Request for Proposal

For service provider(s) interested in offering medical, hospital, and prescription benefit services to Medicare-eligible retirees and their dependents of the State Medical Plan and Partnership Medical Plan.

Released by: Office of the State Comptroller

On: February 28, 2025

Closing Date/Time: 2:00pm ET March 27, 2025

In order to participate in this procurement, follow the process below:

Go to http://www.proposaltech.com/home/app.php/register. Enter your email address into the field provided. No registration code is necessary. Click "Begin Registration." If you already have an account with Proposal Tech it will be listed on the registration page, if you do not, you will be asked to provide company information. Once your account has been confirmed, check the appropriate box for the RFP you're registering for and click the "Register" button. An invitation will be mailed to you within fifteen minutes. If you have any questions regarding the registration process, contact Proposal Tech Support at 877-211-8316 x84.

1 PURPOSE/ INTRODUCTION

1.1 **INTRODUCTION**

The Office of State Comptroller (OSC), State of Connecticut (the "State"), acting through the Health Care Cost Containment Committee ("HCCCC"), is conducting an active search of the marketplace for a service provider(s) that can partner with OSC to provide medical, hospital, and prescription benefit services to its Medicare-eligible retirees and Medicare-eligible dependents of retirees, effective January 1, 2026. It is the intent of the State to continue to offer either a fully insured MAPD, a fully insured Medicare Advantage Medical Plan (MA) with self-funded Part D Employer Group Waiver (EGWP), or fully insured Medicare Supplement and self-funded Part D EGWP. Therefore, OSC is requesting proposals for both a fully insured MAPD and/or a fully insured MA and/or a self-funded EGWP and/or fully insured Medicare Supplement and self-funded EGWP.

Through the issuance of this Request for Proposal (RFP), OSC is soliciting proposals from qualified Bidders that can provide the services listed above. If interested and able to meet the requirements described in this RFP, OSC appreciates and welcomes your offer.

The Comptroller is also empowered by C.G.S. §5-259(i) to procure similar healthcare benefits on an optional basis to the employees and retired employees of groups (mainly local municipalities and public-school districts) who have elected to become members of the Partnership Plan offered by the State. The MAPD plan is offered to those Partnership Groups that provide Medicare-eligible retirees with benefits. See Attachment A.

OSC reserves the right to award any service in whole or in part, if proposals demonstrate that doing so would be in OSC's best interest. OSC also reserves the right to issue multiple awards, no award, cancel, or alter the procurement at any time. In addition, OSC reserves the right to extend the proposed RFP period, if needed. Proposals containing the lowest cost will not necessarily be awarded as OSC recognizes that factors other than costs are important to the ultimate selection of the provider or providers. Proposals provided in response to this RFP must comply with the submittal requirements set forth in later sections, including all forms and certifications, and will be evaluated in accordance with the criteria and procedures described herein. Based upon the results of the evaluation, OSC will award the contract(s) to the most advantageous Bidder(s), based on cost and the technical evaluation factors in the RFP. Any contract awarded hereunder shall be subject to the approval of the Office of the Attorney General in accordance with applicable state laws and regulations.

Please read the entire solicitation package and submit an offer in accordance with the instructions. All forms contained in the solicitation package must be completed in full and submitted along with the Technical Response and Price Proposal, which combined, will constitute the offer. **This RFP and your response, including**

all subsequent documents provided during this RFP process will become part of the contract terms and policy between the parties.

Entities responding to this RFP should also note that the State is requiring access to certain information and that this data must be provided to the State's health care consultant, Segal, and to its Health Benefits Navigator, Quantum Health.

Submission of your proposal will acknowledge acceptance of these requirements. The financial requirements include initial and renewal pricing and projection controls.

OSC has retained Segal to assist in the evaluation of the proposals for responsiveness to the RFP and to review such proposals with them. Each proposal shall be evaluated in accordance the factors listed in Section 1.2.6.:

All Bidders must meet the General Proposal Conditions set forth in this RFP. Bidders are asked to respond only to the specific questions asked.

The State may also conduct multiple Best and Final "Reverse Auction" rounds during which each Bidder will be informed of its ranking in comparison to other Bidders in various financial and technical categories as may be selected by the RFP committee. The State reserves the right to eliminate the lowest ranked Bidder in each round.

Reverse auctions are authorized by Connecticut General Statutes ("C.G.S.") §4a-60b.

Throughout the RFP, proposal requirements, confirmations and questions may apply to one, some or all of the following program options - fully insured MAPD, fully insured MA, self-funded EGWP or fully insured Medicare. Please answer each item based upon the program option(s) you are proposing.

Proposals submitted in response to this RFP must comply with the requirements set forth in later sections, including all forms and certifications, and will be evaluated in accordance with the criteria and procedures described herein. The RFP process and any contract arising therefrom shall be governed in all respects by the laws of the State of Connecticut. Under no circumstances may a contract made with the State contain limited liability and/or binding arbitration provisions. The State may not waive its sovereign immunity or indemnify a Bidder.

Attached Document(s): RFP Attachment A - Participating Partnership Groups.docx

1.2 **Evaluation of Proposals**

1.2.1 Evaluation Process. It is the intent of the Comptroller to conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this RFP. When evaluating proposals, negotiating with successful Bidders, and awarding contracts, the Comptroller will conform with its written procedures for Purchase of Service ("POS") and Personal Service Agreement ("PSA") procurements pursuant to C.G.S. §4-70b and §4-217 and the State's Code of Ethics pursuant to Chapter 10 of the General Statutes. Final funding allocation decisions will be determined during contract negotiation.

1.2.2 Evaluation Review Committee. The Comptroller will designate an RFP Review Committee and Committee Chairperson ("Chairperson") to evaluate proposals submitted in response to this RFP. The RFP Review Committee will be composed of labor and management individuals, Comptroller staff or other designees as deemed appropriate. The contents of all submitted proposals, including any confidential information, will be shared with the RFP Review Committee. Only proposals found to be responsive (that is, complying with all instructions and requirements described herein) will be reviewed, rated, and scored. Proposals that fail to comply with all instructions will be rejected without further consideration. The RFP Review Committee shall evaluate all proposals that meet the minimum submission requirements by score and rank ordered and make recommendations for awards. The Comptroller will make the final selection.

1.2.3 Minimum Submission Requirements. To be eligible for evaluation, proposals must (1) be received on or before the Closing Date and Time; (2) meet the eligibility and qualification requirements to respond to the procurement; (3) follow the required Proposal Outline; and (4) be complete. Proposals that fail to follow instructions, deviate significantly from the requirements of this RFP, or fail to satisfy these minimum submission requirements will not be reviewed further.

1.2.4 Deviations and Negotiation. The Chairperson shall have the sole right to determine whether any deviation from the requirements of this RFP is substantial in nature, and the Chairperson may reject non-conforming proposals. In addition, the Chairperson may waive minor irregularities in proposals, allow a Bidder to correct minor irregularities, and negotiate with eligible Bidders in any manner deemed necessary or desirable to serve the best interests of the State.

1.2.5 Evaluation Considerations. Proposals meeting the minimum submission requirements will be evaluated according to the established criteria. Evaluation will be made on the basis of the evaluation criteria discussed below and may include any oral presentation that may be required by the Chairperson, through a recommendation by the technical review committee, at his or her discretion. The criteria are the objective standards that the RFP Review Committee will use to evaluate the technical merits of the proposals. The Chairperson reserves the right to recommend a Bidder for contract award based upon the Bidder's proposal without oral presentations or further discussion. However, the Chairperson may engage in further discussion if he or she determines that it might be beneficial. In such case, the Chairperson will notify those eligible Bidders with whom further discussion is desired. In addition, the Chairperson may permit qualified Bidders to revise their proposals by submitting "best and final" offers, if necessary.

1.2.6 Evaluation Criteria Proposals by Bidders who meet the minimum qualifications will be evaluated by the RFP Review Committee on the basis of the following factors. (These are not listed in order of importance.)

1. Conformity with procurement specifications.

2. Value of the benefit plans and services, taking into consideration the requirements of the RFP, proposed services and any "value-added" terms, conditions and service levels

3. Proven programs provided by the firm designed and proven to maximize CMS Star Ratings and receive bonus subsidies from CMS and minimize claim cost through medical management strategies.

4. Ability and willingness to customize products, plans, and programs to meet the State's needs.

5. Proven risk adjustment strategies

6. Experience with group Medicare Advantage plans, Medicare Supplement, and/or EGWP Part D plans, commitment to such plans, and experience offering such plans to public sector employers, which includes providing robust public sector references.

7. Availability and competence of personnel and evidence of appropriate staffing and training.

8. Proposed cost of proposed benefits and/or services: Per Member Per Month ("PMPM") costs, discounts, rebates, administrative fees, fees at risk and guarantees, demonstration of robust approach to control costs, robust fraud, waste and abuse prevention systems.

9. Commitment to quality and price transparency.

10. Robust basic member support services that demonstrate superior member experience via call center, member portal and mobile application.

11. Ability to educate and communicate with retirees and families/caretakers.

12. Ability to educate, communicate with and support provider entities.

13. Ability to minimize member disruption.

14. Member satisfaction as measured by NPS score.

15. Ability to provide excellent network access and network management (medical and pharmacy) services and support

16. Formulary and clinical management, including appropriate utilization management decisions as measured by appeal overturn rates, denials, and other factors

17. Implementation and communications plans (workability of transition and implementation schedule; efficiency and fairness of appeals process, sufficiency of member communication programs and systems, assistance with distribution of benefit descriptions, educational materials, notices required by CMS, ACA, IRA and other federal laws).

18. Sufficiency of eligibility management, payment and billing systems, customer service, flexibility, references, reporting capability, member services, and Quality Assurance programs.

19. Information services and reporting: Ability to exchange data with State's data warehouse provider and the State's healthcare consultant and other healthcare vendors, availability of standard reports and

ad hoc reporting functionality; willingness to work cooperatively and seamlessly with State's other healthcare vendors, and sufficiency of infrastructure to support population health management and improve quality of care and health outcomes.

20. Contractor's compliance with state contracting requirements and willingness to enter into Comptroller's standard contract terms and conditions.

21. Demonstration of Bidder's commitment to affirmative action by full compliance with the regulations of the Commission on Human Rights and Opportunities. See Regulations of CT State Agencies §46a-68j-21 et seq.

22. Willingness to accept the terms and conditions of the State's proposed contract.

23. At the option of the RFP review committee, Bidder's oral finalist interview.

2 GENERAL INFORMATION

2.1 **BACKGROUND**

The State Comptroller is empowered by C.G.S.§ 5-259 to arrange and procure a "group hospitalization and medical and surgical insurance plan" for employees and retirees of the State of Connecticut. The Healthcare Policy & Benefits Services Division (“HPBSD”) of the OSC administers the State healthcare coverage program for employees and retirees. The Comptroller may also procure health coverage for non-state public employers through the Connecticut Partnership Plan pursuant to C.G.S.§ 3-123bbb

The HCCCC was established through collective bargaining in 1985 and is composed of labor representatives and management representatives. It is responsible for implementing cost control measures, monitoring and improving plan quality, and implementing health promotion and wellness activities for state employees, retirees, and their eligible dependents.

On October 1, 1993, as an outcome of collective bargaining, the state medical plan introduced elements to manage care with the goal of restraining health care costs while maintaining access and quality of care.

OSC provides hospital-medical benefits for its active members and early retirees. In addition to these benefits, OSC provides group medical and pharmacy benefits to approximately 64,000 State and Partnership Plan Medicare-eligible retirees and Medicare-eligible dependents of retirees through a fully insured Medicare Advantage national passive Preferred Provider Organization (PPO) plan with Part D Prescription Drug coverage. This plan is currently administered by Aetna.

OSC anticipates that all Medicare-eligible retirees, Medicare-eligible dependents of State retirees, and qualifying Medicare-eligible primary End-Stage Renal Disease (“ESRD”) beneficiaries will automatically be enrolled in the Group Medicare plan unless they choose to opt out. If a member beneficiary opts out, he/she will lose their OSC coverage altogether and will not be permitted to re-enroll until the next Open Enrollment period.

Retirees and covered dependents who age into Medicare will automatically be enrolled into the group Medicare plan effective on their Medicare eligibility date. There shall be no gap in coverage for those aging into the plan. Workers over the age of 65 shall be automatically enrolled into the plan effective on their date of retirement. Retirees and their dependents who are enrolled in the plan and subsequently drop, terminate,

or otherwise lose their Medicare Part B coverage will lose their OSC group Medicare coverage and will not be permitted to re-enroll in coverage until the following Open Enrollment.

2.2 **CONTRIBUTION INFORMATION**

State Medicare-eligible retirees and Medicare-eligible dependents of retirees pay no monthly premiums for medical and prescription drug coverage. Please review https://ct.aetnamedicare.com/coverage-and-benefits/plan-benefits-and-forms for retiree plan designs based on retirement date. Premium cost shares for Partnership groups vary by group.

2.3 **OBJECTIVES**

OSC seeks to provide high quality, cost-effective benefits to its retirees and their families. OSC is soliciting offers on a Fully insured, national passive MA-PD PPO plan with a single vendor with the same benefits for services rendered in or out-of-network. OSC is also soliciting proposals for MA services and/or self-insured Medicare Part D EGWPs. The proposed plan(s) should duplicate the plans described in the above summary of benefits, consistent with CMS guidelines. Bidders are encouraged to identify and offer features or enhancements that provide additional value without adding cost as well as any creative solutions that will achieve OSC's goals. Of particular interest are programs that focus on wellness and medical management proven risk adjustment strategies, and maximization of CMS Star Ratings and minimization of claims cost.

2.4 **SCOPE OF WORK**

Provide national MA-PD PPO or MA and/or self-funded Part D EGWP services with respect to such group insurance coverages, plans and programs as listed in this RFP.

The following services are required:

- Member Services
- Claims Adjudication
- Data and Performance Reporting
- Member Enrollment and Eligibility Maintenance
- CMS Star Rating Maximization
- Demonstrated Risk Adjustment Strategies
- Wellness and Medical Management
- Network Access and Network Management
- Formulary and Clinical Management
- Provider Advocacy and Assistance with Claims Issues
- Medicare Advantage and Part D Administrative Assistance
- Effective Member Communications
- Patient and Provider Education
- Ability of Bidder's to share/transfer data and collaborate in the event one Bidder is selected to administer the MA Plan and a different Bidder is selected to administer the Part D EGWP.
- Commercial Plan Point Solution Program Integration

2.5 **CONTRACT TERM**

The contract term is for a three-year period beginning January 1, 2026, with implementation to begin at contract award. The contact term will include a clause that gives the OSC the right to extend the contract for up to two additional one-year periods.

2.6 **PLANNED SCHEDULE OF RFP ACTIVITIES**

It is the State's intention to comply with the following schedule:

Event	2025 Due Dates
Release of RFP	February 27
NDA Submission by 2:00 ET	March 3
Pre-Bid Conference 2:00 p.m. ET	March 4
Written Questions Due (by 2:00 p.m. ET)	March 5
State Response to Questions Posted	March 10
Complete Electronic Proposals Submission - Technical and Interim Price Proposal (by 2:00 p.m. ET)	March 27
Notification of Finalist(s)	Week of April 28
Finalist(s) Presentation(s)	Week of May 5
First round of BAFO (by 2:00 p.m. ET)	Week of May 5
Second Round of BAFO	Week of May 12
Third Round of BAFO, if necessary	Week of May 19
Implementation Begins	June 2
Proposed Effective Date	January 1, 2026

2.7 **OTHER INFORMATION**

Other documents and information that may be helpful in preparing your proposal may be accessed online. Bidders are responsible for checking the OSC website for the most up to date information - https://carecompass.ct.gov/

3 RESPONSE INSTRUCTIONS

3.1 **INSTRUCTIONS FOR SUBMITTING OFFERS**

Detailed instructions for the completion and submission of your proposal will be found in the electronic RFP (eRFP) on ProposalTech. ProposalTech will be available to assist you with technical aspects of utilizing the system.

All sections of the eRFP must be answered completely and as outlined in the RFP, using ProposalTech.

Final submissions must be posted with ProposalTech at www.proposaltech.com no later than the due date and time cited. Access to the eRFP will be locked after that time. Bidders will not be able to post or change their responses. Late proposals will not be considered. OSC reserves the right to ask Bidders follow-up questions through ProposalTech as may be necessary to fully evaluate Bidder capabilities.

Please note that these instructions are to be read and followed by each Bidder and that failure to follow these instructions may result in rejection of a proposal offer for non-responsiveness or cancellation of contract if already awarded. **Any mention of "days" in this RFP will refer to calendar days unless noted otherwise.**

In order for your proposal to be considered and accepted, you must provide answers to the questions presented in this RFP. Each question must be answered specifically and in detail. Be sure to review this entire RFP before responding to any of the questions, so that you have a complete understanding of OSC's requirements with respect to the proposal.

1. Provide answers to all questions in your submission.
2. Provide an answer to each question even if the answer is “not applicable” or “unknown.”
3. Answer the question as directly as possible.

    - If the question asks, “How many…”, provide a number.
    - If the question asks, “Do you…”, indicate Yes or No followed by any additional narrative explanation.

4. Where you desire to provide additional information to assist the reader in more fully understanding a response, refer the reader of your RFP response to your appendix/attachments. However, direct responses to all of the RFP questions must be provided and will be looked upon favorably.
5. Utilize the Proposal Tech's “Disclosure” tool to identify confidential answers or proprietary information you do not believe should be released if the State receives a request for your RFP submission under the State's Freedom of Information Act C.G.S. Sec. 1-200 et seq.
6. Bidder will be held accountable for accuracy/validity of all answers.

If your proposal is different in any way (whether more or less favorable) from what is requested in this RFP, clearly indicate and explain the difference in the response to that particular question and the Bid Exceptions & Deviations Form - Attachment B. If you do not, the submission of your proposal will be deemed a certification that you will comply in every respect (including, but not limited to, coverage provided, funding method requested, benefit exclusions and limitations, underwriting provisions, etc.) with the requirements set forth in this RFP.

If you are unable to perform any required service, indicate clearly: a) what you are currently unable to do, and, b) what steps will be taken (if any) to meet the requirement, the timetable for that process and who will be responsible for the implementation, along with that person's qualifications.

All products should be priced individually. If pricing terms are provided for combining services, show the pricing terms as a separate line item.

Non-Disclosure Agreement (NDA):

Upon logging into the ProposalTech system for this procurement, Segal will review its files for a current Global or Bid-Related NDA/Confidentiality Agreement. If there is an NDA/Confidentiality Agreement on file with Segal, Segal will send the data securely to the interested Bidder, as appropriate.

If there is no NDA/Confidentiality Agreement on file with Segal, an NDA document will be issued to the interested Bidder for signature. **Verbiage is non-negotiable.** Upon receipt of the newly signed NDA, or confirmation of an existing NDA on file, the data will be securely released to the Bidder via Segal's Secure File Transfer (SFT) system.

Secure data will not be released until a signed NDA between the Bidder and Segal is in place.

Bidder questions: Any questions regarding this RFP should be submitted directly via ProposalTech using the “Ask Questions” feature to Jennifer Slutzky, a Segal employee. Please submit your RFP related questions via ProposalTech to Segal no later than the date and time as specified in this RFP. Questions from any potential Bidder that is considering a response to this RFP will be answered. Questions sent via email or telephone will not be accepted. OSC reserves the right to provide a combined answer to similar questions. Any and all questions and answers to this RFP will be posted on ProposalTech and on State procurement websites.

Submission of proposals: Proposals are to be submitted electronically via the ProposalTech system by the specific due date and time. Proposals posted later than the time and date specified in this RFP will not be considered.

All decisions and evaluations will be determined from the proposals submitted electronically via ProposalTech.

For Bidders providing a proposal for a fully insured MAPD and/or a fully insured MA, based upon timing for the release of the **Announcement of Calendar Year (CY) 2026 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies**, Bidders are asked to submit their Technical Proposal and an Interim Price Proposal prior to the release of the 2026 Announcement as well as a Final Price Proposal. The Final Price Proposal will be due approximately two (2) weeks after the 2026 Announcement is released.

Your completed proposal should be submitted in the following format:

- Completed Section 4: Proposal Requirements
- Completed Section 5: Additional OSC Requirements
- Completed Section 6: Medicare Advantage and Prescription Drug Confirmations
- Completed Section 7: Self-insured Part D EGWP Confirmations
- Completed Section 8: Fully insured Medicare Supplement Confirmations
- Signature Ready Contract that includes the sample contract and addresses all the items in Sections 4 through 8, as applicable.
- Completed Section 9: Aggregate Questionnaire - General Information, Capabilities and Experience with National MA/MA-PD Plans, Self-insured Part D EGWPs, and Fully Insured Medicare Supplement Plans
- Completed Section 10: National MA/MA-PD PPO Questionnaire
- Completed Section 11: Medicare Part D EGWP Questionnaire
- Completed Section 12: Fully Insured Medicare Supplement Questionnaire
- Completed Section 13: Price Proposals
- Other requested documents

In addition to the items outlined above, Bidders shall also provide a complete, electronic, redacted copy of your proposal including any attachments with your submission.

Proprietary Items Exempt from Disclosure: Bidders must follow the ProposalTech system when responding to the RFP. If any items of this proposal are considered proprietary or confidential, Bidders must check the box corresponding to that question's answer indicating it is exempt from disclosure. Failure to follow these directions will result in your responses being released as part of any open records request made in compliance with Connecticut state law.

Instructions for downloading a redacted proposal: Click on the **Standard** selection under the **Reports / Print** heading in the left-hand side menu. On the following screen check the box for an **External Report**. Under the filtered report options select **Flagged** and check the box under the **Exclude Marked** column for **Confidential**. Once those selections have been made click **Generate Report** and attach the redacted proposal here.

Confirm you have attached a copy of your redacted proposal submission.

The identification of confidential responses has been turned on for this RFP. If you feel that a response to a question contains proprietary/confidential information, click the "Disclosure" tab located underneath the question and check the box for "Exemption from Disclosure." Provide a reason for the exemption in the text

field provided. If you do not provide a reason for exemption, the question will not be considered answered. If you have any questions regarding this process, please contact ProposalTech Support at 877-211-8316 x84.

Please also include redacted copies of any attachments that you post as part of your response.

3.2 **QUESTIONNAIRE INSTRUCTIONS**

OSC and Segal will review and evaluate each proposal carefully. Many questions within the RFP system do not require lengthy responses. When a question does require a written response, please provide a response that is clear and concise. DO NOT answer any of the questions by referring to a prior answer or by referring to an attachment. Any such answers will not be considered and will constitute sufficient grounds for rejecting a proposal.
OSC understands final CMS call letter details are not yet available. You will have the opportunity to provide any updates or deviations from your initial responses during the BAFO process. ANSWERS TO THE QUESTIONS SHOULD BE AS SHORT AND CONCISE AS POSSIBLE TO FACILITATE OUR ANALYSIS AND TO AVOID CONFUSION.

3.3 **PRE-BID CONFERENCE**

A pre-bid conference call will be held in connection with the RFP. The tentative date for the conference is March 4, 2025, 2:00 p.m. ET. A notice of this will be sent through Proposal Tech and Teams invitation.

3.4 **RESTRICTION ON CONTACT WITH STATE PERSONNEL**

Except as called for in this RFP, from the date of release of this RFP until the right to negotiate a contract is awarded as a result of this RFP, any communications with personnel employed by the Comptroller's Office, members of the HCCCC, and RFP committee members about the RFP are prohibited until selection of the successor Bidder. All communications must be directed to Jennifer Slutzky via ProposalTech. For violation of this provision, the State reserves the right to reject the proposal of the violator.

3.5 **CONFLICT OF INTEREST**

The Bidder shall certify in writing that no relationship exists between the Bidder and the State of Connecticut that interferes with fair competition or is a conflict of interest, and no relationship exists between the Bidder and another person or organization that constitutes a conflict of interest with respect to any State contract. Any successful Bidder must execute a contract and grant disclosure and certification form.

The Bidder shall provide assurances that it presently has no interest and shall not acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its services hereunder. The Bidder shall also provide assurances that no person having any such known interests shall be employed during the performance of this contract.

3.6 **GOVERNING LAW**

The contract shall be governed in all respects by the laws of the State of Connecticut.

3.7 **VERIFICATION ACCURACY**

1. Your response must designate the individual responsible for coordinating proposal responses and for binding the company to the responses to this RFP.
2. Your response must designate the chief actuary or independent actuary retained by the Bidder who certifies the method used to determine and report requested information.
3. Your response must designate Bidder's Medical Director or Chief Medical Officer.
4. Your response must designate Bidder's Medicare Director.

	Proposal Response Coordinator	Chief Actuary/Independent Actuary	Medical Director/Chief Medical Officer	Medicare Director
Name	*20 words.*	*20 words.*	*20 words.*	*20 words.*
Phone #	*20 words.*	*20 words.*	*20 words.*	*20 words.*
Company	*20 words.*	N/A	N/A	N/A
Title	*20 words.*	*20 words.*	*20 words.*	*20 words.*
Email	*20 words.*	*20 words.*	*20 words.*	*20 words.*

4 PROPOSAL REQUIREMENTS

4.1 **OSC General Terms and Conditions**

By submitting a proposal in response to this RFP, a bidder implicitly agrees to comply with the following terms and conditions:

1. **Equal Opportunity and Affirmative Action.** The State is an Equal Opportunity and Affirmative Action employer and does not discriminate in its hiring, employment, or business practices. The State is committed to complying with the Americans with Disabilities Act of 1990 (ADA) and does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services, or activities.

