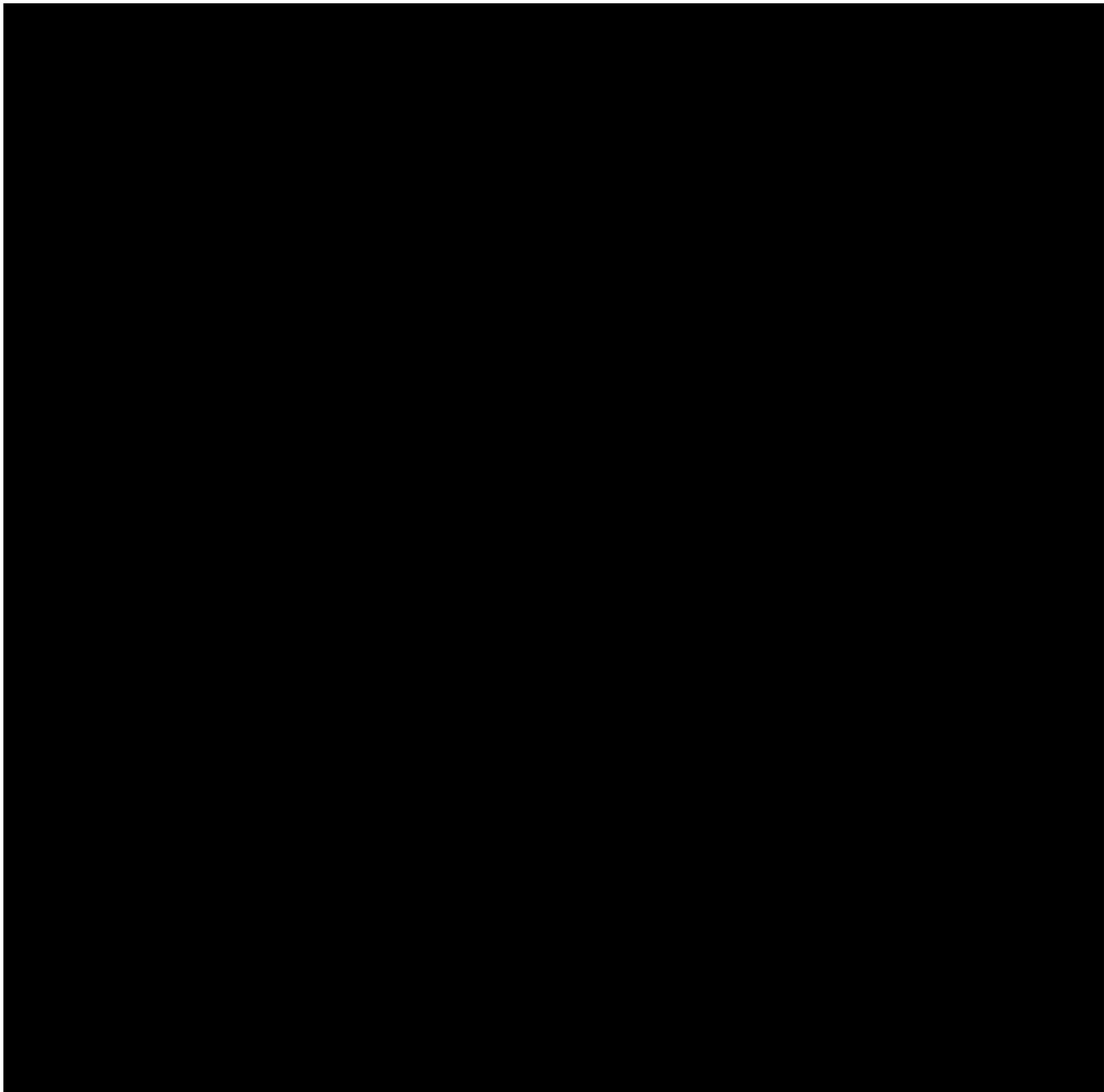
State of Alaska

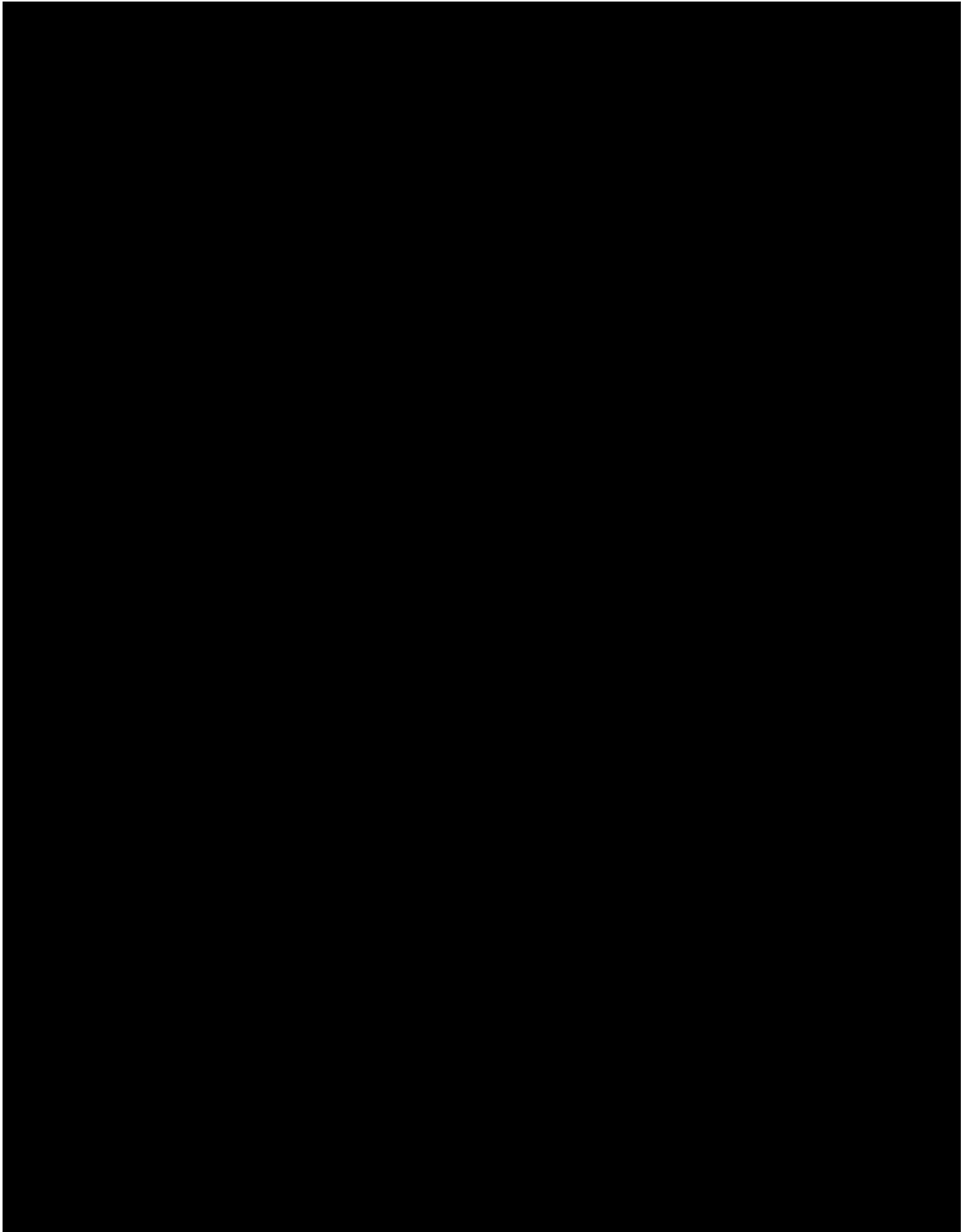
Claims Period: Oct 16 - Sep 17

Formulary Disruption - Premium



OptumRx
Formulary Disruption







CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
06/29/2018

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Marsh USA Inc. 333 South 7th Street, Suite 1400 Minneapolis, MN 55402-2400 Attn: Healthcare.AccountsCSS@marsh.com Fax: 212-948-1307 CN101631729-ALL-ALL-18-20	CONTACT NAME: PHONE (A/C. No. Ext): _____ FAX (A/C. No): _____ E-MAIL ADDRESS: _____ <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;">INSURER(S) AFFORDING COVERAGE</th> <th style="width: 20%;">NAIC #</th> </tr> </thead> <tbody> <tr> <td>INSURER A : Old Republic Insurance Company</td> <td>24147</td> </tr> <tr> <td>INSURER B : XL Specialty Insurance Company</td> <td>37885</td> </tr> <tr> <td>INSURER C : Travelers Property Casualty Company of America</td> <td>25674</td> </tr> <tr> <td>INSURER D :</td> <td></td> </tr> <tr> <td>INSURER E :</td> <td></td> </tr> <tr> <td>INSURER F :</td> <td></td> </tr> </tbody> </table>	INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A : Old Republic Insurance Company	24147	INSURER B : XL Specialty Insurance Company	37885	INSURER C : Travelers Property Casualty Company of America	25674	INSURER D :		INSURER E :		INSURER F :	
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INSURER E :															
INSURER F :															
