STATE OF ARKANSAS
OFFICE OF STATE PROCUREMENT
1509 West 7th Street, Room 300
Little Rock, Arkansas 72201-4222

TECHNICAL PROPOSAL PACKET
SP-15-0115

CAUTION TO VENDOR

Vendor's failure to submit required items and/or information as specified in the *Bid Solicitation Document* **shall** result in disqualification.

STATE OF ARKANSAS

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PROPOSAL SIGNATURE PAGE

Type or Print the following information.

RESPONDENT'S INFORMATION					
Company:					
Address:					
City:		State:		Zip Code:	
Business Designation:	☐ Individual ☐ Partnership	☐ Sole Proprietorship ☐ Corporation	☐ Public Service Corp ☐ Government/ Nonprofit		
Minority Designation: *See Minority Business Policy*	☐ Not Applicable ☐ African American ☐ American Indian	☐ Hispanic American ☐ Asian American	☐ Pacific Islander American ☐ Service Disabled Veteran		
	AR Minority Certification #: _____	Service Disabled Veteran Certification #: _____			

VENDOR CONTACT INFORMATION *Provide contact information to be used for bid solicitation related matters.*			
Contact Person:		Title:	
Phone:		Alternate Phone:	
Email:			

CONFIRMATION OF REDACTED COPY

☐ YES, a redacted copy of submission documents is enclosed.

☐ NO, a redacted copy of submission documents is not enclosed. I understand a full copy of non-redacted submission documents will be released if requested.

*Note: If a redacted copy of the submission documents is not provided with vendor's response packet, and neither box is checked, a copy of the non-redacted documents, with the exception of financial data (other than pricing), **shall** be released in response to any request made under the Arkansas Freedom of Information Act (FOIA). See Bid Solicitation for additional information.*

An official authorized to bind the vendor to a resultant contract must sign below.

The signature below signifies agreement that either of the following **shall cause the vendor's proposal to be disqualified:**

- Additional terms or conditions submitted in their proposal, whether submitted intentionally or inadvertently.
- Any exception that conflicts with a Requirement of this *Bid Solicitation*.

Authorized Signature: _____ **Title:** _____
Use Ink Only.

Printed/Typed Name: _____ **Date:** _____

SECTION 1 - VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*
- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

Authorized Signature: _____

Use Ink Only.

Printed/Typed Name: _____ **Date:** _____

SECTION 2 - VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*
- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

Authorized Signature: _____

Use Ink Only.

Printed/Typed Name: _____ **Date:** _____

SECTIONS 3, 4, 5 - VENDOR AGREEMENT AND COMPLIANCE

- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in these sections of the bid solicitation.

Authorized Signature: _____

Use Ink Only.

Printed/Typed Name: _____ **Date:** _____

PROPOSED SUBCONTRACTORS FORM

- ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

VENDOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.

Type or Print the following information

Subcontractor's Company Name	Street Address	City, State, ZIP

☐ VENDOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.

By signature below, vendor agrees to and **shall** fully comply with all Requirements related to subcontractors as shown in the bid solicitation.

Authorized Signature: _____
Use Ink Only.

Printed/Typed Name: _____ **Date:** _____

INFORMATION FOR EVALUATION

- *Provide a response to each item/question in this section. Vendor may expand the space under each item/question to provide a complete response.*
- ***Do not** include additional information if not pertinent to the itemized request.*