2. **Preparation Expenses.** Neither the State nor OSC shall assume any liability for expenses incurred by a bidder in preparing, submitting, or clarifying any proposal submitted in response to this RFP.

3. **Exclusion of Taxes.** OSC is exempt from the payment of excise and sales taxes imposed by the federal government and the State. Bidders are liable for any other applicable taxes.

4. **Proposed Costs.** No cost submissions that are contingent upon a State action will be accepted. All proposed costs must be fixed through the entire term of the contract.

5. **Changes to Proposal.** No additions or changes to the original proposal will be allowed after submission. While changes are not permitted, OSC may request and authorize bidders to submit written clarification of their proposals, in a manner or format prescribed by OSC, and at the Bidder's expense.

6. **Supplemental Information.** Supplemental information will not be considered after the deadline submission of proposals, unless specifically requested by OSC. OSC may ask a bidder to give demonstrations, interviews, oral presentations or further explanations to clarify information contained in a proposal. Any such demonstration, interview, or oral presentation will be at a time selected, and in a place provided by OSC. At its sole discretion, OSC may limit the number of bidders invited to make such a demonstration, interview, or oral presentation and may limit the number of attendees per bidder.

7. **Presentation of Supporting Evidence.** If requested by OSC, a bidder must be prepared to present evidence of experience, ability, data reporting capabilities, financial standing, or other information necessary to satisfactorily meet the requirements set forth or implied in this RFP. OSC may make onsite visits to an operational facility or facilities of a bidder to evaluate further the Bidder's capability to perform the duties required by this RFP. At its discretion, OSC may also check or contact any reference provided by the bidder.

8. **RFP Is Not An Offer.** Neither this RFP nor any subsequent discussions shall give rise to any commitment on the part of the State or OSC or confer any rights on any bidder unless and until a contract is fully executed by the necessary parties. The contract document will represent the final

agreement between the bidder and OSC and will supersede all prior negotiations, representations or agreements, alleged or made, between the parties. The State shall assume no liability for costs incurred by the bidder or for payment of services under the terms of the contract until the successful bidder is notified that the contract has been accepted and approved by OSC and, if required, by the Office of the Attorney General.

Contractors responding to this RFP must be willing to adhere to the following conditions and must affirmatively state their adherence to these requirements with a transmittal letter appended to their proposal response.

9. **Acceptance or Rejection by the State**—The State reserves the right to accept or reject any or all proposals submitted for consideration. By responding to this RFP, applicants agree to accept the Comptroller's determinations as final.

10. **Conformance with State and Federal Law**—Any contract awarded as a result of this RFP must be in full conformance with statutory and regulatory requirements of the State of Connecticut and the federal government.

11. **Ownership of Proposals**— All proposals submitted in response to this RFP are to be the sole property of the State and will be subject to the applicable Freedom of Information provisions of C.G.S. §§1-200 et seq. In addition to the completed response, any bidder that submits matter that it in good faith determines to contain trade secrets or confidential commercial or financial information must mark such materials as “CONFIDENTIAL” and designate material through Proposal Tech's “Disclosure” tool.

12. **Ownership of Subsequent Products**—Any product, whether acceptable or unacceptable, developed under a contract award as a result of this RFP is to be the sole property of the State of Connecticut, unless explicitly stated otherwise in the RFP or contract.

13. **Communication Blackout Period**—Except as called for in this RFP, Contractors may not communicate about the RFP with any of the following: staff of the Healthcare Policy & Benefit Services Division within the OSC or members of the HCCCC until the successful bidder(s) are selected. No Contractor or Contractor's representative may contact an employee of the OSC or member of the HCCCC or their representatives and Bidder partners - Anthem, CVS Caremark, Upswing Health, Aetna, Cigna, Quantum Health, Virta Health, and Intellihealth (Flyte)) regarding their proposal until final selections have been made. Until such time as final selections are made, any such contact will be considered collusion under the "Terms and Conditions" herein and may be grounds for disqualification of the Contractor's proposal.

14. **Availability of Work Papers**—All work papers and data used in the process of performing this project must be available for inspection by the State of Connecticut Auditors of Public Accounts for a period of three (3) years or until audited.

15. **Timing and Sequence**—All timing and sequence of events resulting from this RFP will ultimately be determined by the State. Late responses may or may not be considered, and it will be left to the Comptroller's discretion whether to accept or reject late responses.

16. **Stability of Proposed Prices**—Any price offerings from Contractors must be valid for a period of one hundred eighty (180) days from the due Date of the Contractor proposals.

17. **Oral Agreements**—Any alleged oral agreement or arrangement made by a Contractor with any agency or employee will be superseded by the written agreement.

18. **Amending or Canceling Requests**—The State reserves the right to amend or to cancel this RFP if such action is deemed to be in the best interest of the State.

19. **Rejection for Default or Misrepresentation**—The State reserves the right to reject the proposal of any Contractor that is in default of any prior contract or for misrepresentation.

20. **Rejection of Qualified Proposals**—Proposals are subject to rejection in whole or in part if they limit or modify any of the terms and conditions and/or specifications of the RFP.

21. **Collusion**—By responding to this RFP, the Contractor implicitly states that the proposal is not made in connection with any competing Contractor submitting a separate response to the RFP and is in all respects fair and without collusion or fraud. It is further implied that the Contractor did not participate in the RFP development process, had no knowledge of the specific contents of the RFP prior to its issuance, and that no employee of the agency participated directly or indirectly in the Contractor's proposal preparation.

22. **Conformance to Instructions**—All responses to the RFP must conform to the instructions herein. Failure to provide any required information, provide the required number of copies, meet deadlines, answer all questions, follow the required format, or failure to comply with any other requirements of this RFP may be considered appropriate cause for rejection of the response.

23. **Appearances**—In some cases, Contractors may be asked to appear (in person or virtually) to give demonstrations, interviews, presentations or further explanation to the RFP's screening committee.

24. **Standard Contract and Conditions**—The Contractor must accept the State's contract language and conditions. See Standard Contract and Conditions - Attachment C.

25. **Agreement**—The contract will represent the final agreement between the Contractor and the State and will supersede all prior negotiations, representations or agreements, alleged or made, between the parties. The State shall assume no liability for payment of services under the terms of the contract until the successful Contractor is notified that the contract has been accepted and approved by the Office of the State Comptroller and by the Office of the Attorney General, if required. The contract may only be amended by means of a written signed agreement by the Office of the State Comptroller, the Contractor, and the Office of the Attorney General, if required.

26. **Rights Reserved to the State**—the State reserves the right to award in part, to reject any and all proposals in whole or in part, to waive technical defects, irregularities and omissions if, in its judgment, the best interest of the State will be served.

27. **Receipt of Summary of State Ethics Laws.** The Contractor must acknowledge that is has received a summary of State Ethics Laws by submitting a signed receipt with its bid. See Attachments D and E hereto.

Attached Document(s): RFP Attachment C - 2023-12-06-OSC Non-IT Template Contract (PSA).docx, RFP Attachment D - Contractors-Guide-to-the-Code-of-Ethics-Rev-11-2021 (1).pdf, RFP Attachment E - Affirmation of Receipt of State Ethics Laws.docx

4.2 **STANDARD CONTRACT, PARTS I AND II**

By submitting a proposal in response to this RFP, the Bidder implicitly agrees to comply with all applicable State and federal laws and regulations, including, but not limited to, those detailed in the State's "standard contract":

Part I of the standard contract will include the scope of services, contract performance, quality assurance, reports, terms of payment, budget, and other program-specific provisions.

Part II of the standard contract includes the mandatory terms and conditions required by state law, may be amended only in consultation with, and with the approval of, the Office of Policy and Management and the Attorney General's Office.

Note:

Included in the standard contract is the State Elections Enforcement Commission's ("SEEC") notice (pursuant to C.G.S. § 9-612(f)(2) advising executive branch State contractors and prospective State contractors of the ban on campaign contributions and solicitations. If a Bidder is awarded an opportunity to negotiate a contract with the State (OSC) and the resulting contract has an anticipated value in a calendar year of $50,000 or more, or a combination or series of such agreements or contracts has an anticipated value of $100,000 or more, the Bidder must inform the Bidder's principals of the contents of the SEEC notice.

4.3 **Additional Procurement Requirements**

The Connecticut Department of Administrative Services ("DAS") has implemented a requirement that all firms seeking to do business with the State must register their business on CTSource. The portal for registering a business is accessible at https://portal.ct.gov/DAS/CTSource.https://portal.ct.gov/DAS/CTSource/Registration. https://portal.ct.gov/OPM/Fin-PSA/Forms/Ethics-Forms

Firms will have the ability to view, verify and update their information by logging in to their CTSource account, prior to submitting responses to an RFP.

The guide to using CTSource appears at https://portal.ct.gov/-/media/DAS/CTSource/Documents/CTsource-Supplier-Registration-Portal-User-Guide- Final.pdf.

Additional required forms as described below must be submitted through CTSource by the deadline for submission of proposals. Paper or electronic copies need not be provided with the submission to the Comptroller's office. If you experience difficulty establishing your firm's account, please call DAS at 860-713-5095 or send an email to das.ctsource@ct.gov.

If you have difficulty accessing your CTSource account call 1-866-889-8533 or email webprocure-support@proactis.com.

Campaign Contribution Certificationhttp://www.ct.gov/opm/cwp/view.asp?a=2982&q=386038&opmNAV_GID=1806https://portal.ct.gov/-/media/CHRO/NotificationtoBidderspdf.pdfwww.state.ct.us/chro

4.4 **RIGHTS RESERVED TO THE STATE**

By submitting a proposal in response to this RFP, a bidder implicitly accepts that the following rights are reserved to the State:

4.4.1. Timing Sequence. The timing and sequence of events associated with this RFP shall ultimately be determined by OSC.

4.4.2. Amending or Canceling RFP. OSC reserves the right to amend or cancel this RFP on any date and at any time, if OSC deems it to be necessary, appropriate, or otherwise in the best interests of the State.

4.4.3. No Acceptable Proposals. In the event that no acceptable proposals are submitted in response to this RFP, OSC may reopen the procurement process, if it is determined to be in the best interests of the State.

4.4.4 Award and Rejection of Proposals. OSC reserves the right to award in part, to reject any and all proposals in whole or in part, for misrepresentation or if the proposal limits or modifies any of the terms, conditions, or specifications of this RFP. OSC may waive minor technical defects, irregularities, or omissions, if

in its judgment the best interests of the State will be served. OSC reserves the right to reject the proposal of any bidder who submits a proposal after the submission date and time.

4.4.5. Sole Property of the State. All proposals submitted in response to this RFP are to be the sole property of the State. Any product, whether acceptable or unacceptable, developed under a contract awarded as a result of this RFP shall be the sole property of the State, unless stated otherwise in this RFP or subsequent contract. The right to publish, distribute, or disseminate any and all information or reports, or part thereof, shall accrue to the State without recourse.

4.4.6. Contract Negotiation. OSC reserves the right to negotiate or contract for all or any portion of the services contained in this RFP. OSC further reserves the right to contract with one or more bidder for such services. After reviewing the scored criteria, OSC may seek Best and Final Offers (BAFO) on cost from bidders. OSC may set parameters on any BAFOs received.

4.4.7. Clerical Errors in Award. OSC reserves the right to correct inaccurate awards resulting from its clerical errors. This may include, in extreme circumstances, revoking the awarding of a contract already made to a bidder and subsequently awarding the contract to another bidder. Such action on the part of the State shall not constitute a breach of contract on the part of the State since the contract with the initial bidder is deemed to be void ab initio and of no effect as if no contract ever existed between the State and the bidder.

4.4.8. Key Personnel. OSC reserves the right to approve any additions, deletions, or changes in key personnel, with the exception of key personnel who have terminated employment. OSC also reserves the right to approve replacements for key personnel who have terminated employment. OSC further reserves the right to require the removal and replacement of any of the Bidder's key personnel who do not perform adequately, regardless of whether they were previously approved by OSC.

By submitting a proposal in response to this RFP, the Bidder implicitly agrees to comply with all applicable state and federal laws and regulations, including, but not limited to, the following:

5 ADDITIONAL OSC REQUIREMENTS

Below are additional requirements for submitting a proposal. By checking “Confirmed”, Bidder represents the proposal submitted adheres to these requirements, unless otherwise noted in the proposal. **Failure to agree to any of these requirements may result in disqualification of proposal.** If a Bidder takes exception to any of these requirements, it must be so noted in the Proposal Exceptions & Deviations Form of their proposal response. These requirements will also explicitly apply to any subcontractors used by the Bidder to deliver services to the State.

5.1 GENERAL

5.1.1 Bidder will provide all labor, equipment, facilities, supplies, and services as needed/specified.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.1.2 Administration of benefit plans for retired State employees and dependents and affiliated groups participating in the program described in Section I:

Bidder must agree to administration of the plan as mutually agreed to by the Bidder and the State, with final determination to be made by the State. All operational aspects of the plan must be clearly described, and the State must reserve the right to review, update, and audit the operations of the plan.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.1.3 Develop and maintain a retiree benefit plan providing benefits as specified by the State. The benefit plans to be offered are described on the State's current micro-website at https://ct.aetnamedicare.com/coverage-and-benefits/plan-benefits-and-forms

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.1.4 Bidder must allow the State to test website structure, pages, and review and approve content for usability as determined by the State; usability concerns must be resolved within two (2) business days.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.1.5 Bidder must agree that all data, records, files and other information relating to the plan belong to the State and are subject to release to the State if the contract is terminated.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.1.6 Bidder must provide a copy of their emergency operations/disaster recovery/business continuity/pandemic flu/COVID-19 plan as part of their response to this RFP.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.1.7 Bidder must 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.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.1.8 Bidder must provide subrogation services.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.1.9 Bidder must disclose offshore relationships, if any.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.1.10 Bidder must receive prior approval for all communications to members. This includes all written website, electronic communication including, but not limited to, media advertising and regulatory mailings required under federal and/or state law. During open enrollment periods, all general media advertising in the State of Connecticut media markets must also be approved by the State. Failure to comply will result in a penalty payment of 0.50% of total expenses, no less than $30,000 and no greater than $100,000.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.2 ON-LINE SERVICES/FUNCTIONS

5.2.1 What on-line services/functions will be made available to the State?

	Response
I. Claims Summary and detail	*Compound, Pull-down list.* 1: Confirmed, 2: Not Confirmed, please explain: [500 words]
II. Billing History	*Single, Pull-down list.* 1: Confirmed, 2: Not Confirmed, please explain
III. Provider Directory	*Compound, Pull-down list.* 1: Confirmed, 2: Not Confirmed, please explain: [500 words]
IV. Enrollment Summary	*Compound, Pull-down list.* 1: Confirmed, 2: Not Confirmed, please explain: [500 words]
V. Medical Cost Tracker by Member	*Compound, Pull-down list.* 1: Confirmed, 2: Not Confirmed, please explain: [500 words]
VI. Ability to Order New Member Materials	*Compound, Pull-down list.* 1: Confirmed, 2: Not Confirmed, please explain: [500 words]
VII. Ability to Print Temporary ID Cards	*Compound, Pull-down list.* 1: Confirmed, 2: Not Confirmed, please explain: [500 words]
VIII. Health Topics/Medical Information	*Compound, Pull-down list.* 1: Confirmed, 2: Not Confirmed, please explain: [500 words]
IX. Special Enrollment	*Compound, Pull-down list.* 1: Confirmed, 2: Not Confirmed, please explain: [500 words]

X. Medical Coverage Positions/Coverage Stance (ex. Cochlear Implants)	*Compound, Pull-down list.* 1: Confirmed, 2: Not Confirmed, please explain: [500 words]
XI. Prescription Drug Look Up	*Compound, Pull-down list.* 1: Confirmed, 2: Not Confirmed, please explain: [500 words]

5.2.2 What training will be made available to the OSC's staff regarding online services and functions?

Unlimited.

5.3 ELIGIBILITY AND ENROLLMENT

5.3.1 Bidder must agree to meet all CMS enrollment and eligibility requirements.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.2 Bidder must agree to accept and provide electronic data feeds in the appropriate HIPAA or State defined format on a schedule determined by the State. Currently retiree enrollment data is sent via the HIPAA 834 format. All carriers will receive the identical format and data structure as defined by the State.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.3 Bidder must agree to share data with health benefits administrators and the State's healthcare consultant and actuary, data manager, and any other vendor partners, as applicable.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.4 Bidder must agree to accept the eligibility structure as defined by the State.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.5 Enrollment data that does not pass carrier system edits must either be corrected or bypassed by the carrier. The remaining data must be posted without delay. Issues related to errant data must be addressed with the Healthcare Policy and Benefit Services Division or the Partnership Group to which the member is assigned, as appropriate.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.6 Bidder must agree to the State-defined Eligibility Periods; award of this contract means that any Medicare-eligible retirees and Medicare-eligible dependents of retirees will be eligible for coverage.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.7 Open enrollment shall be the period announced by the State to allow eligible subscribers to join the plan, change coverage, or add eligible dependents. The open enrollment periods are generally from October 1st to December 15th each year for Medicare-eligible retirees.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.8 HIPAA Events: members may add, drop or make changes as appropriate if an allowable qualifying event occurs.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.9 The Bidder must agree to process retiree enrollment additions, changes and deletions correctly within seven (7) days of the creation date of the file or information provided by the State. The State will provide a weekly file to report any changes within their enrollment data (to be known as the Change File). This file will include additions, terminations, coverage class changes, changes in enrollment, etc. Towards the end of each month, the State will provide a monthly file to report a snapshot of all current live enrollment data (to be known as the Full File). The Full File is typically not loaded and used for comparative purposes only. After receipt of the monthly Full File, the Bidder must reconcile all retiree enrollment data and report any discrepancies, in a format defined by the State, by the 15th of the next month to the Healthcare Policy and Benefit Services Division. The State will review the discrepancies and provide feedback appropriate to the condition being reported and make any necessary corrections to enrollment information.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.10 The Bidder must agree to establish a process for each Participating Employer in the Partnership Plan to report any changes within its enrollment data, such additions, terminations, changes in dependent enrollment and will process enrollment additions, changes and deletions within seven (7) days of the receipt of the file or information provided by a Participating Employer. After receipt of the monthly file, the Bidder must reconcile all retiree enrollment data and report any discrepancies, in an agreed format by the within seven (7) days to the Participating Employer, which will review discrepancies and provide feedback.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.11 The Bidder will capture and report the State provided Employee ID (EMPLID) in data stores and data transfers with the State and other state Bidders. The member's EMPLID must also be connected to all associated dependents.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.12 The Bidder will provide the State and Partnership Plans with online access to their enrollment information in real time.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.13 The Bidder will agree to certify continued dependent status of disabled dependents over age 26 if the dependents are Medicare-eligible.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.3.14 The successful Bidder must agree to administer the billing of all Partnership premium.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.4 FILE EXCHANGE PROTOCOL

5.4.1 There are currently two methods for exchanging files with the State's Core-CT system:

1. The Bidder logs into the secure Core-CT Production Supplier Portal via https to download files. The URL is https://coreps.ct.gov/psp/PSPRD/?cmd=login

   -or-
2. The Bidder logs into the secure Core-CT SFTP Server. The URL is https://sfile.ct.gov/ . For those using an automated system SFTP is secure and can be setup for automation.

Testing Requirements

At least one test cycle must be completed successfully prior to going live employing one of the previously mentioned file transports.

The Core-CT Supplier Portal uses a non-standard port (10400 for Production, 15000 for Test) and that may require action by the carrier's Tech Support area to accomplish this. Bidders must report in their response to this RFP whether they were able to successfully reach the portal sign on page at: https://coreps.ct.gov/psp/PSPRD/?cmd=login or have successfully connected to: https://sft.ct.gov/

For testing purposes, the link to the TEST supplier portal is:
https://corepstprs.ct.gov/psp/PSTPRS/?cmd=login&languageCd=ENG&

Additional information for all parties that exchange data with State's Core-CT system is available at:
http://www.core-ct.state.ct.us/hrint/

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.5 NETWORK DEVELOPMENT, RENTAL AND MANAGEMENT

5.5.1 Bidder will be responsible for maintaining all provider contracts, terms and conditions, within its claims payment system.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.5.2 Bidder will handle all provider quality issues.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.6 ADMINISTRATIVE OR EXECUTIVE SUPPORT

5.6.1 Bidder must verify and commit that during the length of the contract, it shall not undertake a major conversion for, or related to, the system used to deliver services to the plan without specific written notice to the State. This does not apply to any program fixes, modifications and enhancements.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.6.2 Bidder must notify the State prior to any changes in Bidder's representatives account management team.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.6.3 Bidder must agree to change the assigned account management team members at the State's request.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.7 PERFORMANCE STANDARDS

5.7.1 Bidder must propose performance standards as requested in this RFP. The State reserves the right to negotiate all proposed performance standards.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.8 AUDITS

5.8.1 Bidder must agree to audits conducted by the State or their chosen auditor and/or legislative audit.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.8.2 Bidder must agree to annually provide a SSAE-16 Report if the State determines there is a need (allowable time will be given to provide this information, if the Bidder doesn't currently have a completed or a SAS 70 and any other applicable audits and certifications).

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.8.3 Bidder must agree to make available all provider records to the State or its representatives (e.g. State Auditors, the State's actuary, etc.).

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.8.4 Bidder will guarantee to the State or its appointees the right to reasonable inspection of facilities, equipment, and system support operations to ensure the continued ability of the Bidder to support the plan; failure to comply with a reasonable request to inspect will result in a penalty; failure to respond to a finding from an inspection within 30 calendar days will result in a penalty.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.8.5 Bidder must agree to allow the State to audit all reported Federal Revenue.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.8.6 Bidder must agree to allow the State to audit all pharmacy rebates.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.8.7 Bidder must agree to allow the State to audit all fees paid to a Pharmacy Benefit Manager, including fees paid through spread pricing.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.9 DATA REQUIREMENTS

5.9.1 Bidder must agree to provide claims data in the format outlined by the State on a schedule determined by the State.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.9.2 Bidders must agree to provide requested claims, enrollment, and related data to the State's consultant and data manager for inclusion in the State's claims database.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.9.3 Bidder must agree to supply monthly, claim-line detail, medical and prescription drug claims including procedure and diagnosis codes and payment data to the State, Segal, or its designated data manager.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.10 REPORTING REQUIREMENTS

5.10.1 Bidder must provide some form of on-line ad hoc reporting capability with full description of the tools and fees available.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.10.2 Bidder must provide reporting based on the divisions defined by the State.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.10.3 Bidder will provide a detailed description of its capability to track and report on telephone services to include categories being monitored; at a minimum, the Bidder must provide a monthly report of types of calls, number of calls resolved during the month, phone abandonment rate, and average response times.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.10.4 Bidder must negotiate with the State to develop mutually agreeable reporting formats and deadlines; the State reserves the right to establish formats and deadlines, if negotiations fail.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.10.5 Bidder must provide basic provider background information, cost data, and quality data on a scheduled basis as determined by the State.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.10.6 Bidder must provide Annual Reporting of Federal Revenue.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.10.7 Bidder must provide quarterly Pharmacy rebate reporting.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.11 ACCOUNTING/ACTUARY REQUIREMENTS

5.11.1 Bidder must provide a year-end report at the appropriate plan year-end.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.11.2 Bidder will respond to all requests for additional information within a 24-hour period.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.11.3 Bidder will provide a copy of the data dictionary for all fields that are operational in any system proposed. This data dictionary must include the length of the field and a specific description of the data stored in each field.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.12 PRIVACY AND SECURITY

5.12.1 Bidder must comply with HIPAA, ACA, IRA and other federal and/or state mandates to include privacy, security and electronic data transfer requirements.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.12.2 Bidder must describe any breaches, complaints or grievances with regards to protected health information (e.g., security or privacy) for their complete book of business; list the event and resolution in detail.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.12.3 Bidder must disclose any event where its employees have willfully committed acts that compromise member information, regardless of whether it is PHI or not.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

5.12.4 Bidder must describe its HIPAA policies, procedures and training related to quality and provider data.

Single, Radio group.
1: Confirmed,
2: Not Confirmed, please explain: [500 words]

6 MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLAN CONFIRMATIONS

Below are the specific confirmations for submitting a **MA/MA-PD** proposal. By checking "Confirmed", Bidder represents the proposal submitted adheres to these confirmations, unless otherwise noted in the proposal. **Failure to agree to any of these confirmations may result in disqualification of proposal.** If Bidder takes exception to any of these confirmations, it must be so noted in the Bid Exceptions & Deviations Form - Attachment B of their proposal response. These confirmations will also explicitly apply to any subcontractors used by the Bidder to deliver services to the State. If a confirmation does not apply to the plan you are quoting, please respond with, 'Not applicable'.