INSURED OPTUMRX, INC. 11020 OPTUM CIRCLE EDEN PRAIRIE, MN 55344															

COVERAGES **CERTIFICATE NUMBER:** CHI-009015986-01 **REVISION NUMBER:** 1

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER: _____			MWZY313281	05/01/2018	05/01/2020	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 1,000,000 MED EXP (Any one person) \$ 2,500 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$ _____
A	AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			MWTB313284	05/01/2018	05/01/2020	COMBINED SINGLE LIMIT (Ea accident) \$ 2,000,000 BODILY INJURY (Per person) \$ _____ BODILY INJURY (Per accident) \$ _____ PROPERTY DAMAGE (Per accident) \$ _____ \$ _____
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED _____ RETENTION \$ _____			US00075258L18A	05/01/2018	05/01/2019	EACH OCCURRENCE \$ 25,000,000 AGGREGATE \$ 25,000,000 \$ _____
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A	HC2JUB472M475518 (AOS) HRJUB472M476718 (MA & WI) HWXJUB472M477918 (XWC OH)	05/01/2018 05/01/2018 05/01/2018	05/01/2019 05/01/2019 05/01/2019	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000
A	Managed Care Professional Liab Retro Date: 1/1/77			MWZZ313282	05/01/2018	05/01/2020	Each Claim \$10,000,000 Annual Aggregate \$10,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER OPTUMRX, INC. 11020 OPTUM CIRCLE EDEN PRAIRIE, MN 55344	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Manashi Mukherjee <i>Manashi Mukherjee</i>
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