		Maximum RAW Score Available
E.1	**ORGANIZATIONAL DETAILS**	
A.	Detail your organization's ownership history and structure including all separate legal entities and affiliates. Detail any recent acquisitions or liquidations that impacted the PBM operations. What changes in ownership have taken place in the last three years or since corporate inception if less than three years. What changes in ownership is anticipated within the next three years?	5
B.	Describe all major shareholders / owners (5% or greater ownership) and list the percent of total ownership of each such shareholder. List any ownership interest, including pending and publicly disclosed transactions, your company has in any business that provides a service or product related to health care, including any contractual relationship or ownership by a drug manufacturer, distributor, wholesaler, or pharmacy.	5
C.	Provide detailed information on insurance, bonding, and guarantees offered in the event of issues caused by loss of operations due to an emergency or disaster. Identify what general liability and errors and omissions coverage you carry to protect your clients.	5
D.	Provide copies of your company's annual reports, audited financial statements, or best available financial statements for your most recent three fiscal years.	5
E.	Detail all past and pending legal actions involving your company, your parent company, and any affiliated company over the past five years.	5
F.	Detail all regulatory or other governmental investigations, probes, formal inquiries, etc. during the past five years. Include any resolution or outcome.	5
G.	Detail any government health plan contract terminations that occurred within the past 10 years including reason for termination, charges of unethical actions, legal actions, determinations of conflicts of interest or other elements to fully communicate the past experiences with governmental entities.	5
H.	Describe the account management team that will be assigned to EBD, provide credentials / experience, and organizational chart. Provide detailed information regarding the primary Account Manager.	5
E.2	**IMPLEMENTATION**	
A.	Provide a detailed description of your implementation plan of this plan based on your experiences of large self-funded plan implementations of the past. Describe staff members, job descriptions, experience, and other information regarding your anticipated implementation team. What information is generally requested of clients of similar size, scope, and complexity during implementation?	5
B.	Provide a proposed and detailed implementation time chart with implementation beginning on September 1, 2015 and go-live for January 1, 2016. Include process and recommendations for loading eligibility, historical claims, and historical prior authorizations. Final timeline and details shall be established by, or approved by, EBD.	5
C.	What risks do you anticipate EBD, the Plan, or the members facing during implementation? How do you propose to mitigate those risks?	5
D.	Detail your experiences with implementation of three groups of similar size, scope, and complexity with specific information on timelines, goals, results, and other elements to	5

fully communicate your implementation experiences.

E. Detail your process with employee / member education and enrollment services, including telephonic member support and face-to-face benefit meetings during implementation as a function of Open Enrollment. 5

E.3 PROCESS MANAGEMENT

A. Describe your standard payment process to the pharmacies detailing if the payment is electronic or by check, frequency, remittance statements in electronic format or paper, any outside third-party vendors, and any other element to fully communicate your standard process and payment capabilities 5

B. Describe your process of providing EBD with data regarding payments made to the pharmacies in a format that can be verified and audited against the payments from the Plan. 5

C. Provide a high-level graphical process flow chart of your proposed solution describing the integration between EBD, your organization, medical / health plan claims administrator and network pharmacies in regards to claim submission, adjudication and subsequent payment along with other elements to fully communicate the full scope of your PBM solution. 5

D. Describe your process of coordinating deductible/Out-of-Pocket (OOP) in "real time" with EBD's health plans. 5

E. Describe your internal audit process for ensuring compliance with established policies and procedures in all aspects of your operation. 5

F. Describe your experience with traditional e-prescribing functionality. 5

G. Detail your experience with facilitating services in regards to the Medicare Retiree Drug Subsidy program. What services can you provide to EBD to help facilitate RDS administration? 5

H. Explain the difference between your full and limited RDS services. 5

E.4 UTILIZATION MANAGEMENT

A. Can your pre-authorization logic system incorporate medical claims for systemic validation and authorization? If no, describe how this could be implemented in the future. 5

B. EBD requires real-time access to the eligibility and claims system for in-house generated reports, actions, and member support. Detail how this requirement will be met. Provide screenshots of system in electronic format. 5

E.5 HELP DESK (MEMBER and PHARMACY NETWORK)

A. **Optional Member Services** 5

If EBD chooses to implement a member call center through the PBM, detail system, staff, call statistics, and any other element to fully communicate your customer service capabilities and experience within the last 3 years. Detail your customer service representative's real-time access to the claims processing system. Do customer service representatives have knowledge, training, and access to approve claims? Approve a pre-authorization? Approve a quantity limit over-ride? Approve a vacation / refill too soon over-ride?

B. **Pharmacy Network** 5

How does your organization interface with Pharmacy Customer Service Departments and pharmacists to answer questions, resolve issues and assist in claims transactions? Would there be staff assigned specifically to our account?