6.1 Please complete the following table.

Requirement	**Confirmed/ Not Confirmed**
a. Confirm you will possess and maintain all licenses, certifications, or registrations required by State and federal laws, rules, and regulations for the services to be provided under any resulting contract. Additionally, confirm you will be properly authorized by CMS to provide services as required in this solicitation. Attach proof of appropriate licensure and authorization.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
b. Bidder shall have a rating of four stars or better for the duration of any resulting contract. OSC requires that the MA/MA-PD contract will maintain a rating of four stars or better. In the event that the plan rating drops below four stars, Bidder will be required to honor the contract pricing network at the four star or above rating.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
c. Confirm that you will provide an MA/MA-PD PPO plan with same in-network and out-of-network cost sharing for members.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
d. Confirm that you will provide the requested plan design(s) identically in all states.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
e. Confirm that you will provide the same fully insured rates throughout the country.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
f. Confirm you agree that retirees and dependents who are disabled and on Medicare, but who are under age 65, are eligible for the MA/MA-PD PPO plan proposed.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable

g. Confirm that you agree to provide the MMRs and MORs as detailed in this RFP.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
h. Confirm that you agree to provide detailed claims data as detailed in this RFP.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
i. Confirm that your pricing is based on OSC's actual claims data (claims line detail will be provided) provided to Bidders in connection with this RFP.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
j. Confirm you will participate in the validation of the Medical Loss Ratio (MLR) to be performed by OSC or its designee. The validation will include a review of the Quality Improving Activities (QIA) as defined by CMS.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
k. Confirm you will provide all requested data OSC needs to validate a Medical Loss Ratio (MLR).	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
l. Confirm you will notify OSC within one business day of first identifying significant issues that cause member disruption.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
m. Confirm you will notify OSC within one business day of first identifying significant issues that cause provider disruption.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
n. Bidder agrees to send notification letters to members AND their prescribing physicians of drug formulary changes or other changes where there is a negative impact on the member at no additional fee. Letters are to be sent at least 60 days prior to effective date of change.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable

o. Confirm that general communications regarding claims processing instructions, all-provider notifications, Prior Authorization (PA) changes, and similar matters will be sent to all in-network providers plus all current providers of members plus all providers in the State of Connecticut.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
p. Confirm you will provide a designated clinical manager to OSC for both medical and pharmacy programs, who will have full knowledge of all clinical programs in effect as well as all clinical programs offered by your organization. Confirm that the clinical managers will have sufficient resources to efficiently and effectively handle the workload.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
q. Confirm you will provide an OSC-specific web site for members to access plan specific information. The web site shall include provider and pharmacy directories (or look-up functions) and the drug formulary, as well as plan documents sent to all members such as Evidence of Coverage documents and Annual Notice of Change documents.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
r. Confirm you will have a program in place to prevent and detect internal and external fraud and fraudulent practices. The program must have the ability to screen for potential fraud and systematically review provider claims. The Bidder will promptly report its fraud findings and root cause(s) to the OSC and any corrective measures, where necessary.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
s. Confirm you will provide an opportunity to review and approve all communication materials (including letters, brochures, electronic, website, etc.) prior to being sent to members and/or to providers. This includes all CMS-related communications, even if edits are not allowed by CMS. Confirm that, unless prohibited by CMS, you will agree to reasonably requested edits from OSC. Confirm that you agree that this provision will be included in the contract without limitation or edit.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
t. Confirm that you will have certain providers removed from the MA or Medicare Part D Network, at the State' request for such instances as evidence of fraud, waste and abuse or placement on the Office of Inspector General (“OIG”) Exclusions List, evidence of poor member health outcomes/management, etc.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
u. Confirm you will comply with any independent auditing or claims review firm employed by the State in providing required financial information, claim information and claim documents for claims audits and/or review.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
v. Confirm that you will be responsible for defending any litigation concerning erroneous claims administration.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
w. Confirm you will notify the Plan and each affected individual directly if a breach of unsecured protected health information is discovered, as required under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the	*Compound, Pull-down list.* 1: Confirmed,

American Recovery and Reinvestment Act of 2009, and in accordance with the HIPAA/HITECH Comprehensive Final Rule.	2: Not confirmed: [500 words], 3: Not applicable
x. Confirm your willingness and ability to modify claims processing systems in order to administer unique reimbursement schedules and methodologies specific to the state retiree plan.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
y. No covered Medicare-eligible retiree or covered Medicare-eligible dependent of a retiree shall lose or gain coverage as a result of Bidder change. All transition-of-care-related issues and non-confinement provisions must be expressly waived for the initial enrollment for covered retirees and covered dependents that have already satisfied the limitations under the existing plan, unless otherwise specified in the eligibility rules established by OSC and/or CMS.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
z. Confirm you will provide all CMS-required member communications at no additional cost.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
aa. Confirm you will customize for OSC all CMS-required member communications including the EOC and ANOC, at no additional cost.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
bb. Confirm you will co-brand with OSC and include their logo on all CMS-required member communications, at no additional cost.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
cc. Confirm you agree to provide administration services for Disabled Dependents to determine that they meet requirements of dependency.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
dd. Confirm you will assist OSC with tracking of “HEP” members for reimbursement of copays for visits related to certain chronic conditions.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
ee. Confirm you will provide the OSC will a monthly file of members for whom you are tracking HEP information.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable

ff. Confirm the pharmacy claims data will reflect the actual payments to pharmacies for prescription drugs utilized by state plan members, with no spread pricing.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
gg. Confirm you will work with and share data, as necessary, with OSC's self-insured Part D EGWP vendor, if applicable.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable

7 SELF-INSURED PART D EGWP CONFIRMATIONS

Below are the specific confirmations for submitting a self-insured Part D EGWP proposal. By checking "Confirmed", Bidder represents the proposal submitted adheres to these confirmations, unless otherwise noted in the proposal. **Failure to agree to any of these confirmations may result in disqualification of proposal.** If Bidder takes exception to any of these confirmations, it must be so noted in the Bid Exceptions & Deviations Form - Attachment B of their proposal response. These confirmations will also explicitly apply to any subcontractors used by the Bidder to deliver services to the State. If a confirmation does not apply to the plan you are quoting, please respond with, 'Not applicable'.

7.1 Please complete the following table.

Requirement	**Confirmed/ Not Confirmed**
a. Confirm you will possess and maintain all licenses, certifications, or registrations required by State and federal laws, rules, and regulations for the services to be provided under any resulting contract. Additionally, confirm you are properly authorized by CMS to provide services as required in this solicitation. Attach proof of appropriate licensure and authorization.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
b. Confirm you agree to a pass-through of all EGWP revenue streams: • CMS direct subsidies; • Federal reinsurance payments; • Manufacturer discounts; • Selected Drug subsidies; • Low-income subsidies; and • Other revenue sources.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
c. Confirm you maintain a CMS approved Medicare Part D prescription drug plan in the form of an EGWP.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
d. Confirm you will replicate the current plan design for the Medicare Part D EGWP.If not, indicate any deviations.	*Compound, Pull-down list.* 1: Confirmed,

	2: Not confirmed: [500 words], 3: Not applicable
e. Confirm your P&T Committee meets CMS' requirements for objectivity and validity.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
f. Confirm you will provide all CMS required filings related to formulary, medication therapy management (MTM), and other clinical programs on a timely basis.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
g. Confirm that you will provide all CMS required filings related to certification of compliance to all waste, fraud, and abuse requirements.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
h. Confirm that you agree to provide detailed claims data as required in this RFP.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
I. Confirm that your pricing is based on OSC's actual claims data (claims line detail will be provided) provided to Vendors in connection with this RFP.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
j. Confirm you will notify OSC within one business day of first identifying significant issues that cause member disruption.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
k. Confirm you will notify OSC within one business day of first identifying significant issues that cause provider disruption.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
l. Confirm you agree to send notification letters to members AND their prescribing physicians of drug formulary changes or other changes where there is a negative impact to the member. Letters are to be sent at least 60 days prior to effective date of change and without additional cost.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable

m Confirm you will provide a designated clinical manager to OSC for pharmacy programs, who will have full knowledge of all clinical programs in effect as well as all clinical programs offered by your organization. Confirm that the clinical managers will have sufficient resources to efficiently and effectively handle the workload.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
n. Confirm you will provide an OSC-specific web site for members to access plan specific information. The web site shall include provider and pharmacy directories (or look-up functions) and the drug formulary, as well as plan documents sent to all members such as Evidence of Coverage documents and Annual Notice of Change documents.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
o. Confirm you will have a program in place to prevent and detect internal and external fraud and fraudulent practices. The program must have the ability to screen for potential fraud and systematically review provider claims. The Bidder will promptly report its fraud findings and root cause(s) to the OSC and any corrective measures, where necessary.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
p. Confirm you will provide an opportunity to review and approve all communication materials (including letters, brochures, electronic, website, etc.) prior to being sent to members and/or to providers. This includes all CMS-related communications, even if edits are not allowed by CMS. Confirm that, unless prohibited by CMS, you will agree to reasonably requested edits from OSC. Confirm that you agree that this provision will be included in the contract without limitation or edit.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
q. Confirm that you will have certain pharmacies removed from the Medicare Part D Network, at the State' request for such instances as evidence of fraud, waste and abuse or placement on the Office of Inspector General (“OIG”) Exclusions List, evidence of poor member health outcomes/management, etc.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
r. Confirm you will comply with any independent auditing or claims review firm employed by the State in providing required financial information, claim information and claim documents for claims audits and/or review.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
s. Confirm that you will be responsible for defending any litigation concerning erroneous claims administration.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
t. Confirm you will notify the Plan and each affected individual directly if a breach of unsecured protected health information is discovered, as required under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and in accordance with the HIPAA/HITECH Comprehensive Final Rule.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable

u. Confirm your willingness and ability to modify claims processing systems in order to administer unique reimbursement schedules and methodologies specific to the state retiree plan, subject to CMS requirements.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
v. Confirm you will work with and share data, as necessary, with OSC's MA Medical Plan vendor, if applicable.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
w. 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.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
x. Confirm you will provide all CMS-required member communications at no additional cost.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
y. Confirm you will customize for OSC all CMS-required member communications including the EOC and ANOC, at no additional cost.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
z. Confirm you will co-brand with OSC and include their logo on all CMS-required member communications, at no additional cost.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
aa. Confirm the pharmacy claims data will reflect the actual payment to pharmacies for prescription drugs utilized by state plan members, with no spread pricing.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
bb. Confirm you will provide Pharmacy Part D services on a fully transparent, with all profits paid by OSC through fully transparent fees. This means no spread pricing, acquisition cost pricing with explicit dispensing fees at all wholly owned pharmacies (mail and specialty) and all manufacturer revenue associated with the utilization or utilization data of members of the state retiree health plan will be passed through to the state	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
cc. Confirm that you will provide separate reporting and billing for the EGWP group.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed:

	[500 words], 3: Not applicable
dd. Confirm you will process both low-income premium subsidy (LICS) refunds to members and the STATE and as well as low-income cost sharing refunds to members as currently administered.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
ee. Confirm that your member appeals process meets all CMS Medicare Part D requirements.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable

8 FULLY INSURED MEDICARE SUPPLEMENT CONFIRMATIONS

Below are the specific confirmations for submitting a **Medicare Supplement plan** proposal. By checking "Confirmed", Bidder represents the proposal submitted adheres to these confirmations, unless otherwise noted in the proposal. **Failure to agree to any of these confirmations may result in disqualification of proposal.** If Bidder takes exception to any of these confirmations, it must be so noted in the Bid Exceptions & Deviations Form - Attachment B of their proposal response. These confirmations will also explicitly apply to any subcontractors used by the Bidder to deliver services to the State. If a confirmation does not apply to the plan you are quoting, please respond with, 'Not applicable'.

8.1 Please complete the following table.

	Confirmed/ Not Confirmed
a. Confirm you will possess and maintain all licenses, certifications, or registrations required by State and federal laws, rules, and regulations for the services to be provided under any resulting contract.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
b. Confirm that you will provide the requested plan design(s) identically in all states.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
c. Confirm that you will provide the same premium rate throughout the country.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
d. Confirm you agree that retirees and dependents who are disabled and on Medicare, but who are under age 65, are eligible for the Medicare Supplement plan proposed.	*Compound, Pull-down list.*

	1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
e. Confirm that you agree to provide detailed claims data as detailed in this RFP.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
f. Confirm that your pricing is based on OSC's actual claims data (claims line detail will be provided) provided to Bidders in connection with this RFP.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
g. Confirm you will notify OSC within one business day of first identifying significant issues that cause member disruption.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
h. Confirm you will notify OSC within one business day of first identifying significant issues that cause provider disruption.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
i. Confirm you will provide an OSC-specific web site for members to access plan specific information. The web site shall include provider and pharmacy directories (or look-up functions), as well as plan documents sent to all members such as Evidence of Coverage documents and Annual Notice of Change documents.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
j. Confirm you will have a program in place to prevent and detect internal and external fraud and fraudulent practices. The program must have the ability to screen for potential fraud and systematically review provider claims. The Bidder will promptly report its fraud findings and root cause(s) to the OSC and any corrective measures, where necessary.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
k. Confirm you will provide an opportunity to review and approve all communication materials (including letters, brochures, electronic, website, etc.) prior to being sent to members and/or to providers. This includes all CMS-related communications, even if edits are not allowed by CMS. Confirm that, unless prohibited by CMS, you will agree to reasonably requested edits from OSC. Confirm that you agree that this provision will be included in the contract without limitation or edit.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
l. Confirm you will comply with any independent auditing or claims review firm employed by the State in providing required financial information, claim information and claim documents for claims audits and/or review.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed:

	[500 words], 3: Not applicable
m. Confirm that you will be responsible for defending any litigation concerning erroneous claims administration.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
n. Confirm you will notify the Plan and each affected individual directly if a breach of unsecured protected health information is discovered, as required under the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, and in accordance with the HIPAA/HITECH Comprehensive Final Rule.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
o. Confirm your willingness and ability to modify claims processing systems in order to administer unique reimbursement schedules and methodologies specific to the state retiree plan.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
p. No covered Medicare-eligible retiree or covered Medicare-eligible dependent of a retiree shall lose or gain coverage as a result of Bidder change. All transition-of-care-related issues and non-confinement provisions must be expressly waived for the initial enrollment for covered retirees and covered dependents that have already satisfied the limitations under the existing plan, unless otherwise specified in the eligibility rules established by OSC and/or CMS.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
q. Confirm you agree to review Disabled Dependents to determine that they meet requirements of dependency.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
r. Confirm you will assist adjudicate $0 copays for “HEP” members for visits related to certain chronic conditions.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
s. Confirm you will work with and share data, as necessary, with OSC’s self-insured Part D EGWP vendor, if applicable.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
t. Confirm your willingness and ability to modify claims processing systems in order to administer unique reimbursement schedules and methodologies specific to the state retiree plan.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable

u. Confirm you will provide all CMS-required member communications at no additional cost.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
v. Confirm you will customize for OSC all CMS-required member communications including the EOC and ANOC, at no additional cost.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable
w. Confirm you will co-brand with OSC and include their logo on all member communications, at no additional cost.	*Compound, Pull-down list.* 1: Confirmed, 2: Not confirmed: [500 words], 3: Not applicable

9 QUESTIONNAIRE - GENERAL INFORMATION, CAPABILITIES, AND EXPERIENCE WITH NATIONAL MA/MA-PD PLANS, SELF-INSURED PART D EGWPs, AND FULLY INSURED MEDICARE SUPPLEMENT PLANS

9.1 REFERENCES

9.1.1 Provide three (3) current customer group health plan references. For at least one (1) of these references, Bidder should provide a reference for their largest (based on total group membership) Public Sector group health plan client. For at least one (1) reference, Bidder should provide a reference for their longest standing Public Sector group health plan client, based on continuous years of service. The reference for largest client and longest standing client may be the same reference. OSC is interested in working with carriers that have experience with and a history of providing MA/MA-PD and/or self-insured Part D EGWP benefits and/or Fully insured Medicare Supplement benefits to public sector plans of similar size. Provide the following for each reference:

	Reference 1	Reference 2	Reference 3
a. Customer name	*50 words.*	*50 words.*	*50 words.*
b. Length of time serviced	*50 words.*	*50 words.*	*50 words.*
c. Number of covered members	*Integer.*	*Integer.*	*Integer.*
d. Description of services (e.g. MA/MAPD, Self-insured Part D, Fully insured Medicare Supplement)	*200 words.*	*200 words.*	*200 words.*
e. Name of contact	*50 words.*	*50 words.*	*50 words.*
f. Contact title	*50 words.*	*50 words.*	*50 words.*
g. Contact phone number	*50 words.*	*50 words.*	*50 words.*

h. Contact email	*50 words.*	*50 words.*	*50 words.*
i. Contact address	*50 words.*	*50 words.*	*50 words.*

9.1.2 Provide this same information for two (2) recently terminated customers. Include the reason the engagement was terminated.

	Reference 1	Reference 2
a. Customer name	*50 words.*	*50 words.*
b. Length of time serviced	*50 words.*	*50 words.*
c. Number of covered members	*Integer.*	*Integer.*
d. Description of services (e.g. MA/MAPD, Self-insured Part D, Fully insured Medicare Supplement)	*200 words.*	*200 words.*
e. Name of contact	*50 words.*	*50 words.*
f. Contact title	*50 words.*	*50 words.*
g. Contact phone number	*50 words.*	*50 words.*
h. Contact email	*50 words.*	*50 words.*
i. Contact address	*50 words.*	*50 words.*
j. Reason for termination	*200 words.*	*200 words.*

9.2 COMPANY OVERVIEW

9.2.1 Please provide the following information:

	Your Company	Parent Company
Legal Company Name	*500 words.*	*500 words.*
Corporate Office Address	*500 words.*	*500 words.*
Telephone Number	*500 words.*	*500 words.*
Company URL (web address)	*500 words.*	*500 words.*

9.2.2 Provide the location of your office(s) that would be responsible for managing the OSC contract.

500 words.

9.2.3 Provide the names of all subcontractors along with the type of services they will provide, the number of years your firm has utilized the subcontractor, and the contractual relationship between subcontractor and your company. Please use the table provided below.

	Name and Address	**Type of Service(s)**	**Years Utilizing this Contractor**	**Contractual Relationship**
1.	*500 words.*	*500 words.*	*500 words.*	*500 words.*
2.	*500 words.*	*500 words.*	*500 words.*	*500 words.*
3.	*500 words.*	*500 words.*	*500 words.*	*500 words.*
4.	*500 words.*	*500 words.*	*500 words.*	*500 words.*

5.	*500 words.*	*500 words.*	*500 words.*	*500 words.*

9.2.4 Has your organization experienced recent merger or acquisition activity? If so, please describe. Has your organization recently undergone any workforce realignments? If so, please describe. Are there any anticipated changes in ownership or business developments, including, but not limited to, mergers, stock issues, and the acquisition of new venture capital? If so, please explain.

Single, Radio group.
1: Yes, explain: [500 words] ,
2: No

9.2.5 Does your company have any current or pending litigation? If yes, please explain.

Single, Radio group.
1: Yes, explain: [500 words] ,
2: No

9.2.6 Has your company been sanctioned by CMS in the past 5 years, on the contract upon which you are bidding? If so, please explain.

Single, Radio group.
1: Yes, explain: [500 words] ,
2: No

9.2.7 Are there any other sanctions that OSC should be made aware of?

Single, Radio group.
1: Yes, explain: [500 words] ,
2: No

9.2.8 Confirm your organization will be responsible for payment of any fines levied against OSC by CMS as a result of an action by your organization that incurred the citation.

Single, Radio group.
1: Confirmed, explain: [500 words] ,
2: Not confirmed

9.2.9 Describe any staff relocations, computer system changes/upgrades, program changes, or telephone system changes in process at this time or proposed within the next 12-24 months.

1000 words.

9.2.10 What are the most recent ratings for your company by the following?

	Rating	Date
A.M. Best	*10 words.*	*To the day.*
Fitch	*10 words.*	*To the day.*
Moody's	*10 words.*	*To the day.*
Standard and Poor's	*10 words.*	*To the day.*

9.2.11 If your rating has changed within the past 12 months for any of the rating agencies, please explain.

1000 words.

9.2.12 Is your organization:

Single, Radio group.
1: Privately held,
2: Publicly traded,
3: A Mutual Holding Company,
4: Other. Please describe: [500 words]

9.2.13 What fidelity and surety insurance or bond coverage do you carry, or would you recommend to protect OSC? Specifically, describe the type and amount of the fidelity bond insuring your employees, which would protect OSC in the event of a loss.

1000 words.

9.2.14 Confirm that you will provide the most recent 2 years of your firm's audited financial statements. Provide the requested financial statements as an attachment to your proposal.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

9.3 EXPERIENCE

9.3.1 Describe your organization's experience participating in Medicare for both Part C and Part D benefits. Include the number of years that your organization has participated in Medicare and a brief history of key developments over this time, such as when your first group Medicare plan was offered. Please also include insight on the direction of your program over the next five years.

1000 words.

9.3.2 Provide statistics regarding your Medicare business for your entire book of business. Break out your Medicare individual book of business and your Medicare employer group book of business, further broken out for your public sector group of business. Provide both number of enrolled members for individual and group and number of employer group clients for 2021 - 2025.

	Individual Members	**Total Group Members**	**Total Number of Employer Groups**	**Public Sector Members**	**Number of Public Sector Groups**	**Number of Public Sector Groups with 50,000+ lives**
2021	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*
2022	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*
2023	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*
2024	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*
2025	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*

9.3.3 Provide your organization's year-end Medicare membership for each year that you have participated in the Medicare program.

1000 words.

9.3.4 a. How many new group Medicare members did your organization add effective January 1, 2024, and January 1, 2025? b. How many new Medicare groups did your organization add effective January 1, 2024, and January 1, 2025?

	Effective January 1, 2024	Effective January 1, 2025

New group MA members	*Integer.*	*Integer.*
New MA groups	*Integer.*	*Integer.*

9.3.5 What percentage of your 2024 total group Medicare membership renewed for the 2025 plan year?
1000 words.

9.3.6 Provide a list of your 10 largest Medicare group health plan clients. Largest is denoted by size of membership.

Largest Clients	Name of Client	Is the client in the Public Sector, Corporate or Taft – Hartley/Multiemployer market?	Total Membership	MA, MA-PD, self-insured Part D, Fully Insured Medicare Supplement?	Start date	End Date
1	*50 words.*	*Single, Pull-down list.* 1: Public Sector, 2: Corporate, 3: Taft – Hartley/Multiemployer market	*Integer.*	*Single, Pull-down list.* 1: MA, 2: MA-PD, 3: Self-insured Part D, 4: Fully insured Medicare Supplement	*To the day.*	*To the day.*
2	*50 words.*	*Single, Pull-down list.* 1: Public Sector, 2: Corporate, 3: Taft – Hartley/Multiemployer market	*Integer.*	*Single, Pull-down list.* 1: MA, 2: MA-PD, 3: Self-insured Part D, 4: Fully insured Medicare Supplement	*To the day.*	*To the day.*
3	*50 words.*	*Single, Pull-down list.* 1: Public Sector, 2: Corporate, 3: Taft – Hartley/Multiemployer market	*Integer.*	*Single, Pull-down list.* 1: MA, 2: MA-PD, 3: Self-insured Part D, 4: Fully insured Medicare Supplement	*To the day.*	*To the day.*
4	*50 words.*	*Single, Pull-down list.* 1: Public Sector, 2: Corporate, 3: Taft – Hartley/Multiemployer market	*Integer.*	*Single, Pull-down list.* 1: MA, 2: MA-PD, 3: Self-insured Part D, 4: Fully insured Medicare Supplement	*To the day.*	*To the day.*
5	*50 words.*	*Single, Pull-down list.* 1: Public Sector, 2: Corporate, 3: Taft – Hartley/Multiemployer market	*Integer.*	*Single, Pull-down list.* 1: MA, 2: MA-PD, 3: Self-insured Part D, 4: Fully insured Medicare Supplement	*To the day.*	*To the day.*
6	*50 words.*	*Single, Pull-down list.* 1: Public Sector, 2: Corporate, 3: Taft – Hartley/Multiemployer market	*Integer.*	*Single, Pull-down list.* 1: MA, 2: MA-PD, 3: Self-insured Part D, 4: Fully insured Medicare Supplement	*To the day.*	*To the day.*
7	*50 words.*	*Single, Pull-down list.* 1: Public Sector,	*Integer.*	*Single, Pull-down list.* 1: MA, 2: MA-PD,	*To the day.*	*To the day.*

		2: Corporate, 3: Taft – Hartley/Multiemployer market		3: Self-insured Part D, 4: Fully insured Medicare Supplement		
8	*50 words.*	*Single, Pull-down list.* 1: Public Sector, 2: Corporate, 3: Taft – Hartley/Multiemployer market	*Integer.*	*Single, Pull-down list.* 1: MA, 2: MA-PD, 3: Self-insured Part D, 4: Fully insured Medicare Supplement	*To the day.*	*To the day.*
9	*50 words.*	*Single, Pull-down list.* 1: Public Sector, 2: Corporate, 3: Taft – Hartley/Multiemployer market	*Integer.*	*Single, Pull-down list.* 1: MA, 2: MA-PD, 3: Self-insured Part D, 4: Fully insured Medicare Supplement	*To the day.*	*To the day.*
10	*50 words.*	*Single, Pull-down list.* 1: Public Sector, 2: Corporate, 3: Taft – Hartley/Multiemployer market	*Integer.*	*Single, Pull-down list.* 1: MA, 2: MA-PD, 3: Self-insured Part D, 4: Fully insured Medicare Supplement	*To the day.*	*To the day.*

9.4 OPEN ENROLLMENT

9.4.1 Confirm that you will be available and participate in the OSC's Open Enrollment communications campaign. Describe your involvement and how you will assist members in learning about their benefit options. Note: Open Enrollment occurs annually beginning in October.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.4.2 Confirm that your organization will conduct on-site, statewide educational sessions for OSC's Medicare-eligible retirees and Medicare-eligible dependents of retirees during the period from October-December 1st for implementation by January 1st. Confirm that you will conduct at least one meeting in each county plus two or more meetings in the larger populated counties.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.4.3 Confirm your understanding and agreement that ALL on-site staff will be subject to a background check as well as OSC's onboarding processes.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.5 MEMBER SERVICES

9.5.1 Please provide the geographic location of the Member Service unit(s) that will be servicing OSC's members. Will this service be outsourced? If so, provide the name of the outsourcer.

1000 words.

9.5.2 Please describe the hours and days the Members Services unit will have live member service representatives (MSR) available to OSC members. At a minimum, Bidder shall provide a toll-free telephone number and TDD access for member service that will be available at least from 8:00 am to 8:00 pm (Eastern Time) Monday through Friday, except for observed Bidder holidays.

1000 words.

9.5.3 Is there a Pre-Enrollment information line available during Open Enrollment as well as an Information line available throughout the year?

Single, Radio group.
1: Yes, explain: [500 words] ,
2: No

9.5.4 How are calls "after hours" of operation handled?

Single, Radio group.
1: Voice mail,
2: No service,
3: Full service – 24/7,
4: Some extended hours for calls,
5: Other, please specify: [500 words]

9.5.5 Confirm each of the following:

Member Services	Response
a. Bidders will operate a dedicated member services unit to answer questions from OSC's members.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed
b. Bidders will operate a dedicated toll-free member services line to answer questions from OSC's members.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed
c. Bidders will have special telephone features for the hearing impaired.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed
d. Resources will be available to assist non-English speaking callers through a translation service.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed
e. All calls will be recorded and kept for 24 months and made available for OSC's review upon request.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed

f. MSR will warm or soft transfer members to other service areas or Bidders including OSC, if necessary.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed
g. Members will be able to opt out of the Interactive Voice Response (IVR) to speak with a live MSR.	*Single, Pull-down list.* 1: Confirmed, 2: Not confirmed

9.5.6 What is the process for referring calls to an MSR? Are specific MSRs trained and assigned to calls according to the need of the caller (i.e., provider directories vs. claims payment issues)?

1000 words.

9.5.7 Describe the call center organization and structure. How many MSRs are located at the primary call center? What is the ratio of supervisor/team leaders to MSRs at the primary call center?

1000 words.

9.5.8 Confirm that all MSRs reside in the U.S.

1000 words.

9.5.9 Describe your firm's process for providing training to MSRs to serve a senior membership.

1000 words.

9.5.10 Describe the escalation process for Member Service satisfaction and complaints.

1000 words.

9.5.11 Describe the escalation process for urgent drug claim issues where claims are rejecting at the pharmacy and members need immediate assistance and resolution.

1000 words.

9.5.12 Confirm you will handle all initial internal and external appeals in accordance with CMS requirements and guidelines.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.5.13 Confirm you will handle any and all grievances in accordance with CMS requirements and guidelines. Describe how you will comply with this requirement.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.5.14 Confirm that you will mail, via surface mail, a member ID card to all members at least ten (10) business days before the beginning of each plan year. Confirm that you will mail ID cards to newly enrolled members within ten (10) business days of receiving confirmation from CMS. Confirm that you will re-issue the member ID card within five (5) business days of notice if a member reports a lost card or for any reason that results in a change to the information disclosed on the member ID card at no additional charge.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.5.15 Confirm you will provide a member ID card that are CMS/WEDI compliant.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.5.16 Will you issue a combined ID card for medical and PBM services? Provide a sample of the ID card.

Single, Radio group.
1: Yes. Sample is attached,
2: Yes. Sample is not attached, explain: [500 words] ,
3: No, explain: [500 words]

9.5.17 Describe when the Evidence of Coverage (EOC) will be available prior to Open Enrollment annually in accordance with CMS requirements.

1000 words.

9.5.18 Please complete the following table:

Provider Directories	**Response**
Are hard copy provider directories available to your membership? If so, describe how often they are mailed and whether they are sent to new members only.	*Compound, Pull-down list.* 1: Yes: [100 words], 2: No
Are the provider directories also available online?	*Compound, Pull-down list.* 1: Yes: [100 words], 2: No
If so, how often are they updated?	*Compound, Pull-down list.* 1: Yes: [100 words], 2: No

9.5.19 Indicate whether your member website captures the following:

Member Website Capabilities	**Response** (Yes/No)
Provider directory and provider search (physician, hospital, pharmacy, and ancillary providers) for Providers that accept Medicare assignment)	*Single, Radio group.* 1: Yes, 2: No
Ability to review claims payment status online	*Single, Radio group.* 1: Yes, 2: No
Ability to review a history of claims payments (medical and pharmacy), including deductible status, and out-of-pocket maximum status	*Single, Radio group.* 1: Yes, 2: No

Ability to see a summary of OSC's plan design and review the EOC, ANOC and other plan documents	*Single, Radio group.* 1: Yes, 2: No
Ability to print ID cards and request replacement cards	*Single, Radio group.* 1: Yes, 2: No
Ability to contact Member Services online	*Single, Radio group.* 1: Yes, 2: No
Star Ratings	*Single, Radio group.* 1: Yes, 2: No
Information about diseases, conditions, and related clinical programs.	*Single, Radio group.* 1: Yes, 2: No
Contact information for OSC, its other Bidders, and links to their websites	*Single, Radio group.* 1: Yes, 2: No
Online access to forms	*Single, Radio group.* 1: Yes, 2: No
Up to date OSC-specific formularies with tier rankings	*Single, Radio group.* 1: Yes, 2: No
Ability to review/select incentives (i.e., gift cards) when they are available to the member	*Single, Radio group.* 1: Yes, 2: No
Cost Information by Procedure Type	*Single, Radio group.* 1: Yes, 2: No
Access to wellness resources and OSC specific point solutions.	*Single, Radio group.* 1: Yes, 2: No
Other – please describe any additional tools and functionalities available to members in your web portal not captured above	*Single, Radio group.* 1: Yes, 2: No

9.5.20 Confirm your member website is maintained for HIPAA and CMS compliance.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.5.21 Describe your mobile application and how it is designed to serve a senior membership.

1000 words.

9.5.22 Confirm that you will provide all correspondence to members required by CMS regarding terminations and compliance issues.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.5.23 Confirm that you will provide all CMS required filings related to certification of compliance to all fraud and abuse requirements.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.5.24 Confirm that you will provide all CMS required filings related to formulary, medication therapy management (MTM), and other clinical programs on a timely basis.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.5.25 Describe your organization's Member Satisfaction Surveys and provide the most recent results.

1000 words.

9.5.26 Confirm that you will conduct an OSC specific member satisfaction survey at least once annually and will provide full results to OSC.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.5.27 Although the Transparency Law doesn't apply to retirees, what best practices for cost transparency and tools being developed for your commercial plans will you apply to your MA/MA-PD and/or self-insured Part D plans, and/or self/fully insured Medicare Supplement offering to provide better insight to cost transparency for retirees?

1000 words.

9.5.28 Although the No Surprises Act doesn't apply to retirees, what best practices to ensure no surprise billing being developed for your commercial plans will you apply to your MA/MA-PD and/or self-insured Part D plans, and/or self/fully insured Medicare Supplement offering?

1000 words.

9.5.29 How do you assist members in obtaining their medication in the following scenario? A member's prescription, which requires Prior Authorization, is written on a Friday and the provider has not responded to the PA request by Monday.

1000 words.

9.6 ACCOUNT MANAGEMENT/ CLIENT SERVICES

9.6.1 What is the MA-PD PPO and/or Part D EGWP group contract number on which the OSC's account will reside?

1000 words.

9.6.2 Provide contact information for the Account Executive that will be assigned to this engagement.

	Response
Company Name	*100 words.*
Contact Name	*100 words.*
Contact Title	*100 words.*
Address	*100 words.*
Office Number	*100 words.*
Mobile Number	*100 words.*
e-Mail Address	*100 words.*
Company URL (web address)	*100 words.*

9.6.3 Identify the key Account Management team you propose to work on this account and provide an organization chart, including names and titles, of management and key personnel that will be responsible for account management. Some positions may be dedicated, and others may be designated. Please describe your definitions for “Dedicated” and “Designated” and indicate which positions are Dedicated vs. Designated.

1000 words.

9.6.4 Indicate whether the person who will fill each position is already employed by your firm or whether he/she will be recruited upon Contract Award. If the person(s) is already employed, provide resumes, length of time with your firm and length of time in their current position. At a minimum, the positions below should be included, as applicable to the services upon which you are quoting.

1. Account Director - Responsible for overall account relationship including strategic planning in relation to plan performance, consultative services, recommendations for benefit design and cost containment opportunities, overseeing contractual services under the contract with OSC, and managing all other Bidder's staff working on this account. The Account Director shall have at least 3 years of experience with your firm as an Account Director in similar engagements.
2. Actuary - Responsible for developing OSC's premiums for MA/MA-PD, Part D EGWP, and/or self/fully insured Medicare Supplement plan options and projecting future claims costs and CMS reimbursements. Will assist OSC in determining the projected short- and long-term financial impact(s) of prospective programs. The Actuary shall be a Fellow of the Society of Actuaries and have experience in rating MA/MA-PD and Part D EGWP plans for groups similar to OSC.
3. Medical Director - Responsible for design and clinical effectiveness of medical management and wellness programs to manage the risk of OSC's membership and therefore control future cost/premium increases. Will work pro-actively and collaboratively with OSC to identify health risks in OSC's membership that are behaviorally caused and, as necessary, develop modified or additional

programs to target these risks. Will assist OSC in determining the projected short- and long-term clinical and health impact(s) of current and prospective programs.

4. Medicare Director - Responsible for coordinating with CMS to ensure that all MA/MA-PD, Part D EGWP and self/fully insured Medicare Supplement filings are structured to properly and fully support OSC's requirements. Also develops processes and strategies to maximize CMS Star Rating and bonuses to minimize premiums. Proactively assists OSC in developing strategic considerations to maximize operational and cost efficiencies. Responsible for communicating CMS and MA/MA-PD, Part D EGWP and self/fully insured Medicare Supplement program updates and the resulting impact on OSC's program. Must have at least 3 years of experience as a Medicare Director in similar engagements.
5. Pharmacy Director - Responsible for managing the overall pharmacy operation, including all account services directly related to clinical pharmacy including formulary management, clinical plan rules and programs, medication therapy management, and specialty pharmacy. Will provide information and recommendations with respect to new drug/therapy introductions and clinical pharmacy best practices.
6. Clinical Account Director - Responsible for overall account relationship including strategic planning in relation to plan performance, consultative services, recommendations for benefit design, improving clinical outcomes and cost containment opportunities, overseeing clinical services under the contract with OSC, and managing all other Bidder's clinical staff working on this account.
7. Privacy Officer/Attorney - Responsible for ensuring compliance with all applicable laws and regulations, including HIPAA, and ACA. Responsible for maintaining internal controls to protect PHI and adequate and timely steps are taken in the event of a breach of confidentiality. Responsible for communicating program and policy updates to OSC and coordinating as necessary with OSC's internal counsel and staff.
8. Operations Director - Responsible for overseeing the file transfer process of eligibility data, interfaces between Bidders, reporting, and data sharing. Responsible for all Member Services and communications. The Operations Director shall have at least 3 years of experience as an Operations Director in similar engagements.
9. Implementation Manager - Responsible for development and execution of implementation plan. Coordinates with OSC's internal and external resources. The Implementation Manager shall have at least three (3) years of experience as an Implementation Manager covering at least 50,000 group health members and larger.

1000 words.

9.6.5 Confirm that you will provide an Account Executive and a backup account staff member that will handle ALL service matters related to the operation of the program.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.6.6 Confirm that you will respond to all OSC inquiries within one (1) business day.

Single, Pull-down list.
1: Confirmed,
2: Not confirmed

9.6.7 Discuss how your firm will escalate issues through the corporate structure and track and report issues/findings to OSC.

1000 words.

9.6.8 What influence does the client account management team have within the call center, particularly if the client is reporting an issue to account management? How does the account management team address the issues with the call center to get resolution?

1000 words.

9.6.9 Confirm that you will provide an annual score card to OSC so that OSC can assess your performance. Please upload a sample of your annual score card.

Single, Radio group.
1: Confirmed, sample attached,
2: Confirmed, sample not attached explain: [500 words] ,
3: Not confirmed, explain: [500 words]

9.6.10 Confirm that your team will attend on-site quarterly meetings with OSC to present current plan and service performance, address any recent issues/challenges encountered, suggest potential savings opportunities, and discuss other pertinent topics to be identified prior to each meeting.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.6.11 Please provide a sample of your quarterly reporting format.

Single, Pull-down list.
1: Attached,
2: Not provided

9.6.12 Are you willing to customize this report for the OSC?

Single, Radio group.
1: Yes: [500 words] ,
2: No: [500 words]

9.6.13 Are legislative updates part of your quarterly reporting package?

1000 words.

9.6.14 Confirm that your team will attend OSC's HCCCC Meetings as necessary, and at your expense.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.6.15 Do your services include legislative updates to plan sponsors?

Single, Pull-down list.
1: Yes – included in Standard Fees,
2: Yes – for Additional Charge,
3: No

9.6.16 Discuss how your firm will notify OSC when you first identify significant issues that cause provider disruption. How will you track the issue through to resolution while keeping the OSC updated on status?

1000 words.

9.6.17 Will you make available to OSC staff and its designees an on-line claims query/reporting tool for the purposes of standard and ad-hoc report generation and queries? How soon after the end of each month are claims reports available?

1000 words.

9.7 MEDICAL CLAIMS PROCESSING

9.7.1 Using most recent year-end data, complete the table below for the claim office that will have payment responsibility for this account:

	Target	**Actual 2024 year end results**
Total annual claim volume per year (in total number of claims)	*500 words.*	*500 words.*
Average claims processed per processor per day.	*500 words.*	*500 words.*
Claims turnaround time (percent of clean claim transactions processed within 14 calendar days following receipt of claim)	*500 words.*	*500 words.*
Average number of business days to process a clean claim from date received to date check/EOB issued.	*Decimal.*	*Decimal.*
Financial accuracy (percentage of claim dollars paid without error, relative to total claim dollars paid)	*500 words.*	*500 words.*
Processing accuracy (percentage of claims processed without error, relative to the total number of claims processed)	*500 words.*	*500 words.*
What percent of all non-clean claims submitted are processed (from date received to date check/EOB issued) within 10 business days?	*Percent.*	*Percent.*
What percent of all non-clean claims submitted are processed (from date received to date check/EOB issued) within 30 business days?	*Percent.*	*Percent.*

9.7.2 Confirm that the claims processing system is integrated with the eligibility and Member Services system.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

9.7.3 Provide the following information regarding internal claims audit(s):

	Response
What are the current standards for internal claim audits?	*500 words.*

How often are claim processors audited?	*500 words.*
When an error is found, what is the time period for correction of the claim?	*500 words.*
Are reports monthly, quarterly, semi-annual, etc.?	*500 words.*
What claims do you consider for high dollar audits?	*500 words.*
Are high dollar audit claims handled internally?	*500 words.*
How are criteria determined for internal audits? What triggers do you utilize?	*500 words.*
What percent of claims are audited internally?	*500 words.*
What is the ratio of quality reviewers to claim processors?	*500 words.*

9.7.4 Describe your process to ensure that benefits or program changes that have the potential to create member disruption and provider payment issues are made timely and accurately. Such changes include mandated CMS updates of service codes, fee schedules, etc.

1000 words.

9.7.5 Describe protocol and use of proper quality control testing for any benefit or program changes (e.g. codes or fee schedule updates) prior to live release.

1000 words.

9.7.6 Describe the process and timing to implement any OSC requested benefit or program changes.

1000 words.

9.7.7 Describe the standard number of tests and applicable test areas.

1000 words.

9.7.8 Confirm that you will share the results of the internal audit testing with the OSC and its designee.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.7.9 Describe the process to address errors and adjustments found from your internal audit and quality assurance review. How are adjustments issued and what impact does it have, if any, on the implementation timing?

1000 words.

9.7.10 Confirm the OSC will have the ability to review your organization's comprehensive external audit benefit testing scenarios.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.7.11 Describe how you monitor denied claims for trends and patterns to timely determine if outreach is needed to a provider's office for educating/training on proper filing, codes, etc. so the provider may submit a clean and accurate claim.

1000 words.

9.7.12 Describe how claims are reviewed for medical necessity including for post-acute care. What type of algorithms, technology, and tools are used to assist in determinations for post-acute care?

1000 words.

9.7.13 Describe the outreach and other efforts that are made to ensure providers submit all required clinical information to accurately determine medical necessity in the PA process.

1000 words.

9.7.14 Describe the outreach made to providers and the education/training provided in the event a provider needs to be contacted as a result of trends and patterns related to denied claims.

1000 words.

9.7.15 Describe your medical PA and medical pre-certification process. Describe your appeal process for denied PAs and medical pre-certifications. Describe how you report PAs, pre-certifications and appeals to reflect end result and value of these Utilization Management tools. Please indicate if you use a third-party vendor.

1000 words.

9.7.16 Complete the following table indicating services for which you are proposing a PA, that includes the total number of PAs submitted, denied (including breakout of denied due to insufficient information), appealed and overturned at each level of appeal for your group Medicare book of business.

Service	PA Required	PAs submitted	PAs denied	PAs denied due to insufficient information	Denials appealed	Appeals overturned level 1	Appeals overturned level 2	Appeals overturned total
Chiropractic Services	*Single, Radio group.* 1: Yes, 2: No	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Diagnostic Radiology (MRI, MRA, CT or PET Scan)	*Single, Radio group.* 1: Yes, 2: No	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Durable Medical Equipment	*Single, Radio group.* 1: Yes, 2: No	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Home Health Services	*Single, Radio group.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*

	1: Yes, 2: No							
Inpatient Hospital Care	*Single, Radio group.* 1: Yes, 2: No	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Inpatient Services in a psychiatric hospital	*Single, Radio group.* 1: Yes, 2: No	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Inpatient Surgery	*Single, Radio group.* 1: Yes, 2: No	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Non-Emergency Facility to Facility Transportation Services	*Single, Radio group.* 1: Yes, 2: No	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Outpatient Surgery	*Single, Radio group.* 1: Yes, 2: No	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Private Duty Nursing	*Single, Radio group.* 1: Yes, 2: No	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Prosthetic or Orthotic Devices	*Single, Radio group.* 1: Yes, 2: No	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Skilled Nursing Facility	*Single, Radio group.* 1: Yes, 2: No	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Sleep Studies	*Single, Radio group.* 1: Yes, 2: No	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*

9.7.17 Please identify how many additional services for which you are proposing a PA. Your response will activate the applicable rows in the table below.

Single, Pull-down list.
1: 0,
2: 1,
3: 2,
4: 3,
5: 4,
6: 5,
7: 6,
8: 7,
9: 8,
10: 9,
11: 10

9.7.18 Provide a table of all additional services for which you are proposing a PA, that includes the total number of PAs submitted, denied (including breakout of denied due to insufficient information), appealed and overturned at each level of appeal for your group Medicare book of business.

Service	Define	PAs submitted	PAs denied	PAs denied due to insufficient information	Denials appealed	Appeals overturned level 1	Appeals overturned level 2	Appeals overturned total
Service 1 - please define	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Service 2 - please define	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Service 3 - please define	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Service 4 - please define	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Service 5 - please define	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Service 6 - please define	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Service 7 - please define	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Service 8 - please define	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*
Service 9 - please define	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*

Service 10 - please define	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*	*500 words.*

9.7.19 Describe the use of any artificial intelligence (AI) as it relates to review of PA approvals and denials.

1000 words.

9.7.20 Describe any additional resources, programmatic changes or specific efforts that would be made on behalf of the state plan to reduce appeal overturn rates or denial rates due to insufficient information.

1000 words.

9.7.21 Describe your process to work with the existing MA-PD carrier and the State's medical carrier to ensure such medical PA and precertification criteria are transferred properly to your system.

1000 words.

9.7.22 Describe your process to honor existing medical PAs and pre-certifications.

1000 words.

9.7.23 Confirm members' existing medical PAs and pre-certifications be transitioned and/or re-issued so they are accessible for use by the go-live date.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

9.8 REPORTING TO OSC

9.8.1 Bidders shall create and generate standard utilization and cost reports. Provide a sample of your standard reporting package. In addition, include a description of each report and the frequency of the report. Confirm the standard reporting package will be sent to OSC within 30 days of end of reporting period.

1000 words.

9.8.2 Confirm that you will provide monthly prior authorization reporting to OSC. Including, but not limited to count of prior authorization requests submitted by service, initial denials, appeal requests, appeal overturn status.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.3 Are these reports available online currently? If they are not, how will they be provided to the OSC?

Single, Radio group.
1: Yes: [500 words] ,
2: No: [500 words]

9.8.4 Confirm that you are able to customize reports, and this is included in your quoted premium(s).

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.5 Confirm that your organization will provide claim line detail for ALL claims on a monthly basis throughout the contract term — medical and pharmacy—including, but not limited to all required fields, which can be found in Attachment F - MAPD Monthly Data Request and Attachment G - Rx Monthly Data Request, as applicable.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.6 Confirm that your organization will provide this data in a mutually agreed upon format by the 15th calendar day of the month following the subject month.

Single, Radio group.
1: Confirmed, explain: [500 words] ,
2: Not confirmed, explain: [500 words]

9.8.7 Confirm that your organization will report all CMS and Manufacturer paid and anticipated revenues (CMS direct subsidy; Federal reinsurance payments including prospective amounts, Manufacturer discounts, Selected Drug subsidies, Low-income premium and cost-sharing subsidies). All reporting should be based on estimates for the month based on incurred claims. This monthly reporting will be submitted by the end of the following month throughout the contract term.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.8 Confirm that your organization will report pharmacy rebates, at the NDC-level to the OSC on a quarterly basis.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

9.8.9 Confirm that your organization will provide this data to Segal in a mutually agreed upon format by the 15th day of the month following the subject month.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.10 Describe your process of transferring data to Segal and ensuring the data will be HIPAA-compliant and subject to confidentiality and data security policies of OSC. Describe whether software used is capable of analyzing and producing reports for the physician and hospital profiling. In addition, describe whether your data warehouse is capable of producing utilization and pricing information in various categories.

1000 words.

9.8.11 Confirm that you will submit the Part C and Part D Medicare Membership Reports (MMR) monthly, including all fields as received from CMS. The monthly MMR will be submitted by the end of the corresponding month throughout the contract term.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.12 Confirm that you will submit the Part C and Part D Model Output Reports (MOR) upon request, no more often than annually, including all fields as received from CMS. The latest MOR will be submitted within 30 days of request.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.13 Please list and describe the reports received from CMS, other than the MMR and MOR that will be available for the proposed services upon whi9ch you are quoting, including frequency of the reports.

1000 words.

9.8.14 Confirm that you will provide a denied claims report, including number of denials by reason, to the OSC? What is the frequency of this reporting? Provide a sample denied claims report.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.15 Confirm that you will provide and present quarterly reports to the OSC.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.16 Confirm you will provide a report on member calls, concerns and grievances throughout the contract? What is the frequency of this reporting?

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.17 Confirm that you will provide monthly, quarterly, and annual appeals and grievances reports to the OSC.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.18 Complete the table below on your 2024 MA/MA-PD PPO, Part D EGWP, Medicare Supplement group book of business statistics on appeals and grievances.

	Response	Provide additional explanation for these statistics as needed.
Total 2024 Member Medical Appeals	*Integer.*	*500 words.*
Total Dismissed	*Integer.*	*500 words.*
Total Overturned	*Integer.*	*500 words.*
Total Upheld	*Integer.*	*500 words.*
Total 2024 Member Pharmacy Appeals	*Integer.*	*500 words.*
Total Dismissed	*Integer.*	*500 words.*
Total Overturned	*Integer.*	*500 words.*
Total Upheld	*Integer.*	*500 words.*
Total 2024 Provider Medical Appeals	*Integer.*	*500 words.*

Total Dismissed	*Integer.*	*500 words.*
Total Overturned	*Integer.*	*500 words.*
Total Upheld	*Integer.*	*500 words.*
Total 2024 Member Grievances	*Integer.*	*500 words.*

9.8.19 Describe your standard web portal and Member Services utilization reports (i.e., number of hits and calls and the nature of the members' inquiries) and provide examples.

1000 words.

9.8.20 Describe how your organization monitors and provides reporting on contractual Performance Guarantees. Provide a sample Performance Guarantee report.

1000 words.

9.8.21 Is there an additional charge for ad hoc reporting? If so, please provide the average cost per report and the average preparation time.

1000 words.