C. **Member Services(Optional) and Pharmacy Network(required)** 5

1. Would your organization assign specific staff accountable to respond to the EBD plan requests? Define your ability to administer special handling requests.
2. Provide an overview of call center/provider relations services including hours of operation.
3. Describe in detail your customer service call issue escalation procedure.
4. What is the average tenure of your customer service staff?
5. Provide a detailed description of pre-employment screening for your customer service staff? Including information on if and when criminal background checks are performed.
6. Describe the training procedure for your customer service staff.
7. How do you provide service to Spanish speaking callers?

E.6 PHARMACY AUDIT

A.	Detail your process for auditing network pharmacies with specific details to address your compliance with applicable state pharmacy audit laws. Describe how a pharmacy would file an appeal regarding any audit finding	5
B.	Describe the results of your most recent customer and member satisfaction surveys as it relates to the quality of care provided by your network of providers and by your organization as well.	5
C.	Provide detail of all audits performed on network pharmacies within last month, last quarter, and last year including, at a minimum, audit trigger, finding, and financial recoupment.	5
D.	Do you perform your own audits or use an outside third-party? Provide details of third-party if applicable including financial terms and conditions, years of relationship, ownership, and other elements to fully communicate nature of relationship.	5
E.	Provide a copy of your most recent IT audit with an auditor opinion, auditor testing, and results. Include any information regarding Cyber Liability Insurance.	5

E.7 SYSTEM INFORMATION

A.	Detail your claims processing system, capabilities, limitations, age, update history, technical security / monitoring controls, and other elements to fully describe your technical / system environment.	5
B.	Do you have authority to access and edit source code for the claims system? How rapidly can you revise your software program to accommodate significant plan changes? How are source codes edited and how rapidly is it done?	5
C.	What is your source for determining AWP? How frequently is your source updated? How do you ensure that claims adjudication and billing systems use the same updated AWP? If multiple sources are used, detail reason and specify situations when one source is used as opposed to other.	5
D.	What specific data elements define a “generic” medication for your company?	5
E.	Describe, in detail, your MAC pricing program. How was it developed? How is it updated? How many drugs are included? How many NDC numbers does it represent? What is your MAC program philosophy?	5
F.	Describe your level of access and frequency to wholesaler cost information used in the MAC management process. Is this information accessible to EBD?	5
G.	Provide, in electronic copy only, your most current full detailed MAC list including but not limited to pricing, GPI, AWP, standard dispensing fee, supplemental fees and other elements to fully detail each MAC list, with your list in alpha order by generic name.	5
H.	EBD requires a duplicate copy of each and every MAC list, as well as other drug price source document, so that each individual claim may be re-priced during an audit. How do you anticipate fulfilling this requirement?	5
I.	What overall percentage off AWP does your proposed MAC pricing generate? How do you calculate this figure?	5

J.	Does your system have the ability to assign a specific member to an individual physician and/or pharmacist for management of their drug claims? If not, would you be able to add this function to your system and how long will it take to implement?	5
K.	Have you ever administered, and/or do you have the ability to administer, a plan which provides for "favored nation" pricing with different reimbursement rates for each pharmacy?	5
L.	Detail your system down-time due to all scheduled events during last 36 months. Include, at a minimum, details about the event, resolution, duration of downtime, likelihood of repeat, and other elements to completely communicate the issue.	5
M.	Describe your training process for personnel handling PA requests.	5

E.8 REPORTING CAPABILITY

A.	Detail your reporting capabilities. Provide examples of standard reporting in electronic format sufficient enough to fully communicate the capabilities of your reporting utility.	5
B.	Describe process and turn-around time for custom reports. Provide a detailed description of the process to request ad hoc reports not available via the on-line tool mentioned above, as well as requesting the standardization of an ad hoc report with a specific periodicity.	5
C.	Can your reports handle multiple group numbers? Any limitations? Any sub-group reporting capabilities?	5
D.	Can your system generate mailings based on a custom query of system information? If not, would you be able to add this function to your system and how long would it take to implement?	5
E.	Provide, in electronic version only, de-identified examples of reporting previously provided to a plan's actuary for rating purposes.	5
F.	Do you have the capability to benchmark the Plan with other clients of similar characteristics (size, geography, industry, etc.)? What specific entities comprise your "Government" industry benchmark?	5