9.8.22 Confirm that the reports listed above and any others that may be developed throughout the contract term will be reviewed and verified for accuracy prior to distribution.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.23 Confirm that OSC will be provided sufficient information regarding the previous year's renewals to audit them for accuracy and compare them to actual experience.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.24 Included as an attachment to this RFP, please find Segal's current template for renewals. Confirm you will provide, at a minimum, the detail requested in our template. Note this template may be subject to change depending on detail that may be needed for analysis.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.25 The State reimburses Medicare premium to their retirees. Regarding Medicare premium reimbursement, the current carrier sends annual communications to all over 65 members noting the new premium rate and advising when and where to send their premium statements/notifications. They then collect all of the submitted information from Medicare-eligible retirees and their Medicare-eligible dependents and confirm receipt by way of call center calls and email. Confirm your ability to match the current administration process for premium reimbursements. If there are deviations to the above in your process, please describe.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.8.26 The current carrier also sends a monthly file of premium reimbursements to OSC's Core-CT payroll team to upload to OSC's system, which updates the members' monthly reimbursement rates for each month. The

carrier then provides any retro amounts due to the members. The carrier also shares all collected documentation with OSC. Confirm your ability to match the current administration for premium reimbursements. If there are deviations to the above in your process, please describe.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.9 ELIGIBILITY

9.9.1 Confirm that you will update eligibility data within 24 hours from receipt of data.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.9.2 Confirm that you will provide direct same day email confirmation that the eligibility file was received, properly loaded, processed, and that this confirmation will include the date of receipt, for the State Plan and the Partnership Plan.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.9.3 Confirm you will post data, not identified as errant, within 24 hours, for the State Plan and the Partnership Plan.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.9.4 Confirm that your organization will not enroll or cancel OSC members on its own unless there is a conflict from CMS.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.9.5 Discuss how you manage enrollment discrepancies (i.e., issues with Medicare acceptance of enrollment request) with the OSC and its designees.

1000 words.

9.9.6 If a conflict from CMS is found, confirm that the conflict information will be reported back to OSC within one business day so OSC can correct and retransmit their records.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.9.7 Confirm that you will be responsible for validating participant eligibility through CMS.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.9.8 Can the State staff make eligibility changes online?

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No

9.9.9 Explain your process of working error reports generated from the file loads.

1000 words.

9.9.10 Confirm that your organization will store member-level detail and will include it on any member-level reporting back to OSC.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.9.11 Confirm that your organization will generate a reconciliation file monthly or on demand and that this file will contain, at a minimum, demographics, enrollment date, and cancel date.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.9.12 Describe the processing procedures to ensure files are received and processed timely. What safeguards are in place to detect missing files?

1000 words.

9.9.13 Confirm that you will stop an eligibility upload in the event that established error thresholds are exceeded, and that you will communicate this event to the OSC within 24 hours of the stop.

Single, Radio group.
1: Confirmed: [500 words] ,
2: Not confirmed: [500 words]

9.9.14 Describe the procedures in place to accommodate a confidential mailing address as required by Title II of HIPAA.

Unlimited.

9.9.15 How much historical eligibility information is maintained on an individual's file? How much is accessible online, real time versus archived?

1000 words.

9.9.16 Describe your ability to manage CMS eligibility issues and how you propose to work with OSC staff on these issues.

1000 words.

9.9.17 Describe your internal processes to locate a member's physical address and other necessary contact or enrollment information, if the information is not initially provided on an enrollment file. Outline the Bidder's responsibilities and any OSC responsibilities that are part of this process.

1000 words.

9.9.18 Describe how you address CMS eligibility issues for members that only have a P.O. Box address.

1000 words.

9.9.19 Confirm that there will be no minimum participation requirements.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

9.10 COORDINATION OF BENEFITS (COB)

9.10.1 Confirm that, at a minimum, your organization will accept and use the COB data provided by OSC in the 834 files to process claims.

Single, Pull-down list.
1: Confirmed,
2: Not confirmed

9.10.2 Indicate whether you have any sources of COB information in addition to the information received in OSC's 834 file.

Unlimited.

9.11 STAR RATING MAXIMIZATION AND RISK ADJUSTMENT STRATEGIES

9.11.1 In the table below, provide your CMS Five-Star Quality Rating used for pricing the 2023 - 2025 national MA or MA-PD PPO plan you will be offering, and comment on the ratings (or lack of ratings, if applicable).

CMS Five-Star Quality Rating	2023	2024	2025	Comments
Staying Healthy: Screenings, Tests and Vaccines	*500 words.*	*500 words.*	*500 words.*	*500 words.* Nothing required
Managing Chronic (Long-Term) Conditions	*500 words.*	*500 words.*	*500 words.*	*500 words.* Nothing required
Member Experience with Health Plan	*500 words.*	*500 words.*	*500 words.*	*500 words.* Nothing required
Member Complaints and Changes in the Health Plan's Performance	*500 words.*	*500 words.*	*500 words.*	*500 words.* Nothing required
Health Plan Customer Service	*500 words.*	*500 words.*	*500 words.*	*500 words.* Nothing required
Drug Plan Customer Service	*500 words.*	*500 words.*	*500 words.*	*500 words.* Nothing required
Member Complaints and Changes in the Drug Plan’s Performance	*500 words.*	*500 words.*	*500 words.*	*500 words.* Nothing required

Member Experience with the Drug Plan	*500 words.*	*500 words.*	*500 words.*	*500 words.* Nothing required
Drug Safety and Accuracy of Drug Pricing	*500 words.*	*500 words.*	*500 words.*	*500 words.* Nothing required
Total Five-Star Quality Rating	*500 words.*	*500 words.*	*500 words.*	*500 words.* Nothing required

9.11.2 Describe your plans for CMS Star Rating maximization.

1000 words.

9.11.3 Describe your approaches to risk adjustment. Include in your response any innovative programs you use to improve the accuracy of the risk scores and any increase in scores you have been able to achieve.

1000 words.

9.11.4 Describe your process for reconciling member risk scores with risk scores on file with CMS, tracking member risk scores, and tracking the financial impact of risk-adjusted scores.

1000 words.

9.11.5 How do your risk adjustment strategies impact the pharmacy risk score?

1000 words.

9.11.6 How will rate adjustments be handled if CMS changes the formula or process for risk adjustments?

1000 words.

9.11.7 How does your organization work to maximize risk scores for individuals aging into Medicare?

1000 words.

9.11.8 What does your organization do to educate providers on the importance of complete medical record documentation to support the data used for risk adjustment?

1000 words.

9.11.9 What provisions are in your provider contracts to incent them to routinely input complete medical documentation, including documentation of known chronic conditions?

1000 words.

9.11.10 How do you work with contracted providers to ensure they routinely input complete medical documentation?

1000 words.

9.11.11 How do your risk adjustment strategies impact the pharmacy risk score?

500 words.

9.12 DATA REPORTING TO CMS

9.12.1 What controls does your organization have in place to ensure all required data is sent to CMS for each data collection period?

1000 words.

9.12.2 What does your organization do to audit the quality and completeness of provider claims data?

1000 words.

9.12.3 Provide your book of business prescription drug event (PDE) error rate for 2023 and 2024.

1000 words.

9.13 MEDICAL MANAGEMENT

9.13.1 GENERAL

9.13.1.1 Describe in detail all programs and services, such as wellness programs, disease management programs, case management programs, pharmacy utilization management programs, dieticians, social workers, engagement rates, etc. you will offer with this plan that may control costs. Describe how these programs and services have been designed for a senior population.

1000 words.

9.13.1.2 Describe your approach to large case management and complex care, including any specialty programs that are included in your proposal. Describe any special programming for High cost/high risk, Oncology, Transplant, Maternity, NICU, ESRD/CKD, Musculoskeletal, Cardiovascular, behavioral health, and substance use.

1000 words.

9.13.1.3 Describe how your program design enhances quality of care, including how you engage targeted individuals and how you improve health status and clinical outcomes.

1000 words.

9.13.2 DISEASE MANAGEMENT

9.13.2.1 Describe how enrollees are identified for a disease management program, how frequently the process occurs and stratification processes. What data sources are utilized? How are comorbidities handled?

1000 words.

9.13.2.2 Once identified for the program, is enrollment into the program automatic or must action be taken to enroll (i.e., is the program opt-in or opt-out)?

1000 words.

9.13.2.3 Provide a timeline from identification of the enrollee to point of contact. Do all identified members receive a telephone call? If not, please describe outreach protocol.

1000 words.

9.13.2.4 OSC provides point solutions on the commercial medical plan to address certain disease conditions and wellness efforts. It is our intent that those enrolled in particular point solution programs are able to continue to do so when they convert to the Medicare Advantage plan. Confirm you will be willing to directly contract with these programs to allow continued participation for Medicare Advantage members. Two programs of particular are of most interest to OSC, Flyte medical weight loss program (State of Connecticut - Aetna Medicare - Join FlyteHealth) and Virta Diabetes Management & Diabetes Reversal (Sustainable Weight Loss and Diabetes Reversal | Virta Health).

1000 words.

9.13.3 CASE MANAGEMENT

9.13.3.1 Indicate which of the following Case Management components are offered by your organization:

Case Management	Offered
a. Pre-admission outreach	*Single, Radio group.* 1: Yes, 2: No
b. In-patient confinement outreach	*Single, Radio group.* 1: Yes, 2: No
c. Discharge planning	*Single, Radio group.* 1: Yes, 2: No
d. Post-discharge outreach	*Single, Radio group.* 1: Yes, 2: No
e. Catastrophic/long-term Case Management	*Single, Radio group.* 1: Yes, 2: No
f. Episodic/short-term Case Management	*Single, Radio group.* 1: Yes, 2: No
g. End-of-life program identification and transition	*Single, Radio group.* 1: Yes, 2: No
h. Other	*200 words.* Nothing required

9.13.3.2 It is important to OSC that members are consistently informed of discharge planning activities, denials related to post discharge levels of care and educated on the criteria necessary to be admitted to post hospital facilities. Communication with hospital discharge planners and case mangers is critical to achieving this goal. How will your case management program achieve this?

1000 words.

9.13.3.3 Do you have the capability to customize denial and authorization letters to include the contact information of the carrier's case manager managing the case?

1000 words.

9.13.3.4 Do you have hospital based on-site case managers? How many do you have? What are their locations?

1000 words.

9.13.3.5 How are requests for care after-hours handled? By whom?

1000 words.

9.13.3.6 Describe the criteria and process for case management referrals to the Medical Director, specialty programs, and community resources including how you address social drivers of health.

1000 words.

9.13.3.7 Describe your value-based arrangements with providers. How do these arrangements encourage and partner with providers to better manage care and improve outcomes - provide as much detail of the program as possible including quality metrics, risk levels, care coordination fees etc. Please list the specific provider groups participating in each type of value-based arrangement and how the number may increase if you administer the state employee MAPD plan.

1000 words.

9.13.3.8 Prior authorization for skilled nursing care is a particularly sensitive issue. Describe in detail, the approval process for inpatient skilled nursing care. What is your denial rate, appeal rate and overturn rate upon appeal for this specifically? What efforts have you undertaken to reduce denial rates?

1000 words.

9.13.4 UTILIZATION MANAGEMENT

9.13.4.1 Outline your organization's programs and options related to utilization management, concurrent review, retroactive review, appeals, and cost containment. Include a description of Medical Director involvement on clinical review, peer-to-peer, denials, and appeals.

1000 words.

9.13.4.2 Please respond to the following Utilization Management questions:

Utilization Management	Offered
a. What do you require prior authorization for? Is it customizable and is there a fee?	*1000 words.*
b. Confirm OSC will have the ability to include or exclude specific services from medical necessity review.	*Single, Radio group.* 1: Yes, 2: No
c. Describe what you perform concurrent review on and how often.	*1000 words.*
d. Do you offer Retrospective Review?	*Single, Radio group.*

	1: Yes, 2: No
e. Do you perform Discharge Planning as part of Utilization Management? Describe discharge planning as part of your UM process.	*1000 words.*
f. Do you agree to redirect pre-certification requests to in-network providers?	*Single, Radio group.* 1: Yes, 2: No

9.13.4.3 What process is used to provide training for providers regarding Utilization Management issues? How are non-compliant providers identified and educated and/or sanctioned?

1000 words.

9.13.4.4 Describe in detail your capabilities and processes regarding discharge planning. Include how many on-site (in facility) and remote case managers you propose at the various facilities statewide to serve the OSC membership to minimize as much as possible any disruption during the discharge or transition of care process.

1000 words.

9.13.4.5 Please complete the table below on provider advocates:

	Response
Number of provider advocates physically working in the State of Connecticut	*Integer.*
Number of provider advocates working telephonically in the State of Connecticut	*Integer.*
Number of provider advocates working on this account in a remote setting (outside Connecticut)	*Integer.*
Add any detail you would like to include about your provider advocates services	*1000 words.*

9.13.4.6 What guidelines are used to determine medical necessity? How do you ensure the guidelines align with the OSC's benefit intent and not necessarily the intent of the Medicare guidelines? What is the frequency for evaluating and updating/revising the guidelines/protocols?

500 words.

9.13.4.7 Describe your process to comply with the annual health equity analysis of utilization management policies and procedures per the Contract Year 2025 Medicare Advantage and Part D Final Rule.

1000 words.

9.13.5 ADDITIONAL MEDICAL MANAGEMENT QUESTIONS

9.13.5.1 Describe any efforts used to educate members of available behavioral health services. Also describe education efforts to medical providers and facilities of your behavioral health services so that members who could benefit from those services can be referred if presenting at a medical provider.

500 words.

9.13.5.2 Describe any value-based contracting practices you have in place and in development both nationally and in Alabama (to the extent permitted by CMS). Please list the entities in Connecticut under such contracts.

500 words.

9.13.5.3 Describe any current or planned "bundled payment/episodes of care" arrangements with Providers. Please list the entities in Connecticut under such contracts.

500 words.

9.13.5.4 Describe any other "total cost of care" reduction programs. Please list the entities in Connecticut under such contracts.

500 words.

9.13.5.5 Describe the support you provide to members that reside in lower income zip codes to access/link to community-based services including any tools to help members access and use virtual health care services.

500 words.

9.14 REDUCING HEALTH DISPARITIES AND COMMITMENT TO COMMUNITY PARTNERSHIPS

The State is committed to advancing health equity, reducing disparities, and improving access to services for communities experiencing inequities. Respondents are required to propose an intervention to address social determinants of health. This includes the identification and elimination of health disparities faced by participants enrolled with the State programs, whether based on race, ethnicity, sexual orientation, geography, age, gender, disability status, socio-economic background, or other factors.

9.14.1 Access to network providers in underserved zip codes: Provide the current count of network providers in your organization whose practices are physically located in each of lower income zip codes that have enrolled members for the group.

	Zip code # 1 – 06360 – Norwich, CT	**Zip code # 2 – 06268 – Storrs Mansfield, CT**	**Zip Code #3 – 06053/50– New Britain CT**	**Zip Code #4 06450 Meriden, CT**	**Zip Code #5 06226 Willimantic, CT**
Primary Care Providers/Internist/Geriatrics	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*
OB/GYNs	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Endocrinologists	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Psychiatry/Psychology	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Immunologist/Allergist	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Cardiologist	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Gastroenterologist	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Substance Use Disorder specialists	*Integer.*	*Integer.*	*Integer.*	*Integer.*	*Integer.*

9.14.2 Describe the support you provide to members that reside in lower income zip codes to access/link to community-based services including any tools to help members access and use virtual health care services.

1000 words.

9.14.3 Does the network incorporate providers who offer culturally responsive approaches to care? Describe.

1000 words.

9.14.4 How diverse is your physician/health professional/provider network panel? Provide percentage of providers by race for the network being proposed.

1000 words.

9.14.5 Describe efforts to recruit minority providers.

1000 words.

9.14.6 Do you track member satisfaction by gender and race (if permissible)?

1000 words.

9.14.7 Can you track and report clinical outcomes results by zip code, gender and race? If so, explain how outcomes are tracked and provide sample reports.

1000 words.

9.14.8 Detail any investments/charitable contributions (lend expertise, etc.) you make in underserved and minority communities to improve health literacy, access and outcomes.

1000 words.

9.14.9 How do you address local community issues when applying care management strategies to plan participants?

1000 words.

9.14.10 Describe programs that address improving nutrition and access to healthier food choices.

1000 words.

9.14.11 Describe the criteria and process for case management referrals to the Medical Director, specialty programs, and community resources including how you address social determinates of health.

1000 words.

9.15 FINANCE AND BANKING

9.15.1 Please provide a sample detailed invoice.

Single, Radio group.
1: Attached,
2: Not attached, explain: [500 words]

9.15.2 Currently, OSC can remit payment for an invoice via ACH transfer. Confirm that you are able to accept this payment format.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

9.15.3 Confirm you will provide invoices/billing on a monthly basis.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

9.15.4 Confirm you will provide invoices/billing to each Participating Employer in the Partnership Plan monthly and are able to accept payment from each via ACH transfer or by check.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

10 NATIONAL MA/MA-PD PPO QUESTIONNAIRE

10.1 PLAN DESIGN

OSC wishes to procure a Fully insured, national MA and/or MA-PD PPO plan with the same benefits for services rendered in-network and out-of-network. The MA/MA-PD PPO should function as a passive PPO that provides the same level of benefits for retirees when they see a provider outside the network that accepts Medicare. The national MA/MA-PD PPO plan you propose must meet all CMS requirements, and any benefits not delineated in the plan design must be covered at least at the minimum requirement set by CMS. **Bidder may not deviate downward from these plan designs in any manner other than to meet CMS requirements, and the plan design proposed must be at least equal to the current plan.** Any such deviations must be noted on Attachment B. Please note that diabetic drugs and supplies are covered in full for all plans. You may offer supplemental benefits and/or enhanced benefits as long as they are at no cost to OSC and its membership. Please review https://ct.aetnamedicare.com/coverage-and-benefits/plan-benefits-and-forms for retiree plan designs based on retirement date.

10.1.1 Confirm you will be able to replicate the current plan design for the national MA/MA-PD PPO plan, with the same benefits for services rendered in-network and out-of-network for medical and Part D prescription drug services, if applicable. If not, indicate any deviations.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

10.1.2 If you are offering additional supplemental benefits and/or enhanced benefits, please describe.

1000 words.

10.1.3 Please describe how your plan covers emergency services incurred outside of the U. S.

1000 words.

10.1.4 The OSC and Partnership Plans offer certain benefits that are required by the plan. Such benefits include:

- Hearing aids with no member cost
- Routine vision exams including refraction
- Chiropractic care
- Coverage for Naturopathic Providers
- Routine foot care
- Acupuncture

Confirm you will duplicate these benefits as part of your proposal.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

10.1.5 Describe how you will administer each of these benefits to match the OSC's current benefit levels and administration.

Benefits	Benefit Administration
Hearing aids	*1000 words.*
Routine vision exams including refraction	*1000 words.*
Chiropractic care	*1000 words.*
Coverage for Naturopathic Providers	*1000 words.*
Routine foot care	*1000 words.*
Acupuncture	*1000 words.*
Other	*1000 words.*

10.1.6 The OSC and Partnership Plans offer a more robust behavioral health benefit than Medicare allows. For example, Medicare only covers a certain level of therapist, which is a lower level of care than what the OSC and Partnership Plans provide. Describe your ability to match the current level of behavioral health benefit offered by the plan. If there is an additional charge related to matching the current benefit level, please indicate in your Price Proposal.

Unlimited.

10.1.7 Describe any enhanced benefits you offer to members regarding transportation to/from provider appointments, medical facilities, etc.

1000 words.

10.1.8 Do you offer a discounted hearing aid network or any other cost savings program for the State? Please describe.

1000 words.

10.1.9 Describe any member rewards or incentive programs you offer to promote wellness.

1000 words.

10.2 NETWORK ACCESS AND MANAGEMENT

10.2.1 Indicate in which of the 50 states and U.S. territories your organization is licensed to offer employer-sponsored, network-based MA/MA-PD solutions.

1000 words.

10.2.2 What is your percentage of network adequacy with regard to the 51% rule based on OSC's membership?

1000 words.

10.2.3 Please complete the following table:

	Response
a. Based upon the retiree census data (provided to Bidders with a fully executed NDA), identify any areas in which you are filed to operate where your provider network and network pharmacies may not have adequate capacity to meet the potential demand.	*500 words.*
b. How is adequacy determined by your organization?	*500 words.*
c. What are your plans for expansion in these areas?	*500 words.*
d. What is your solution to meet the pharmaceutical needs of members who live in areas where pharmacy access is inadequate?	*500 words.*
e. Indicate any areas where your network access does not meet the CMS-standard access requirements.	*500 words.*

10.2.4 Describe in detail your organization's approach to contract with providers currently utilized by OSC members. Include in your response how you outreach to providers, build and maintain relationships, work through contractual issues, etc. to bring them into your network.

1000 words.

10.2.5 2.5 Are members restricted from using physicians and hospitals of their choice?

1000 words.

10.2.6 Describe how your organization will target and educate providers that are considered out-of-network in the analysis above.

1000 words.

10.2.7 For out of network providers, how are provider prices determined? Generally, how do these prices compare to your in-network pricing?

1000 words.

10.2.8 Provide a list of hospitals and large out-of-network provider groups that are not currently willing to treat or bill for members on your plan. What plans do you have to facilitate engagement with these providers?

1000 words.

10.2.9 An Excel file labeled Medical Providers and Rx Pharmacies - Attachment H - is a provider utilization file representative of the medical and Rx utilization experience for the OSC's Medicare-eligible retirees and their Medicare-eligible dependents for this plan. For each provider listed, please indicate if the medical provider or pharmacy is in your proposed network (i.e., a participating provider) based on the instructions in the file.

Single, Radio group.

1: Attached,
2: Not attached, explain: [500 words]

10.2.10 Describe how your organization will target and educate providers that are considered out-of-network in the analysis above, particularly if those providers are highly utilized by OSC members.

1000 words.

10.2.11 What PBM do you currently use? How long have they been in place? When does your current contract with your PBM expire?

1000 words.

10.2.12 Provide the name of your proposed pharmacy retail network.

1000 words.

10.2.13 List any major pharmacy chains excluded from your network.

1000 words.

10.2.14 Confirm any retail pharmacy in your proposed pharmacy retail network will dispense a covered script regardless of days' supply (e.g., 0-90 days' supply).

Single, Radio group.
1: Confirm, explain: [500 words] ,
2: Not confirmed, explain: [500 words]

10.2.15 Should the OSC wish to add a retail pharmacy to the network, confirm you will contact the pharmacy and offer the contract for network inclusion within two (2) business days following the OSC's request. Please confirm your willingness to comply with this provision.

1000 words.

10.2.16 Provide a summary of the disruption analysis using your proposed Broad Retail Network using the table below:

Type of Change	**Broad Retail (1-90 days' supply) Network**
Number of Currently Utilized Retail Pharmacies that are Not Part of Proposed Network and are Eligible to Solicit	*Integer.*
Number of Members that are Using Those Retail Pharmacies that are Not Part of Proposed Network and are Eligible to Solicit	*Integer.*
Number of Prescriptions that Adjudicated via Those Retail Pharmacies that are Not Part of Proposed Network and are Eligible to Solicit	*Integer.*
Number of Currently Utilized Retail Pharmacies that are Part of Proposed Network	*Integer.*
Number of Members that are Using Those Retail Pharmacies that are Part of Proposed Network	*Integer.*
Number of Prescriptions that Adjudicated via Those Retail Pharmacies that are Part of Proposed Network	*Integer.*

10.2.17 Who manages your mail order services?

1000 words.

10.2.18 If a submitted mail order claim for a member cannot be completed in its entirety within a designated timeframe, what communications are provided to the member and what policy is followed for splitting orders? How is the un-sent portion of the order tracked from the time of splitting until fulfillment?

1000 words.

10.2.19 Describe your proposed specialty pharmacy network and services.

1000 words.

10.2.20 Provide details on the plan for transition of members engaged in treatment and how continuity of care can be assured when a member changes carriers. Discuss in detail how cases are transmitted if a provider terminates the contractual relationship with Vendor during the plan year.

500 words.

10.2.21 How do you manage your specialty drug program? Provide a description of the specialty drug program, including coordination with medical providers and the medical claims administrator.

1000 words.

10.2.22 The State's plan includes a Preferred Mail Order and Retail network at which members can receive up to a 90-day supply of lower cost drugs to treat certain chronic conditions (asthma or COPD, heart disease/heart failure, hypertension and cholesterol).Please indicate if you would recommend this same benefit and the pricing differential between applying this benefit and not.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

10.2.23 If an individual has prescription drug coverage under the State's Rx plan and also enrolls in another Medicare Part D prescription drug plan, how do you identify such a situation at the point of sale?

1000 words.

10.2.24 How will rate adjustments be handled to reflect reduced plan costs from Medicare direct negotiations with manufacturers? What information will be provided to the state to validate the rate impact of Medicare negotiated reimbursement rate.

1000 words.

10.2.25 Describe any provider advocacy services or programs you offer between your organization and providers including education, communication and support for providers including items such as:

- payment services and policies and claim payment issues
- provider relations and outreach strategies
- types of providers included
- topic specific education
- changes such as new products or policies
- practice-based support
- alignment with local and statewide provider societies continuous improvement

1000 words.

10.2.26 Please complete the table below on provider advocates:

	Response
Provider advocates physically working in the State of Connecticut	*Integer.*
Provider advocates working on this account in a remote setting	*Integer.*
Add any detail you would like to include about your provider advocates services	*1000 words.*

10.2.27 Describe any processes, interactions and resources you employ to support providers with payment services and policies including items such as:

- claims filing and processing
- coding
- clinical criteria and code editors
- coverage determinations
- prior authorizations
- rejected claims or claims denial outreach
- medical necessity denials verses admin denials
- other carrier policies
- escalated issues and quick/accurate issue resolutions
- review of trends for targeted and ongoing education

1000 words.

10.2.28 Does your organization provide satisfaction surveys to providers? If so, describe the survey and uses of results. Please provide the results of the latest survey.

1000 words.

10.2.29 Confirm you offer a comprehensive behavioral health network that includes a variation of providers such as Psychiatrists (MDs), Psychologists, Therapists, Counselors, Social Workers, DEA waiver providers, etc.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

10.2.30 What percentage of the providers in your behavioral health network are accepting new patients?

Percent.

10.2.31 How many of your network providers are certified in medication assisted treatment (MAT)?

1000 words.

10.2.32 Describe your processes to comply with the improved access to behavioral health care providers guidelines per the Contract Year 2025 Medicare Advantage and Part D Final Rule.

1000 words.

10.2.33 Describe your telemedicine benefit. How is this benefit designed to address the needs of a senior membership?

1000 words.

10.2.34 Describe your network providers' ability to support telehealth visits with their members. *Please note this question and the two below it are specific to members having telehealth visits with their own physicians as opposed to a visit with a provider through a telemedicine carrier.*

500 words.

10.2.35 What percentage of providers in your network offer this benefit?

500 words.

10.2.36 Describe how you support your network provider community to offer telehealth to their patients.

500 words.

10.3 FORMULARY AND CLINICAL MANAGEMENT

10.3.1 OSC is requesting a generic first/lowest net cost formulary. Please confirm this is the formulary you are proposing for this procurement.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

10.3.2 Provide the generic first/lowest net cost formulary listing with your proposal submission.

Unlimited.

10.3.3 Given the changes to the Part D program continuing throughout the length of this contract, describe the generic first/lowest net cost formulary strategy you are proposing for OSC.

1000 words.

10.3.4 Provide the name of the proposed formulary program.

1000 words.

10.3.5 Describe your formulary management support services.

1000 words.

10.3.6 What tools are available to promote formulary compliance and education? Include frequency of mailings, faxes, telephone interventions [provide samples of letters sent to patients, physicians, and pharmacies].

1000 words.

10.3.7 Describe whether your proposal includes an optional supplemental coverage for non-Part D drugs that wraps around the basic Medicare Part D benefits (i.e., bonus drug list) and what this supplemental coverage looks like.

1000 words.

10.3.8 Provide a formulary listing of the non-Part D covered drugs under the supplemental coverage.

1000 words.

10.3.9 How does your organization manage the non-Part D covered drugs?

1000 words.

10.3.10 Confirm your changes to your formulary, from one year to another, will not impact more than two percent (2%) of members.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

10.3.11 Describe how you will work closely with the OSC on the drug formulary to ensure the least amount of member disruption as members transition from the active/non-Medicare plan to the MA/MA-PD plan.

1000 words.

10.3.12 Confirm that you will maintain individual member status of utilization management such as prior authorization approvals, step level, and quantity limit level, at go-live until their individual expiration date if applicable.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

10.3.13 Confirm a member will be able to obtain an excluded prescription through a Prior Authorization for medical necessity.

1000 words.

10.3.14 Describe your Prior Authorization process. Please indicate if you use a third-party vendor. Describe your appeal process of denied Prior Authorizations. Describe how you report Prior Authorizations and appeals to reflect end result and value of Prior Authorizations.

1000 words.

10.3.15 Describe your transition fill process.

1000 words.

10.3.16 Describe your Rx utilization management programs (Prior Authorizations, Quantity Level Limitations, age and gender restrictions, Medication Therapy Management program, high-risk drug programs for the elderly, etc.). In your response, include the process for enrollment, targeting, reporting, and outcomes reporting.

1000 words.

10.3.17 Can the above programs be customized for the OSC's membership?

1000 words.

10.3.18 What is you process to work with the existing MA-PD carrier to ensure such Rx utilization management criteria are transferred properly to your system?

1000 words.

10.3.19 Describe the transition process you will utilize to limit member disruption for those members currently using prescription drugs requiring Rx utilization management criteria. If the process differs for formulary versus non-formulary drugs, please elaborate.

1000 words.

10.3.20 Will members' existing prior authorization or quantity level limits be transitioned and accessible for use by the go-live date? If not, please explain.

1000 words.

10.3.21 How do you mine data from the incumbent vendor for either existing UM rules or new UM rules to identify members that will need UM criteria under the proposed MA-PD plan? How else do you use the incumbent's data to identify better clinical management?

1000 words.

10.3.22 Provide detail on how you will provide the OSC with a list of proposed formulary exclusions, in subsequent years of the contract, that the OSC can review and approve or deny, including any potential fees or charges. Include in your response timing with respect to when you will provide the proposed formulary exclusions to the OSC and when you will need to finalize and file the proposed formulary exclusions with CMS.

1000 words.

10.3.23 Confirm you will provide a detailed disruption with the proposed formulary exclusions.

1000 words.

10.3.24 Confirm you will not charge a fee for the customization of the Formulary.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

10.3.25 With the exception of FDA recalls or other safety issues, confirm you agree not to remove any drug products, brand or generic, from the OSC's non-specialty and specialty formulary or non-specialty and specialty preferred drug listings without notification and prior approval from the OSC.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

10.3.26 How are new drug therapies added to the formulary?

1000 words.

10.3.27 Complete and submit the formulary disruptions based on your proposed formulary with drug exclusions and on the most recent **four months** in the claims data that is provided. Results to be included are the number of members that will require a change as well as the number of prescriptions associated with the formulary change. An Excel file that lists the specific drugs that will be negatively impacted (excluded or higher-cost tier) along with the total number of scripts and members impacted for each of these drugs should also be provided.

1000 words.

10.3.28 Please provide a summary of your formulary disruption based on the most recent four months in the claims data provided and on your proposed formulary with exclusions using the table below:

Type of Change	Member Impact	% of Total Members	Number of Scripts Impacted	% of Total Scripts (including all brands and generics)
No Change	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Positive (higher-cost tier to lower tier)	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Negative (lower tier to higher-cost tier)	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Moving from covered to not covered/Excluded	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Total	*Integer.*	*Percent.*	*Integer.*	*Percent.*

10.3.29 Complete and provide the following table:

	#1 Drug that is Moving from Covered to Not Covered/Excluded based on impacted Members: [Indicate Member and Script Impact.]	**#2 Drug that is Moving from Covered to Not Covered/Excluded based on impacted Members: [Indicate Member and Script Impact.]**	**#3 Drug that is Moving from Covered to Not Covered/Excluded based on impacted Members: [Indicate Member and Script Impact.]**
Name of Drug	*1000 words.*	*1000 words.*	*1000 words.*
Member Impact	*Integer.*	*Integer.*	*Integer.*
% of Total Members	*Percent.*	*Percent.*	*Percent.*
Number of Scripts Impacted	*Integer.*	*Integer.*	*Integer.*
% of Total Scripts (including all brands and generics)	*Percent.*	*Percent.*	*Percent.*
Name of Preferred Alternative	*1000 words.*	*1000 words.*	*1000 words.*

10.3.30 The name of the Formulary you are proposing should be included in your contract. The number of drug exclusions as well as a list of the excluded drugs and the therapeutic alternatives should also be provided as an attachment. Provide Information and Names of Attachments.

1000 words.

10.3.31 Please describe your mail order services and support.

1000 words.

10.3.32 If a submitted mail order claim for a member cannot be completed in its entirety within a designated timeframe, what communications are provided to the member and what policy is followed for splitting orders? How is the un-sent portion of the order tracked from the time of splitting until fulfillment?

1000 words.

10.3.33 Describe your specialty pharmacy services.

1000 words.

10.3.34 How do you manage your specialty drug program? Provide a description of the specialty drug program, including coordination with medical providers and the medical claims administrator.

1000 words.

10.3.35 If an individual has prescription drug coverage under the State's Rx plan and enrolls in another Medicare Part D prescription drug plan, how do you identify such a situation at the point of sale?

1000 words.

10.3.36 Please describe your specialty drug management services. How do you 1) ensure that members are on the most effective medication 2) avoid waste 3) direct members to lower cost alternatives when clinically appropriate

1000 words.

10.3.37 Do you evaluate the effectiveness of high-cost drugs, e.g. collect clinical information on patients to determine if their conditions are improving or well managed on the drug? If so, how do you leverage this information to engage providers or in determining prior authorization approvals? Do you negotiate any drug manufacturer outcomes-based rebates for high-cost medication outcomes? If so, describe the nature of these performance measures.

1000 words.

10.3.38 Please describe your biosimilar strategy. When do you prefer biosimilars, how do ensure the formulary includes all appropriate clinical alternatives and prefers lowest net cost bio-similar options. Please use your Humira biosimilar policy as an example to highlight your decision making and note the net costs of the biosimilars preferred on the formulary.

1000 words.

10.3.39 Please confirm that you would allow the state to make formulary adjustments based upon recommendations from its contracted third-party formulary advisor and that you would provide estimated financial and member impact of any such proposed adjustments. Confirm that you agree the PMPM guarantee will be adjusted based upon difference between the net costs of the state initiated and approved formulary change and the net cost of the PBMs standard formulary, positive and negative. The final reconciliation will use actual claims experience, not projected impact.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

10.3.40 Provide the name of the Specialty Formulary you are proposing. If applicable, provide the number of drug exclusions as well as a list of the excluded drugs and the therapeutic alternatives. Provide Information and Names of Attachments.

1000 words.

10.3.41 Provide a complete list of your additional clinical programs not included in your base offering with pricing associated with each program and highlight those programs recommended for the OSC. Describe the type of impact members will face for each of these programs. Indicate the name of the attachment containing this list and respective pricing.

1000 words.

10.3.42 Confirm you will allow the OSC to make edits and modifications to your standard PA criteria.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

10.3.43 Confirm you will allow the OSC to remove and/or add PAs and quantity limits on an individual drug level.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

10.3.44 Confirm the OSC will have the authority to override the vendor regarding decisions on individual medication choices of members.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

10.3.45 Confirm you will keep accurate and detailed information regarding every PA the Bidder approves and such information will be available for the OSC's review upon request.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

10.3.46 How does your organization use pharmacy data to identify high risk, high need populations?

1000 words.

10.3.47 Describe how members receive reminders regarding refills and medication adherence.

1000 words.

10.3.48 Confirm your capabilities surrounding e-Prescribing. Would the member's physician be able to see the formulary status of a drug and enter the prior authorization criteria into the e-Prescribing tool?

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

10.3.49 How are individual physician prescribing patterns monitored? What action is taken with physicians who have a high degree of non-compliance to improve their compliance?

1000 words.

10.3.50 Confirm you are able to administer a Medicare B vs. D program at point of sale, at no additional cost to OSC.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

10.3.51 Confirm that you will report to OSC and OSC's designated health care consultant rebates received associated with the reimbursement of Medicare Part B drugs at least quarterly.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

10.3.52 How do you manage waste - e.g. 14 months of medication dispensed in a 12-month calendar year, required 90-day fills when a lower amount is requested by provider, autofill for medications that are used inconsistently (seasonal asthma, topical creams etc.)Have you identified specific drug therapies that are more prone for waste? If so, what methods can the State employ to reduce future waste for these drug therapies?

1000 words.

10.3.53 What are your standard PA criteria GLP-1s, specifically Ozempic and Monjauro - please share? Please confirm that your standard PA does not negatively impact rebates. Are adjustments to your standard PA requirement allowable, what can be changed to reduce off label utilization without losing the rebates?

1000 words.

10.3.54 Please describe your specialty drug management services. How do you 1) ensure that members are on the most effective medication 2) avoid waste 3) direct members to lower cost alternatives when clinically appropriate.

1000 words.

10.3.55 Do you evaluate the effectiveness of high-cost drugs, e.g. collect clinical information on patients to determine if their conditions are improving or well managed on the drug? If so, how do you leverage this information to engage providers or in determining prior authorization approvals? Do you negotiate any drug manufacturer outcomes-based rebates for high-cost medication outcomes? If so, describe the nature of these performance measures.

1000 words.

10.3.56 Please describe your biosimilar strategy. When do you prefer biosimilars, how do ensure the formulary includes all appropriate clinical alternatives and prefers lowest net cost bio-similar options. Please use your Humira biosimilar policy as an example to highlight your decision making and note the net costs of the biosimilars preferred on the formulary.

1000 words.

10.3.57 Please confirm that you would allow the state to make formulary adjustments based upon recommendations from its contracted third-party formulary advisor and that you would provide estimated financial and member impact of any such proposed adjustments. Confirm that you agree the PMPM guarantee will be adjusted based upon difference between the net costs of the state initiated and approved formulary change and the net cost of the PBMs standard formulary, positive and negative. The final reconciliation will use actual claims experience, not projected impact.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

10.3.58 Please describe your pharmacy reimbursement strategy. Do you reimburse pharmacies on an AWP-basis. Do you provide dispensing fees? As a result of cost efficiencies, are the per script dispensing fee costs from mail order and retail 90-day prescriptions producing savings to the plan over a year of supply? If so, provide the actual dispensing fee savings advantage to the State for maintenance drugs (not what you charge the client but what the actual costs are per Rx to dispense a 30-day fill and a 90-day fill)?How closely does your reimbursement track to acquisition costs for brand and generics, if at all?

1000 words.

10.3.59 The State requests the exploration of direct manufacturer contracting for high-cost medications such as GLP-1's to help control costs to the plan. In certain instances, the state plan utilization or programmatic needs may not align with the standard manufacturer contract held by the PBM - this could also occur if the state prefers an alternative brand drug. Please confirm that you would be willing to, and in certain cases proactively, engage manufacturers in unique contractual arrangements to best meet the state's needs.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

10.4 IMPLEMENTATION

10.4.1 Provide an Implementation Project Plan for the national MA-PD PPO plan. Include a detailed timetable assuming a Notice of Contract Award by June 1 for a January 1, 2026 Program ‘go-live' date. Note that OSC's Open Enrollment Period for retirees takes place in October through December for coverage beginning January 1. Development of communications is expected to commence immediately to assist OSC with any communications necessary prior to Open Enrollment. At a minimum, the Implementation Project Plan must provide specific details on the following:

a. Identification and timing of significant responsibilities and tasks

b. Names, titles, and implementation experience of key implementation staff and time dedicated to OSC during implementation

c. Identification and timing of OSC's responsibilities

d. Transition requirements with the incumbent vendors

e. Staff assigned to attend and present (if required) at Open Enrollment/educational sessions

f. Member communication plan - including development and assistance to OSC, prior to Open Enrollment, and on-site Open Enrollment meetings

g. Data and timing requirements from current vendors to ensure transition of care and prior-authorization data is appropriately transferred.

Single, Radio group.
1: Attached,
2: Not attached, explain: [1000 words]

10.4.2 Demonstrate how your organization will test the program to ensure claims will process correctly on the Program ‘go-live' date of January 1, 2026. Confirm you will conduct testing with an actual retail pharmacy from the Point-of-Sale transaction to a completed transaction where the pharmacy successfully processes the prescription drug claim for a successful fill of the medication, if applicable.

1000 words.

10.4.3 Describe the process and timing if the OSC elects to perform a third-party pre-implementation audit. Please include in your response the development of testing scenarios, the duration of the audit and any blackout audit dates, the format of the audit and whether there will be a “live” webinar where the OSC and third-party auditor can see claims being adjudicated on the Vendor's system).

1000 words.

10.4.4 If the answers differ for the medical program audit component versus the prescription drug plan (PDP) audit component, please outline the differences.

1000 words.

10.4.5 Provide an implementation and audit timeline inclusive of key milestones and stakeholders related to coding, program confirmation and document execution, internal audit/quality assurance review and testing, external audit kickoff, process and timing, reconciliation of findings or issues for changes or plan intent confirmations, go-live date and post-implementation audit kickoff and process, etc.

1000 words.

10.4.6 Are you willing to provide a one-time implementation allowance to fund, as approved by OSC, implementation support, pre-implementation audits, readiness assessments, communication plans, outside printing costs, etc.? What dollar amount are you willing to provide?

1000 words.

10.4.7 Identify the Implementation Team you propose to assign to this account and provide an organization chart defining the Implementation Team roles. Include names and titles for the entire proposed Implementation Team including key positions and support staff.

1000 words.

10.4.8 Please provide resumes and MA-PD experience and qualifications for each individual, listed in the organization chart provided to respond to the above question.

1000 words.

10.4.9 Confirm that all OSC members will have a valid ID card in hand prior to January 1, 2026.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

10.4.10 Confirm your organization will provide a status report on the Implementation Project Plan detailing current activities, closed tasks, problems, and any recommendations.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

10.4.11 How long will the Implementation Team stay involved after the Program ‘go-live' date for troubleshooting before a handoff to the Account Management team?

1000 words.

10.5 COMMUNICATION AND EDUCATION

10.5.1 Describe how your organization can effectively communicate with and educate OSC's retirees about your programs and services available to them.

1000 words.

10.5.2 What will be your communication and education strategy, and why do you think this strategy is the right one?

1000 words.

10.5.3 How will you implement this strategy?

1000 words.

10.5.4 4 Please list all communication and educational materials CMS requires you to provide to members.

1000 words.

10.5.5 What do you provide above and beyond what CMS requires?

1000 words.

10.5.6 Provide samples of communications and educational materials.

Single, Radio group.
1: Attached,
2: Not attached, explain in comments: [500 words]

10.5.7 Confirm that letters are able to be customized with OSC's logo as requested by OSC.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain in comments: [500 words]

10.5.8 Confirm that OSC will be provided an opportunity to review and approve all communication materials (including letters, brochures, electronic, website, etc.) prior to being sent to members and providers.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain in comments: [500 words]

10.5.9 Identify your standard communication materials and indicate those that can be customized at no additional charge and those that require an additional charge. Indicate fee if there is an additional charge.

	Response	Amount of Fee
Member ID Cards	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Claim Forms	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Summary Plan Description	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Summary of Material Modifications	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Internet Access	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
General Letters and Correspondence sent to Participants	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*

Annual Benefit Statements	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
HIPAA Privacy Notices	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
HIPAA Proof of Coverage document	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*

10.5.10 What materials do you create and distribute to MA/MA-PD members? Provide a copy of the most recent materials such as any newsletters, brochures, flyers, etc. Confirm that OSC may review the member materials in advance and that you will respect a request by OSC to not send a communication to OSC members if, in OSC's discretion, the information contained therein would not apply to its members or cause confusion. *1000 words.*

10.6 SELF-FUNDED MEDICARE SUPPLEMENT EXEMPTION PLAN

10.6.1 PLAN DESIGN

It is understood that in extremely rare cases, Medicare providers may refuse to treat patients enrolled in a Medicare Advantage plan. State members may apply to be enrolled in a self-funded Medicare Supplement Exemption Plan if they meet a strict list of criteria. It is important to note that there are not currently any members eligible for participation in this offer, however, OSC is required to have the option available for any potential members. Eligibility criteria are:

- The only licensed hospital or tertiary hospital within a 25-mile radius refuses to accept the Connecticut Retiree Health Medicare Advantage Plan patients. Excluded from these criteria would be hospitals or providers that are willing to provide services to a member but simply unwilling to bill the Medicare Advantage plan. In this event, members must pay the hospital or provider directly and submit claims to the Medicare Advantage plan administrator for reimbursement.
- Member is being treated by a specialty provider for an advanced episodic health condition, such as cancer, HIV, or multiple sclerosis, who refuses to continue treatment due to Connecticut Retiree Health Plan Medicare Advantage Plan enrollment. Provider must accept Medicare. Additionally, member must have received care from this specialty provider within the last six months and such care must be documented by a medical claim.
- Member's provider attests that a particular specialty provider is the most appropriate provider to care for the member's condition. Absent exigent circumstances, the attesting provider should be a treater recommending the provider for which the exclusion is needed meaning a provider cannot self-attest to their own services.
- Member has developed an episodic or chronic health condition and the only specialist group within 25 miles that treats this condition refuses to accept Connecticut Retiree Health Medicare Advantage Plan patients. Provider/Provider group must accept Medicare. Additionally, for continued exemption member must have a claim on record within six months at the time of annual review.

OSC seeks to procure a self-insured Medicare Supplement plan. This plan must mirror the same retiree plan designs established for the MA/MAPD plan, as outlined here: https://ct.aetnamedicare.com/coverage-and-benefits/plan-benefits-and-forms

10.6.1.1 Confirm you will be able to replicate the current plan design for the MA/MAPD plan. If not, indicate any deviations.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

10.6.1.2 Indicate in which of the 50 states and U.S. territories your organization is licensed to offer a Medicare Supplement plan.

1000 words.

10.7 IMPLEMENTATION

10.7.1 Provide an Implementation Project Plan for the Self-funded Medicare Supplement plan. Include a detailed timetable assuming a Notice of Contract Award by June 1 for a January 1, 2026 Program 'go-live' date. Note that OSC's Open Enrollment Period for retirees takes place in October through December for coverage beginning January 1. Development of communications is expected to commence immediately to assist OSC with any communications necessary prior to Open Enrollment. At a minimum, the Implementation Project Plan must provide specific details on the following:
a. Identification and timing of significant responsibilities and tasks
b. Names, titles, and implementation experience of key implementation staff and time dedicated to OSC during implementation
c. Identification and timing of OSC's responsibilities
d. Transition requirements with the incumbent vendors
e. Staff assigned to attend and present (if required) at Open Enrollment/educational sessions

1000 words.

10.7.2 Identify the Implementation Team you propose to assign to this account and provide an organization chart defining the Implementation Team roles. Include names and titles for the entire proposed Implementation Team including key positions and support staff.

1000 words.

10.7.3 Please provide resumes and Part D EGWP experience and qualifications for each individual, listed in the organization chart provided to respond to the above question.

1000 words.

10.7.4 Confirm that all OSC members will have a valid ID card in hand prior to January 1, 2026.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [1000 words]

10.8 COMMUNICATION AND EDUCATION

10.8.1 Describe how your organization can effectively communicate with and educate OSC's retirees about your programs and services available to them.

1000 words.

10.8.2 What will be your communication and education strategy, and why do you think this strategy is the right one?

1000 words.

10.8.3 How will you implement this strategy?

1000 words.

10.8.4 Please list all communication and educational materials CMS requires you to provide to members.

1000 words.

10.8.5 What do you provide above and beyond what CMS requires?

1000 words.

10.8.6 Provide samples of communications and educational materials.

Single, Radio group.
1: Attached,
2: Not attached, explain in comments: [1000 words]

10.8.7 Confirm that letters are able to be customized with OSC's logo as requested by OSC.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain in comments: [1000 words]

10.8.8 8 Confirm that OSC will be provided an opportunity to review and approve all communication materials (including letters, brochures, electronic, website, etc.) prior to being sent to members and providers.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain in comments: [1000 words]

11 MEDICARE PART D EGWP QUESTIONNAIRE

11.1 PLAN DESIGN

OSC may wish to procure a self-insured Medicare Part D EGWP plan. Please review https://ct.aetnamedicare.com/coverage-and-benefits/plan-benefits-and-forms for retiree plan designs based on retirement date. Please note that diabetic drugs and supplies are covered at 100% for all plans.

The state seeks a transparent relationship with an EGWP provider, this means that all administrative costs and profit received by the EGWP administrator associated with the utilization of prescription drugs by members of the retired state employee health plan, will be paid by OSC to the vendor through transparent fees. The vendor shall not engage in spread pricing, shall pass through all manufacturer and federal revenue to the state

and shall have acquisition cost pricing at the PBMs wholly owned mail and specialty pharmacies with transparent dispensing fees.

11.1.1 Confirm you will be able to replicate the current plan design for the Medicare Part D EGWP. If not, indicate any deviations.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

11.1.2 Are there any CMS filing limitations that would impact benefit coverage levels for any benefit design elements? If yes, please explain and include in your pricing.

1000 words.

11.1.3 Please indicate the year your firm began offering EGWP plans to clients.

1000 words.

11.1.4 Please indicate whether any EGWP functions are sub-contracted to other organizations. If so, please describe the role of each Subcontractor.

1000 words.

11.1.5 Will member services for EGWP retirees be handled by a separate unit or by the same unit that supports actives members?

1000 words.

11.1.6 Other than member services, please describe any other services that will be handled by a separate unit from the one that handles active members (e.g. account service, billing, etc.).

1000 words.

11.1.7 Provide your book-of-business prescription drug event (PDE) error rate for 2023 and 2024.

1000 words.

11.1.8 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.

1000 words.

11.1.9 How does your organization handle split contracts (one Medicare, one non-Medicare)?The Medicare member will be covered by the EGWP but the non-Medicare member cannot be.

1000 words.

11.2 PLAN ADMINISTRATION

11.2.1 Confirm you maintain a CMS approved prescription drug Medicare Part D plan in the form of an EGWP.

Single, Pull-down list.
1: Yes,
2: No

11.2.2 Confirm you agree to a pass-through of all EGWP revenue streams:

- CMS direct subsidy;
- Federal reinsurance payments;
- Manufacturer coverage gap discounts;
- Selected Drug subsidies;
- Low-income subsidies, and
- Other revenue sources.

Single, Radio group.
1: Agree,
2: Disagree, explain: [500 words]

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

1000 words.

11.2.4 Confirm you are able to administer a Medicare B vs. D program at point of sale, at no additional cost to the State.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

11.2.5 How do you propose to submit claims information for drugs that may be payable under either Medicare Part B or D and indicate which CMS approved methodology is utilized?

1000 words.

11.2.6 If an individual has prescription drug coverage under the State plan and then enrolls in another Medicare Part D prescription drug plan, how do you identify such a situation at the point of sale?