E.9 ONLINE CAPABILITY

A.	Describe your current website accessibility to members. Is it "secure" based on a member ID and password or is the site "public" where information is accessible by any user and no member-specific data is required for access?	5
B.	Detail technical structure and security for online information. How is a member's information protected?	5
C.	Does the site provide member specific health / pharmacy plan information including deductible accumulation, co-pay amounts, co-insurance limits, etc.? Provide details.	5
D.	Does the site offer a retail ("brick & mortar") network pharmacy locator? Provide details.	5
E.	Does the site offer a formulary search function with client-specific formulary and co-pay / pricing information? Provide details.	5
F.	Does your web site offer a listing or search feature showing drugs that require prior authorization? Step Therapy? Quantity Limits? Other? Provide details.	5

E.10 DISASTER RECOVERY

A.	Provide in electronic copy only, your current emergency operations and fully describe your disaster preparedness.	5
B.	Describe your disaster recovery service. Does your company use a "hot site"?	5

C.	How do you propose to address major disruptions in air / ground transportation due to acts of terrorism / war / civil unrest / natural disasters which may have an impact on pharmacy operations both brick and mortar and mail?	5
D.	Detail your recovery process whenever you have had any unscheduled system down time for more than one (1) hour per occurrence in the last two (2) years. Describe the cause of the downtime, how the situation was handled, and the time frame needed for full recovery.	5
E.	Describe your database backup system, including on-site and off-site facilities and procedures used to maximize data security. Include information on how often the backup system is tested.	5

E.11 ELIGIBILITY PROCESSING

A.	Describe your experience and capability in processing eligibility files received from a plan administrator such as EBD.	5
B.	What is your standard process when a claim request is received from someone who is ineligible or is shown as terminated from the plan?	5
C.	How is coordination of benefits handled?	5
D.	How do you coordinate / facilitate claims payment and / or secondary filing for Medicare part B qualified medications? If so, describe your process in detail.	5
E.	What procedures are followed to ensure prescriptions will not be filled for a member after termination or prior to effective date?	5
F.	Is the pharmacy made / kept whole for their good-faith effort in filling the prescription based on incorrect eligibility information in your system? How do you make a pharmacy whole?	5

E.12 NETWORK MANAGEMENT

A.	How does your organization contract with the pharmacy network? If subcontracted, then with whom?	5
B.	In Arkansas, how many pharmacies are in the network? Please provide, in electronic format only, listing by city in alpha order.	5
C.	Provide a list, in electronic format only, of Arkansas pharmacies that do not participate in the respective networks. How many do not participate?	5
D.	Provide, in electronic format only, a blank copy of standard provider contracts with specific information regarding negotiable items.	5
E.	Provide, in electronic format only, complete listing of entire national network.	5
F.	Provide an overview of call center/provider relations including hours of operation.	5
G.	How do you monitor, report and eliminate fraud, waste, and abuse of the medications dispensed?	5
H.	What processes do you have in place to make the plan whole for your mistakes in processing claims for members after termination or prior to effective date?	5

E.13 SPECIALTY PHARMACY SERVICES

A.	Provide a list, in electronic format only, of all medications considered by you to be a “specialty” medication including GPI numbers. How do you define specialty drug?	5
B.	Do you own a specialty pharmacy or provide services through a sub-contractor? Describe in detail the relationship and financial terms and conditions.	5
C.	Describe how your operations will facilitate the distribution of specialty medications along	5

with allowing all applicable specialty drugs to be dispensed at in-state network pharmacies.

E.14 MAIL ORDER SERVICES

A.	Describe in detail your experience and capabilities in facilitating mail order services.	5
B.	Describe how you provide mail order services? Do you use a subcontractor? If so, detail the relationship and financial terms and conditions.	5
C.	Describe your audit process as it relates specifically to the mail order pharmacy services	5

E.15 COMPLIANCE

A.	Describe any breaches, complaints or grievances with regards to protected health information (e.g., security or privacy) for your complete book of business and for any affiliated company, including sub-contracts, parent company, or subsidiaries. List the event and resolution in detail.	5
B.	Provide, in electronic format only, HIPAA policies, procedures and training materials which is provided to your employees and providers.	5
C.	What level of compliance related education, HIPAA and otherwise, do you coordinate, facilitate or manage for providers in your network?	5