1000 words.

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

1000 words.

11.2.8 Are there any charges for CMS required services that are not included in the EGWP base administrative fee? Please list each service separately and include any additional charges in your Price Proposal response.

1000 words.

11.3 NETWORK ACCESS AND MANAGEMENT

11.3.1 indicate in which of the 50 states and U.S. territories your organization is licensed to offer employer-group waiver plans

1000 words.

11.3.2 Please complete the following table:

	Response
a. What is your solution to meet the pharmaceutical needs of members who live in areas where pharmacy access is inadequate?	*500 words.*

b. Indicate any areas where your network access does not meet the CMS-standard access requirements.	*500 words.*

11.3.3 Provide the name of the pharmacy retail network you are proposing for the OSC.

1000 words.

11.3.4 Provide the number of participating pharmacies and list any pharmacy chains that are excluded from the proposed pharmacy retail network

1000 words.

11.3.5 Confirm that network, mail, specialty, long-term care, home infusion and Indian and Tribal pharmacy provider agreements are compliant with CMS Part D requirements including access.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

11.3.6 Should the State wish to add a retail pharmacy to the network, confirm you will contact the pharmacy and offer the contract for network inclusion within 2 business days following the request.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

11.3.7 Confirm any retail pharmacy in your proposed pharmacy retail network will dispense a covered script regardless of days' supply (e.g., 0-90 days' supply).

Single, Radio group.
1: Confirm, explain: [500 words] ,
2: Not confirmed, explain: [500 words]

11.3.8 An Excel file labeled Rx Pharmacies - Attachment I - is a provider utilization file representative of the Rx utilization experience for the OSC's Medicare-eligible retirees and their Medicare-eligible dependents for this plan. For each provider listed, please indicate if the pharmacy is in your proposed network (i.e., a participating provider) based on the instructions in the file.

Single, Radio group.
1: Attached,
2: Not attached, explain: [500 words]

11.3.9 In addition to standard retail pharmacy contracts, do you have any affiliations or alliances with retail pharmacy providers? If yes, with which provider(s) and in what ways will the relationship affect the State?

1000 words.

11.3.10 Do you produce network pharmacy report cards? If Yes, explain the nature and uses of the report and include a sample.

1000 words.

11.3.11 With regard to the mail order dispensing facility to be used for this account, provide the following:

	Primary Mail Order Pharmacy
Years in Operation	*Integer.*
Location	*200 words.*

Claims Volume (2024)	*Dollars.*
Annual Claim Volume Capacity	*Dollars.*
Number of pharmacists	*Integer.*

11.3.12 13 Provide a summary of the disruption analysis using your proposed Broad Retail Network using the table below:

Type of Change	**Retail (30 days** supply	**Retail 90 days** supply
Number of Currently Utilized Retail Pharmacies that are Not Part of Proposed Network and are Eligible to Solicit	*Integer.*	*Integer.*
Number of Members that are Using Those Retail Pharmacies that are Not Part of Proposed Network and are Eligible to Solicit	*Integer.*	*Integer.*
Number of Prescriptions that Adjudicated via Those Retail Pharmacies that are Not Part of Proposed Network and are Eligible to Solicit	*Integer.*	*Integer.*
Number of Currently Utilized Retail Pharmacies that are Part of Proposed Network	*Integer.*	*Integer.*
Number of Members that are Using Those Retail Pharmacies that are Part of Proposed Network	*Integer.*	*Integer.*
Number of Prescriptions that Adjudicated via Those Retail Pharmacies that are Part of Proposed Network	*Integer.*	*Integer.*

11.3.13 Does your organization own a mail order and specialty pharmacy? If not, who provides mail order and specialty pharmacy services?

1000 words.

11.3.14 Describe your proposed specialty pharmacy network.

1000 words.

11.4 FORMULARY AND CLINICAL MANAGEMENT

11.4.1 OSC is requesting a generic first/lowest net cost formulary. Please confirm this is the formulary you are proposing for this procurement.

Single, Radio group.

1: Confirmed,
2: Not confirmed, explain: [500 words]

11.4.2 Provide the generic first/lowest net cost formulary listing with your proposal submission.

Unlimited.

11.4.3 Given the changes to the Part D program continuing throughout the length of this contract, describe the generic first/lowest net cost formulary strategy you are proposing for OSC.

1000 words.

11.4.4 Provide the name of the proposed formulary program.

1000 words.

11.4.5 How are new drug therapies added to the formulary?

1000 words.

11.4.6 Describe your formulary management support services.

1000 words.

11.4.7 Describe whether your proposal includes an optional supplemental coverage for non Part D drugs that wraps around the basic Medicare Part D benefits (i.e., bonus drug list) and what this supplemental coverage looks like.

1000 words.

11.4.8 Provide a formulary listing of the non-Part D covered drugs under the supplemental coverage.

1000 words.

11.4.9 How does your organization manage the non-Part D covered drugs?

1000 words.

11.4.10 Confirm your changes to your formulary, from one year to another, will not impact more than two percent (2%) of members.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

11.4.11 Describe how you will work closely with the OSC on the drug formulary to ensure the least amount of member disruption as members transition from the active/non-Medicare plan to the Part D EGWP.

1000 words.

11.4.12 Confirm that you will maintain individual member status of utilization management such as prior authorization approvals, and quantity limit level, at go-live until their individual expiration date if applicable.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

11.4.13 Confirm a member will be able to obtain an excluded prescription through a Prior Authorization for medical necessity.

1000 words.

11.4.14 Describe your Prior Authorization process. Please indicate if you use a third-party vendor. Describe your appeal process of denied Prior Authorizations. Describe how you report Prior Authorizations and appeals to reflect end result and value of Prior Authorizations.

1000 words.

11.4.15 Describe your transition fill process.

1000 words.

11.4.16 Describe your Rx utilization management programs (Prior Authorizations, Quantity Level Limitations, age and gender restrictions, Medication Therapy Management program, high-risk drug programs for the elderly, etc.). In your response, include the process for enrollment, targeting, reporting, and outcomes reporting.

1000 words.

11.4.17 Can the above programs be customized for the OSC's membership?

1000 words.

11.4.18 What is you process to work with the existing MA-PD carrier to ensure such Rx utilization management criteria are transferred properly to your system?

1000 words.

11.4.19 Describe the transition process you will utilize to limit member disruption for those members currently using prescription drugs requiring Rx utilization management criteria. If the process differs for formulary versus non-formulary drugs, please elaborate.

1000 words.

11.4.20 Will members' existing prior authorization or quantity level limits be transitioned and accessible for use by the go-live date? If not, please explain.

1000 words.

11.4.21 Describe how your organization will utilize current utilization management files from the prior vendor, such as for prior authorization, in order to minimize member disruption.

1000 words.

11.4.22 Provide detail on how you will provide the OSC with a list of proposed formulary exclusions, in subsequent years of the contract, that the OSC can review and approve or deny, including any potential fees or charges. Include in your response timing with respect to when you will provide the proposed formulary exclusions to the OSC and when you will need to finalize and file the proposed formulary exclusions with CMS.

1000 words.

11.4.23 Confirm you will provide a detailed disruption with the proposed formulary exclusions.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

11.4.24 Confirm you will not charge a fee for the customization of the Formulary.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

11.4.25 With the exception of FDA recalls or other safety issues, confirm you agree not to remove any drug products, brand or generic, from the OSC's non-specialty and specialty formulary or non-specialty and specialty preferred drug listings without notification and prior approval from the OSC.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

11.4.26 Complete and submit the formulary disruptions based on your proposed formulary with drug exclusions and on the most recent **four months** in the claims data that is provided. Results to be included are the number of members that will require a change as well as the number of prescriptions associated with the formulary change. An Excel file that lists the specific drugs that will be negatively impacted (excluded or higher-cost tier) along with the total number of scripts and members impacted for each of these drugs should also be provided.

Please provide a summary of your formulary disruption based on the most recent **four months** in the claims data provided and on your proposed formulary with exclusions using the table below:

Type of Change	Member Impact	% of Total Members	Number of Scripts Impacted	% of Total Scripts (including all brands and generics)
No Change	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Positive (higher-cost tier to lower tier)	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Negative (lower tier to higher-cost tier)	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Moving from covered to not covered/Excluded	*Integer.*	*Percent.*	*Integer.*	*Percent.*
Total	*Integer.*	*Percent.*	*Integer.*	*Percent.*

11.4.27 The name of the Formulary you are proposing should be included in your contract. The number of drug exclusions as well as a list of the excluded drugs and the therapeutic alternatives should also be provided as an attachment. Provide Information and Names of Attachments.

1000 words.

11.4.28 Complete the following table:

	#1 Drug that is Moving from Covered to Not Covered/Excluded based on impacted Members: [Indicate Member and Script Impact.]	#2 Drug that is Moving from Covered to Not Covered/Excluded based on impacted Members: [Indicate Member and Script Impact.]	#3 Drug that is Moving from Covered to Not Covered/Excluded based on impacted Members: [Indicate Member and Script Impact.]
Name of Drug	*1000 words.*	*1000 words.*	*1000 words.*
Member Impact	*Integer.*	*Integer.*	*Integer.*
% of Total Members	*Percent.*	*Percent.*	*Percent.*
Number of Scripts Impacted	*Integer.*	*Integer.*	*Integer.*

% of Total Scripts (including all brands and generics)	*Percent.*	*Percent.*	*Percent.*
Name of Preferred Alternative	*1000 words.*	*1000 words.*	*1000 words.*

11.4.29 Please describe your mail order services and support.

1000 words.

11.4.30 If a submitted mail order claim for a member cannot be completed in its entirety within a designated timeframe, what communications are provided to the member and what policy is followed for splitting orders? How is the un-sent portion of the order tracked from the time of splitting until fulfillment?

1000 words.

11.4.31 Describe your specialty pharmacy services.

1000 words.

11.4.32 How do you manage your specialty drug program? Provide a description of the specialty drug program, including coordination with medical providers and the medical claims administrator.

1000 words.

11.4.33 Please describe your specialty drug management services. How do you 1) ensure that members are on the most effective medication 2) avoid waste 3) direct members to lower cost alternatives when clinically appropriate

1000 words.

11.4.34 Do you evaluate the effectiveness of high-cost drugs, e.g. collect clinical information on patients to determine if their conditions are improving or well managed on the drug? If so, how do you leverage this information to engage providers or in determining prior authorization approvals? Do you negotiate any drug manufacturer outcomes-based rebates for high-cost medication outcomes? If so, describe the nature of these performance measures.

1000 words.

11.4.35 Please describe your biosimilar strategy. When do you prefer biosimilars, how do ensure the formulary includes all appropriate clinical alternatives and prefers lowest net cost bio-similar options. Please use your Humira biosimilar policy as an example to highlight your decision making and note the net costs of the biosimilars preferred on the formulary.

1000 words.

11.4.36 Please confirm that you would allow the state to make formulary adjustments based upon recommendations from its contracted third-party formulary advisor and that you would provide estimated financial and member impact of any such proposed adjustments. Confirm that you agree the PMPM guarantee will be adjusted based upon difference between the net costs of the state initiated and approved formulary change and the net cost of the PBMs standard formulary, positive and negative. The final reconciliation will use actual claims experience, not projected impact.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

11.4.37 Provide the name of the Specialty Formulary you are proposing. If applicable, provide the number of drug exclusions as well as a list of the excluded drugs and the therapeutic alternatives. Provide Information and Names of Attachments.

1000 words.

11.4.38 Provide a complete list of your additional clinical programs not included in your base offering with pricing associated with each program and highlight those programs recommended for the OSC. Describe the type of impact members will face for each of these programs. Indicate the name of the attachment containing this list and respective pricing.

1000 words.

11.4.39 Confirm you will allow the OSC to make edits and modifications to your standard PA criteria.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

11.4.40 Confirm you will allow the OSC to remove and/or add PAs and quantity limits on an individual drug level.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

11.4.41 Confirm the OSC will have the authority to override the Vendor regarding decisions on individual medication choices of members.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

11.4.42 Confirm you will keep accurate and detailed information regarding every PA the Vendor approves and such information will be available for the OSC's review upon request.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

11.4.43 How does your organization use pharmacy data to identify high risk, high need populations?

1000 words.

11.4.44 Describe how members receive reminders regarding refills and medication adherence.

1000 words.

11.4.45 Confirm your capabilities surrounding e-Prescribing. Would the member's physician be able to see the formulary status of a drug and enter the prior authorization criteria into the e-Prescribing tool?

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed, [500 words]

11.4.46 How are individual physician prescribing patterns monitored? What action is taken with physicians who have a high degree of non-compliance to improve their compliance?

1000 words.

11.4.47 Confirm you are able to administer a Medicare B vs. D program at point of sale, at no additional cost to OSC.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

11.4.48 Confirm that you will report to OSC and OSC's designated health care consultant rebates received associated with the reimbursement of Medicare Part B drugs at least quarterly.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

11.4.49 How do you manage waste - e.g. 14 months of medication dispensed in a 12-month calendar year, required 90-day fills when a lower amount is requested by provider, autofill for medications that are used inconsistently (seasonal asthma, topical creams etc.)Have you identified specific drug therapies that are more prone for waste? If so, what methods can the State employ to reduce future waste for these drug therapies?

1000 words.

11.4.50 What are your standard PA criteria GLP-1s, specifically Ozempic and Monjauro? Please confirm that your standard PA does not negatively impact rebates. Are adjustments to your standard PA requirement allowable, what can be changed to reduce off label utilization without losing the rebates?

1000 words.

11.4.51 Describe the process by which formulary changes are made, including member communication notices and indicate how often formulary changes are made.

1000 words.

11.4.52 Describe how you will work closely with the State on the drug formulary to ensure the least amount of member disruption.

1000 words.

11.4.53 Do you have fees associated with ePA? If so, what are they?

50 words.

11.4.54 How does your ePA program drive to the most clinically effective, lowest cost therapy? Please provide examples.

1000 words.

11.4.55 Please provide the following data surrounding your ePA program.

	Response	Comments
% of your network that has ePA available and turned on in their EMR	*Percent.*	
% of PA claims run through ePA	*Percent.*	
% of ePA claims that are approved first pass	*Percent.*	

% of ePA claims that result in a lower cost drug to be dispensed (include savings)	*Percent.*	*100 words.*
% of ePA claims that result in a higher cost drug to be dispensed (include costs)	*Percent.*	*100 words.*
% of ePA claims that are denied	*Percent.*	

11.4.56 Confirm lowest net cost options will be provided through the e-Prescribing tool and describe the technical process and user experience in providing this information.

Single, Radio group.
1: Confirmed, [500 words] ,
2: Not confirmed: [500 words]

11.4.57 How does your organization leverage its proposed formulary, access and programs to ensure members obtain the lower net cost options and/or highest value prescription?

500 words.

11.4.58 Do you report target and achieved rates for medication adherence and at what proposed frequency? If yes, what medications/disease would you report on for this client?

1000 words.

11.5 PROVIDER AUDITS

11.5.1 Confirm your agreement to retain network contract records for 10 years for the purpose of auditing.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

11.5.2 Describe your pharmacy audits. Include in your response the areas that are evaluated and how often they are performed.

1000 words.

11.5.3 Complete the following table for the last calendar year or most recent 12-month period available.

	% of Network Pharmacies Audited Annually
Percent of Pharmacies Audited Annually: Desktop	*Percent.*
On-Site	*Percent.*
At Random	*Percent.*
By Independent Agent	*Percent.*
Percent of Pharmacies Needing Corrective Action	*Percent.*
Percent of Contracts Terminated due to Result of Audit	*Percent.*
Most Prevalent Reason for Termination	*200 words.*

11.5.4 Confirm the right to audit is included in all standard provider contracts.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

11.5.5 What percentage of total ingredient costs do annual recoveries generally represent?

1000 words.

11.5.6 Confirm that 100% of all recoveries will be returned to the State.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

11.5.7 Describe how a full pass-through network pricing arrangement is managed and auditable by a client.

1000 words.

11.5.8 If mail order benefits are provided through a third party, explain any audit procedures in place to ensure proper dispensing and pricing practice adherence.

1000 words.

11.6 AUDIT RIGHTS

11.6.1 Right to Audit: All bidders agree to extend audit rights to OSC and cooperate with any outside audit firm OSC selects to perform a claim administration audit. This might include the provision of space and system terminals for a reasonable period of time to accomplish the audit objectives.

Single, Radio group.
1: Agree,
2: Disagree, explain: [500 words]

11.6.2 OSC or its designee will have the right to audit annually, with an auditor of its choice who will be identified, (for both claims and rebate audits), with full cooperation of the selected Bidder, the claims, services and pricing and/or rebates, including the manufacturer rebate contracts held by the Bidder, to verify compliance with all program requirements and guarantees with no additional charge from the bidder. Confirm OSC's auditor does not need to be mutually agreed upon by the bidder but will have to sign a confidentiality agreement.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.3 Confirm OSC will have the right to use an auditor of its choice for rebate audits, and the auditor of manufacturer agreements may be an auditing consulting company and is not restricted to a mutually agreed upon CPA accounting firm whose audit department is a separate stand-alone division of the business, which carries insurance for professional malpractice of at least two million dollars ($2,000,000).

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.4 OSC or its designee will have the right to audit up to the last three complete contractual years (36 months) of claims at no additional charge from the bidder. Confirm all audits will not be limited to information relating to the calendar year in which the audit is conducted or the immediately preceding calendar year.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.5 OSC 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 bidder will provide all documentation necessary to perform the audit.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.6 OSC will not be held responsible for time or miscellaneous costs incurred by the bidder in association with any audit process including, all costs associated with provision of data, audit finding response reports, or systems access, provided to OSC or its designee by the bidder 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.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.7 The bidder will provide complete claim files and documentation (i.e., full claim files, financial reconciliation reports, inclusion files, and plan documentation) to the auditor within 15 calendar days of receipt of the audit data request as long as a non-disclosure agreement is in place between the auditor and the bidder.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.8 The bidder will not set a maximum of claim samples per audit. OSC or the auditor, on behalf of OSC, will be able to provide all claims in question (e.g., claim samples separately without limit) during an audit for each contract year that is being audited regardless of whether the scope of the audit is for one year or multiple contractual years.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.9 The bidder agrees to a 30-calendar day turnaround time to provide the full responses to all of the sample claims, suspected errors and claims audit findings regardless of the number of claim samples sent to the bidder or the number of years that encompass the scope of the audit.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.10 OSC or its designee will have the right to audit to the top 20 pharmaceutical manufacturer contracts during the selected audit period during an on-site rebate audit. Confirm these are actual pharmaceutical manufacturer contracts and not contracts with a rebate aggregator. Confirm your agreement with both of these provisions.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.11 The bidder will correct any errors that OSC, or its representative, brings to the bidder's attention whether identified by an audit or otherwise. Describe the process that the bidder will undergo to correct the error and make the appropriate payments to the member and/or OSC, if applicable.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.12 Confirm the audit provision shall survive the termination of the agreement between the parties for a period equivalent to the Initial Term of the contract.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.13 Confirm only OSC, or the auditor on behalf of OSC, is able to formally close an audit initiated by OSC or the auditor on behalf of OSC.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.14 Confirm OSC is able to initiate a new audit even if all parties have not agreed that the prior audit is closed.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.15 Confirm OSC is able to conduct additional audits such as (including, but not limited to) operational, clinical or rebate audits while an annual financial audit is in process.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.6.16 Confirm you have provided a document outlining the Audit Rights and Procedures. Indicate the name of the attachment.

Single, Radio group.
1: Yes, please explain: [500 words] ,
2: No, please explain: [500 words] .

11.7 CONFIRMATIONS

11.7.1 Confirm that you have at least five (5) years of experience in providing prescription drug benefit plan services, including claims administration and retail pharmacy network services for a minimum of five (5) years.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.2 Please confirm your agreement with the following statement: The Bidder agrees to act in the best interest of the plan and plan members in providing (i) claim files, (ii) pricing information, and (iii) rebate information, to the plan sponsor. In this regard, the bidder agrees to provide biweekly or monthly disclosure of all ingredient costs, dispensing fees, taxes, and any other charges incurred by the plan sponsor under this contract for the reporting period.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.3 3 Confirm you will provide to the State 100% pass-through of all manufacturer revenue received by your organization (i.e., formulary rebates, manufacturer admin fees, price protection/inflation protection payments, and any other payments currently received or will be received in the future from manufacturers that in anyway relate to the utilization or data associated with the plan).

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.4 Confirm you will provide drug specific rebates at the point of sale for all applicable Rx claims that generate a rebate.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.5 Confirm you will honor 100% pass through retail pricing.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.6 Confirm you will provide annual or quarterly prospective unit cost price maximums.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.7 Confirm you will offer fixed Prospective Pricing Guarantees.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.8 Confirm you will pay reasonable and transparent and dispensing fees to pharmacies.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.9 Confirm you will negotiate rebates based on the State plan's book of business market share and not Contractor's book of business market share when advantageous to the state.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.10 Confirm you will provide quarterly rebate reporting at the NDC level by manufacturer.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.11 Confirm you will include actual allowed amount in claims feed including what is paid to pharmacy as well as POS rebates.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.12 OSC may, at its discretion, engage outside vendors, consultants or other experts to recommend changes to the PDL and utilization management policies, Contractor shall work with any such outside group as directed by the Comptroller to implement such changes. Confirm your agreement.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.13 Contractor will allow third party to bid on consulting for PDL development as described in the confirmation above.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.14 Will you apply specialty rebates at the point of sale as credit with annual reconciliations?

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.7.15 Confirm that you have the ability to interface, at a minimum, with OSC, Quantum Health, the medical and dental carriers, their consultant and data warehouse vendors for data and file sharing at a frequency requested by OSC.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.16 Confirm that you have been administering such programs to at least two clients with a minimum of 100,000 lives for a minimum of two (2) years.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.17 Confirm you will develop data sharing with Provider Groups, particularly those groups engaged in value-based contracts with the State plan or its medical carrier.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.18 Confirm you will disclose 340B relationships and terms.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.19 Confirm you will require dispensing of the full range of legal medications for reproductive health services when appropriate and where legal.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.20 Confirm you will explore options for better participation in maintenance drug network by independent pharmacies.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.21 Confirm you will expand the State audit rights to include:

- Ability to audit top 20 rebate manufacturers in any given years
- Identification of State plan's contracted auditor to be approved as part of RFP process
- No black out periods
- No physical onsite requirements

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.22 Confirm you will allow third party pre-adjudication review of pharmacy claims payments performed by the state's vendor of choice.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.23 Confirm you will dispense specialty drugs from source/channel with lowest net cost to plan.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.24 Confirm that you agree to provide reporting to the State's consultant, details to be determined.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.25 Do you agree to offer average annual per Rx price inflation guarantees by channel, adjusted for day supply, for all drugs that have been available in the market for at least 12 months? Provide separately for each year of the initial contract term.

Distribution Channel	Average Adjudication Cost per Rx	Target Annual Max Trend Rate (%)	Excess above Trend Rate Reimbursed
Retail Brand	*Dollars.*	*Percent.*	*Compound, Pull-down list.* 1: Yes, 2: No: [500 words }
Retail Generic	*Dollars.*	*Percent.*	*Compound, Pull-down list.* 1: Yes, 2: No: [500 words }
Retail/Mail Brand 90 day	*Dollars.*	*Percent.*	*Compound, Pull-down list.* 1: Yes, 2: No: [500 words }
Retail/Mail Generic 90 day	*Dollars.*	*Percent.*	*Compound, Pull-down list.* 1: Yes, 2: No: [500 words }

Specialty Brand	*Dollars.*	*Percent.*	*Compound, Pull-down list.* 1: Yes, 2: No: [500 words }
Specialty Generic	*Dollars.*	*Percent.*	*Compound, Pull-down list.* 1: Yes, 2: No: [500 words }

11.7.26 Confirm you will provide drug specific rebates at the point of sale for all applicable Rx claims that generate a rebate.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.27 Confirm you will honor 100% pass through retail pricing.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.28 Confirm you will provide annual or quarterly prospective unit cost price maximums.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.29 Confirm you will pay reasonable and transparent and dispensing fees to pharmacies.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.30 Confirm you will negotiate rebates based on the State plan's book of business market share and not Contractor's book of business market share when advantageous to the state.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.31 Confirm you will provide quarterly rebate reporting at the NDC level by manufacturer.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.32 Confirm you will include actual allowed amount in claims feed including what is paid to pharmacy as well as POS rebates.

Single, Radio group.
1: Confirmed

11.7.33 Confirm you will disclose 340B relationships and terms.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.7.34 Confirm that you agree to provide reporting to the State's Consultant (Segal), details to be determined.

Single, Radio group.
1: Confirmed,
2: Not confirmed: [500 words]

11.8 FINANCIAL DEFINITIONS

11.8.1 Confirm you agree to the following contract definitions:

	Response
a. **"100% Pass Through of Rebates"** – The PBM agrees to pass through 100% of ALL pharmaceutical manufacturer revenue earned to the Plan and will not charge an administrative fee for this arrangement. The PBM also agrees to disclose details of all other programs and services generating financial remuneration from outside entities, including manufacturers and retailers. The PBM will confirm all of this revenue will be verifiable and auditable.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
b. Confirm the PBM will pass through 100% of Manufacturer Administrative Fees paid by manufacturers to the PBM in relation to the Plan's non-specialty, specialty and overall utilization.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
c. Confirm the PBM will pass through 100% of Inflation Protection Payments paid by pharmaceutical manufacturers to the PBM in relation to the Plan's utilization.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
d. Confirm the PBM will pass through 100% of rebates invoiced and collected from pharmaceutical manufacturers/rebate aggregators for excluded products that are not included in the minimum rebate and financial guarantee calculations.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
e. Confirm the PBM agrees to pay participating pharmacies at the PBM's contracted rate. In the event that the amount paid to the participating pharmacy does not equal the amount invoiced to the Plan, the PBM may retain the difference.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
If the member's copay is less than the cost of the drug, the member should pay the less of the drug cost or the standard member copay.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed

	contractual language.): [500 words]
Members - All eligible employees and their eligible dependents enrolled under the Plan's prescription benefit program.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
Paid Claims - Defined as all transactions made on eligible members that result in a payment to pharmacies or members from the Plan or the Plan 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.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
Confirm the PBM will only charge a fee (e.g., administrative fee or dispensing fee) for Paid Claims and will not charge a fee for reversals, rejected claims, adjustments or reprocessed claims.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
Client claims data - All claims data records are the sole property of the Plan and must be made available upon request to the Plan and its representatives. Selling or providing of the Plan's claims data to ANY outside entities must be approved in advance, reported on a monthly basis and all income derived must be disclosed and shared per agreement with the Plan. Even if PBM has not "sold" the claims data, it is NOT free to use the claims data for analyses that they publish or provide to outside industries.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
Maximum Allowable Cost ("MAC") - The maximum allowable unit cost of a drug and establishes an upper limit reimbursement price for certain drugs dispensed without regard to the specific manufacturer whose drug is dispensed, and which drugs are identified on a "MAC List."	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]

11.9 FINANCIAL ASSUMPTIONS AND CALCULATIONS

11.9.1 Confirm the pricing listed in this proposal reflects the following:

Assumptions	**Response**
a. All guarantees, including the aggregate ingredient cost and the aggregate AWP, are calculated using the AWP based on the 11-digit NDC of the actual product and actual package size that is dispensed from the actual date the claim adjudicated.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]

b. The PBM's financial reconciliation that occurs after the end of the contract year will use the lower of the AWP pricing at the point of adjudication or the retroactive AWP pricing, if the pricing source the PBM uses issues retroactive AWP pricing for that annual reconciliation time period.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
c. You will quote an overall generic guarantee inclusive of single-source generics	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
d. Drugs with an "Insufficient Supply" are included in the guarantees	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
e. Select, sole source or authorized generics from at least one FDA-approved generic manufacturer with exclusivity, limited supply, limited availability, or limited competition will be included in the generic pricing guarantees and excluded from the brand pricing guarantees.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
f. No single-source generic or generic drug will be included in the brand drug component for the annual discount guarantee reconciliation.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
g. Confirm "House Generics"/ Brand claims with a DAW 5 will be included in the generic guarantee financial reconciliation calculations and GDR guarantee calculations.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
h. Confirm "House Generics"/ Brand Claims with DAW 5 will be included as brands in the minimum rebate guarantee calculations.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
i. Confirm any rebates derived from "House Generics" or DAW 5 claims will be passed through at 100% to The Plan.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please

	provide your proposed contractual language.): [500 words]
j. Confirm The Plan will not pay more for any "House Generics" or DAW 5 claims compared to the respective generic equivalent before the application of rebates.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
k. Confirm members will pay the generic copay for any "House Generics" or DAW 5 claims.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
l. Confirm brands with a DAW code (DAW 1 or DAW 2) requiring the substitution of a brand product over a generic product will be included in the brand discount guarantees, dispensing fees, and minimum rebate guarantees.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
m. Confirm brands with a DAW code of 0, 3, 4, 6, 7, 8, and 9 will be included in the brand discount guarantees, dispensing fees, and minimum rebate guarantee calculations.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
n. Confirm any formulary excluded brand products that were adjudicated as a result of an exception process such as for medical necessity will be included in the discount, dispensing fee, minimum rebate guarantees and any rebates associated with such drugs will be passed through at 100% to The Plan.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
o. Confirm any penalty amounts paid by the member as a result of the DAW 1 or 2 penalty program will not be used by the PBM in discount guarantee reconciliations.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
p. Member Cost Share at the point-of-sale (for retail and mail) is based on the lowest of The Plan copay/coinsurance, usual and customary charges, negotiated discounted ingredient cost plus dispensing fee or retail cash price.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]

q. Confirm the PBM guarantees that members will always pay the lowest price (member cost share, discounted ingredient cost plus dispensing fee, MAC, U&C). If so, what procedures are established to ensure that the pharmacy is in compliance with this provision? Confirm The Plan's members will never pay a full co-payment in instances where The Plan co-pay is greater than the discounted cost plus dispensing fee plus any sales taxes.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
r. Confirm all of the proposed dispensing fee guarantees are on a maximum guaranteed basis.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
s. Confirm that the proposed pricing will apply to The Plan. Otherwise, clearly identify deviations.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
t. The PBM agrees to provide upon request any proprietary algorithms, hierarchy or other logic employed to define a prescription drug as generic or brand, as part of this competitive bid process or at any point during any resulting contract term.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]

11.9.2 Brand and Generic Discount Guarantee Calculations:

Note: Discount and dispensing fee guarantees are limited to the following exclusions.

1. *Compound Drugs,*
2. *OTC claims that are not rebate eligible.*
3. *Non-Network pharmacy claims*
4. *340B pharmacy claims*
5. *Paper submitted claims by participants*
6. *Secondary Payor Claims where the primary plan paid at least 50% of the claim cost.*
7. *Supplies billed separately to administer drugs, except blood glucose testing strips*

	Response
a. Minimum Brand and Minimum Generic Discount Guarantees for retail, mail and specialty shall be defined and calculated as follows: (1-Aggregate Ingredient Cost/Aggregate AWP)	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]

b. Aggregate Ingredient Cost prior to the application of The Plan specific co-payments (including member paid penalties) will be the basis of the calculation.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
e. Guarantee reconciliation will not be limited to net cost claims. Zero balance due claims or zero amount claims will be included in the guaranteed measurement for AWP, ingredient cost, achieved discounts or dispensing fee calculations at the discounted cost before copay.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
f. Both non-MAC, MAC, single-source and multiple source generic products are to be included in the generic guarantee measurement.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]
h. Confirm all of the proposed discount guarantees are on a minimum guaranteed basis (i.e., not a flat, fixed or locked basis) and any discount achieved beyond the minimum guarantee will be passed on to The Plan.	*Compound, Pull-down list.* 1: Yes, 2: No (If "No", please provide your proposed contractual language.): [500 words]

11.9.3 For number 2 above "OTC claims that are not rebate eligible", please indicate which specific OTC products are eligible for discount and dispensing fee guarantees.

500 words.

11.9.4 For number 4 above "340B pharmacy claims", PBM to define "340B eligible pharmacies" and "340B drug pricing adjudication methodology."

500 words.

11.9.5 In addition to confirmation above, indicate if the following products listed below are included or excluded from your proposed discount and dispensing fee guarantees:

List of Products	**Response**	**Comments**
a. Vaccines	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
b. All Insulins/ Glucose/ Blood Glucose/ Ketone Test Strips/ Diabetic Test Strips (Including those considered as OTC Products)	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required

c. Prescription Vitamins, Smoking Cessation Products, Contraceptives (Including those considered as OTC Products)	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
d. Lipid Disorder – PCSK9 Products	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
e. Long Term Care (LTC)	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
f. Home Infusion	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
g. Indian Health Services and Tribal Claims	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
h. Ancillary Supplies	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
i. HIV Products. If included, confirm if HIV products are included with the specialty or the non-specialty guarantees.	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
j. Transplant Medications. If included, confirm if Transplant products are included with the specialty or the non-specialty guarantees.	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
k. Biosimilars	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
l. Veteran Administrative claims	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
m. Multi-source brand claims	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required

11.9.6 Confirm that you will not add other exclusions outside of the above. Note that if you add other exclusions, you may be disqualified.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.9.7 Confirm responses above regarding the “340B” remain the same.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.9.8 In addition to confirmation above, indicate if the following products listed below are included or excluded from your proposed rebate guarantees:

List of Products	**Response**	**Comments**
a. Vaccines	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
b. All Insulins/ Glucose/ Blood Glucose/ Ketone Test Strips/ Diabetic Test Strips (Including those considered as OTC Products)	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
d. Prescription Vitamins, Smoking Cessation Products, Contraceptives (Including those considered as OTC Products)	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
d. Lipid Disorder – PCSK9 Products	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
e. Long Term Care (LTC)	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
f. Home Infusion	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
g. Indian Health Services and Tribal Claims	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
h. Ancillary Supplies	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required

i. HIV Products. If included, confirm if HIV products are included with the specialty or the non-specialty guarantees.	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
j. Transplant Medications. If included, confirm if Transplant products are included with the specialty or the non-specialty guarantees.	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
k. Biosimilars	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
l. Veteran Administrative claims	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required
m. Multi-source brand claims	*Single, Pull-down list.* 1: Included, 2: Excluded	*500 words.* Nothing required

11.9.9 Confirm that you will not add other exclusions outside of the above. Note that if you add other exclusions, you may be disqualified.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

11.10 IMPLEMENTATION

11.10.1 Provide an Implementation Project Plan for the national Part D EGWP plan. Include a detailed timetable assuming a Notice of Contract Award by June 1 for a January 1, 2026 Program ‘go-live' date. Note that OSC's Open Enrollment Period for retirees takes place in October through December for coverage beginning January 1. Development of communications is expected to commence immediately to assist OSC with any communications necessary prior to Open Enrollment. At a minimum, the Implementation Project Plan must provide specific details on the following:

a. Identification and timing of significant responsibilities and tasks

b. Names, titles, and implementation experience of key implementation staff and time dedicated to OSC during implementation

c. Identification and timing of OSC's responsibilities

d. Transition requirements with the incumbent vendors

e. Staff assigned to attend and present (if required) at Open Enrollment/educational sessions

f. Member communication plan - including development and assistance to OSC, prior to Open Enrollment, and on-site Open Enrollment meetings

g. Data and timing requirements from current vendors to ensure transition of care and prior-authorization data is appropriately transferred.

Single, Radio group.
1: Attached,
2: Not attached, explain: [1000 words]

11.10.2 Demonstrate how your organization will test the program to ensure claims will process correctly on the Program ‘go-live' date of January 1, 2026. Confirm you will conduct testing with an actual retail pharmacy from the Point-of-Sale transaction to a completed transaction where the pharmacy successfully processes the prescription drug claim for a successful fill of the medication, if applicable.

1000 words.

11.10.3 Describe the process and timing if the OSC elects to perform a third-party pre-implementation audit. Please include in your response the development of testing scenarios, the duration of the audit and any blackout audit dates, the format of the audit and whether there will be a “live” webinar where the OSC and third-party auditor can see claims being adjudicated on the Vendor's system).

1000 words.

11.10.4 Provide an implementation and audit timeline inclusive of key milestones and stakeholders related to coding, program confirmation and document execution, internal audit/quality assurance review and testing, external audit kickoff, process and timing, reconciliation of findings or issues for changes or plan intent confirmations, go-live date and post-implementation audit kickoff and process, etc.

1000 words.

11.10.5 Identify the Implementation Team you propose to assign to this account and provide an organization chart defining the Implementation Team roles. Include names and titles for the entire proposed Implementation Team including key positions and support staff.

1000 words.

11.10.6 Please provide resumes and Part D EGWP experience and qualifications for each individual, listed in the organization chart provided to respond to the above question.

1000 words.

11.10.7 Confirm that all OSC members will have a valid ID card in hand prior to January 1, 2026.

Single, Pull-down list.
1: Confirmed,
2: Not confirmed, explain:

11.10.8 Confirm your organization will provide a status report on the Implementation Project Plan detailing current activities, closed tasks, problems, and any recommendations.

Single, Pull-down list.
1: Confirmed,
2: Not confirmed, explain:

11.10.9 How long will the Implementation Team stay involved after the Program ‘go-live' date for troubleshooting before a handoff to the Account Management team?

1000 words.

11.11 COMMUNICATION AND EDUCATION

11.11.1 Describe how your organization can effectively communicate with and educate OSC's retirees about your programs and services available to them.

1000 words.

11.11.2 What will be your communication and education strategy, and why do you think this strategy is the right one?

1000 words.

11.11.3 How will you implement this strategy?

1000 words.

11.11.4 4 Please list all communication and educational materials CMS requires you to provide to members.

1000 words.

11.11.5 What do you provide above and beyond what CMS requires?

1000 words.

11.11.6 Provide samples of communications and educational materials.

Single, Radio group.
1: Attached,
2: Not attached, explain in comments

11.11.7 Confirm that letters are able to be customized with OSC's logo as requested by OSC.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain in comments

11.11.8 Confirm that OSC will be provided an opportunity to review and approve all communication materials (including letters, brochures, electronic, website, etc.) prior to being sent to members and providers.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain in comments

11.11.9 Identify your standard communication materials and indicate those that can be customized at no additional charge and those that require an additional charge. Indicate fee if there is an additional charge.

	Response	Amount of Fee
Member ID Cards	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Claim Forms	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*

Summary Plan Description	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Summary of Material Modifications	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Internet Access	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
General Letters and Correspondence sent to Participants	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Annual Benefit Statements	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
HIPAA Privacy Notices	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
HIPAA Proof of Coverage document	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*

11.11.10 What materials do you create and distribute to Part D EGWP members? Provide a copy of the most recent materials such as any newsletters, brochures, flyers, etc. Confirm that OSC may review the member materials in advance and that you will respect a request by OSC to not send a communication to OSC members if, in OSC's discretion, the information contained therein would not apply to its members or cause confusion. *1000 words.*

12 FULLY INSURED MEDICARE SUPPLEMENT QUESTIONNAIRE

12.1 PLAN DESIGN

OSC wishes to consider procurement of a Fully insured, national Medicare Supplement PPO plan as full replacement for our current Fully insured MA PPO plan with the same benefits for services rendered in-network and out-of-network. The plan should function as a passive PPO that provides the same level of benefits for retirees when they see a provider outside the network that accepts Medicare. **Bidder may not deviate downward from these plan designs in any manner other than to meet CMS requirements, and the plan design proposed must be at least equal to the current plan.** Any such deviations must be noted on Attachment B. Please note that diabetic drugs and supplies are covered in full for all plans. You may offer supplemental benefits and/or enhanced benefits as long as they are at no cost to OSC and its membership.

Please review https://ct.aetnamedicare.com/coverage-and-benefits/plan-benefits-and-forms for retiree plan designs based on retirement date.

12.1.1 Confirm you will be able to replicate the current plan design for the national Medicare Supplement PPO plan, with the same benefits for services rendered in-network and out-of-network for medical and hospital services. If not, indicate any deviations.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

12.1.2 If you are offering additional supplemental benefits and/or enhanced benefits, please describe.

1000 words.

12.1.3 Please describe how your plan covers emergency services incurred outside of the U. S.

1000 words.

12.1.4 The OSC and Partnership Plans offer certain benefits that are required by the plan. Such benefits include:

- Hearing aids with no member cost
- Routine vision exams including refraction
- Chiropractic care
- Coverage for Naturopathic Providers
- Routine foot care
- Acupuncture

Confirm you will administer these benefits to match the OSC's current administration as part of your proposal.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

12.1.5 Describe how you will administer each of these benefits to match the OSC's current benefit levels and administration.

Benefits	Benefit Administration
Hearing aids	*1000 words.*
Routine vision exams including refraction	*1000 words.*
Chiropractic care	*1000 words.*
Coverage for Naturopathic Providers	*1000 words.*
Routine foot care	*1000 words.*
Acupuncture	*1000 words.*
Other	*1000 words.*

12.1.6 The OSC and Partnership Plans offer a more robust behavioral health benefit than Medicare allows. For example, Medicare only covers a certain level of therapist, which is a lower level of care than what the OSC and Partnership Plans provide. Describe your ability to match the current level of behavioral health benefit offered by the plan. If there is an additional charge related to matching the current benefit level, please indicate in your Price Proposal.

Unlimited.

12.1.7 Describe any enhanced benefits you offer to members regarding transportation to/from provider appointments, medical facilities, etc.

1000 words.

12.1.8 Do you offer a discounted hearing aid network or any other cost savings program for the State? Please describe.

1000 words.

12.1.9 Describe any member rewards or incentive programs you offer to promote wellness.

1000 words.

12.2 IMPLEMENTATION

12.2.1 Provide an Implementation Project Plan for the national Medicare Supplement plan. Include a detailed timetable assuming a Notice of Contract Award by June 1 for a January 1, 2026 Program ‘go-live' date. Note that OSC's Open Enrollment Period for retirees takes place in October through December for coverage beginning January 1. Development of communications is expected to commence immediately to assist OSC with any communications necessary prior to Open Enrollment. At a minimum, the Implementation Project Plan must provide specific details on the following:

a. Identification and timing of significant responsibilities and tasks

b. Names, titles, and implementation experience of key implementation staff and time dedicated to OSC during implementation

c. Identification and timing of OSC's responsibilities

d. Transition requirements with the incumbent vendors

e. Staff assigned to attend and present (if required) at Open Enrollment/educational sessions

f. Member communication plan - including development and assistance to OSC, prior to Open Enrollment, and on-site Open Enrollment meetings

g. Data and timing requirements from current vendors to ensure transition of care and prior-authorization data is appropriately transferred.

Single, Radio group.
1: Attached,
2: Not attached, explain: [1000 words]

12.2.2 Demonstrate how your organization will test the program to ensure claims will process correctly on the Program ‘go-live' date of January 1, 2026.

1000 words.

12.2.3 Describe the process and timing if the OSC elects to perform a third-party pre-implementation audit. Please include in your response the development of testing scenarios, the duration of the audit and any blackout audit dates, the format of the audit and whether there will be a “live” webinar where the OSC and third-party auditor can see claims being adjudicated on the Vendor's system).

1000 words.

12.2.4 Provide an implementation and audit timeline inclusive of key milestones and stakeholders related to coding, program confirmation and document execution, internal audit/quality assurance review and testing, external audit kickoff, process and timing, reconciliation of findings or issues for changes or plan intent confirmations, go-live date and post-implementation audit kickoff and process, etc.

1000 words.

12.2.5 Are you willing to provide a one-time implementation allowance to fund, as approved by OSC, implementation support, pre-implementation audits, readiness assessments, communication plans, outside printing costs, etc.? What dollar amount are you willing to provide?

1000 words.

12.2.6 Identify the Implementation Team you propose to assign to this account and provide an organization chart defining the Implementation Team roles. Include names and titles for the entire proposed Implementation Team including key positions and support staff.

1000 words.

12.2.7 Please provide resumes and MA-PD experience and qualifications for each individual, listed in the organization chart provided to respond to the above question.

1000 words.

12.2.8 Confirm that all OSC members will have a valid ID card in hand prior to January 1, 2026.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

12.2.9 Confirm your organization will provide a status report on the Implementation Project Plan detailing current activities, closed tasks, problems, and any recommendations.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain: [500 words]

12.2.10 How long will the Implementation Team stay involved after the Program ‘go-live' date for troubleshooting before a handoff to the Account Management team?

1000 words.

12.3 COMMUNICATION AND EDUCATION

12.3.1 Describe how your organization can effectively communicate with and educate OSC's retirees about your programs and services available to them.

1000 words.

12.3.2 What will be your communication and education strategy, and why do you think this strategy is the right one?

1000 words.

12.3.3 How will you implement this strategy?

1000 words.

12.3.4 Provide samples of communications and educational materials.

Single, Radio group.
1: Attached,
2: Not attached, explain in comments: [500 words]

12.3.5 Confirm that letters are able to be customized with OSC's logo as requested by OSC.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain in comments: [500 words]

12.3.6 Confirm that OSC will be provided an opportunity to review and approve all communication materials (including letters, brochures, electronic, website, etc.) prior to being sent to members and providers.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain in comments: [500 words]

12.3.7 Identify your standard communication materials and indicate those that can be customized at no additional charge and those that require an additional charge. Indicate fee if there is an additional charge.

	Response	Amount of Fee
Member ID Cards	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Claim Forms	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Summary Plan Description	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Summary of Material Modifications	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Internet Access	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
General Letters and Correspondence sent to Participants	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
Annual Benefit Statements	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*

HIPAA Privacy Notices	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*
HIPAA Proof of Coverage document	*Single, Radio group.* 1: Standard, 2: Custom, 3: Additional Fee	*500 words.*

12.3.8 Do you publish a member newsletter for members? If so, provide a copy of the most recent member newsletter.

Single, Radio group.
1: Yes. Copy is attached,
2: Yes. Copy is not attached, explain: [1000 words] ,
3: No

13 PRICE PROPOSALS

13.1 MA/MAPD PRICING

Pricing must be based on OSC's data provided. Bids based on manual data will not be accepted.
13.1.1 This RFP requires that pricing be based on OSC's actual Medicare allowed claims data (claims line detail) as well as OSC's plan design provided to Bidders in connection with this RFP. Proposals based upon manual rates will not be accepted. Confirm your agreement with this requirement.

Single, Radio group.
1: Confirmed, explain [500 words] ,
2: Not confirmed, explain [500 words]

13.1.2 The State, in partnership with the selected carrier, may decide that certain changes to coverage may be necessary upon renewal (removal of certain high-cost drug(s) for ex.). Please confirm that the renewal rates will reflect these changes.

Single, Radio group.
1: Confirmed, explain [500 words] ,
2: Not confirmed, explain [500 words]

13.1.3 The State, in partnership with the selected carrier, may consider a risk sharing arrangement for one or more years that would be based on a targeted medical loss ratio. Please confirm your openness to exploring such an arrangement.

Single, Radio group.
1: Confirmed, explain [500 words] ,
2: Not confirmed, explain [500 words]

13.1.4 Confirm that pricing will not include any taxes unless accompanied by proof that OSC is subject to the tax. If necessary, Bidders may request OSC's tax exemption number and federal tax exemption information.

Single, Radio group.
1: Confirmed, explain [500 words] ,
2: Not confirmed, explain [500 words]

13.1.5 Confirm you will administer the Medicare Prescription Payment Program (M3P) at no additional cost.

Single, Radio group.
1: Confirmed,
2: Not confirmed, explain [500 words]

13.1.6 Confirm you have completed and attached the Price Proposal with your submission.

Single, Radio group.
1: Confirmed and attached,
2: Not confirmed/not attached, explain [500 words]

13.2 MA/MAPD - FORMAT OF PRICING

13.2.1 Bidders shall submit pricing in the format described below for the national MA/MA-PD PPO proposed, based on the terms and conditions set forth in this RFP. Bidder's price offer shall serve as the basis for compensation terms of the resulting contract. Failure to submit pricing as provided in this section may render Bidder's entire offer non-responsive and ineligible for award.

It is understood that if CMS requires a certain benefit level that is superior to what is listed in this RFP, then the CMS benefit should be applied and noted. The premium rate quoted is to cover all services Bidder must provide as described in this RFP.

Cost proposals shall be submitted in the following format:

Bidder's offer will consist of the components as described below and in the Price Proposal instructions.

1. Provide the Fully insured per member monthly premium rates for 2026 (first year of the contract: January 1, 2026 - December 31, 2026) based on the services required as specified in this RFP by completing the Price Proposal - Attachment J.

Bidder is required to break out its premium between the medical (MA) and prescription drug (PD) components of the plan. Bidder must further break out the two components into the claims components and the non-claims components.

2. OSC is seeking a partner to provide MA-PD services as a viable long-term solution for their Medicare population. This requires pricing throughout the contract term that recognizes the need for reasonable year over year increases in premiums. While we recognize certain provisions of the pricing is dependent on CMS pricing terms released annually, we also believe organizations should be able to price for such fluctuations in a three-year contract. Therefore, we are requesting that Bidders provide annual total premium guarantees, or at a minimum, rate cap guarantees for each succeeding year under the contract. These should be meaningful guarantees not tied to any loss ratio targets.

Subsequent annual premium rates (2027 and 2028) will be based on claims experience of those enrolled in each plan, verified demographics, other documented actuarial factors, and projected health care cost trends. Subsequent annual premium rates will be negotiated annually and reflected in a written amendment to the Contract executed by both parties.

13.3 SELF-FUNDED MEDICARE SUPPLEMENT PRICING

13.3.1 Complete the following Administrative Fee Table. Please offer your administrative fee on PMPM basis. Administrative fees should include all services related to customer service, communications, claims adjudication, dispensing fees, reporting, utilization management, and appeals processing.

	Year 1	Year 2	Year 3
Administrative Fee	*Dollars.*	*Dollars.*	*Dollars.*

13.3.2 List any OPTIONAL services and supplies and their respective fee that are not included in the base administrative fees.

500 words.

13.3.3 Upon receipt of a signed and executed Non-Disclosure Agreement, a repricing file will be made available through a secure file transfer protocol. No data will be made available prior to the NDA being signed and submitted. No modifications to the NDA verbiage will be accepted.
Using the repricing file, Bidders are expected to reprice these files. The layout of the fields that will be included in the repricing file are detailed in Attachment L.
Offerors are required to complete and submit the repricing file in the exact formats requested.

13.4 FULLY INSURED MEDICARE SUPPLEMENT PRICING

13.4.1 Bidders shall submit pricing in the format described below for the national Medicare Supplement PPO proposed, based on the terms and conditions set forth in this RFP. Bidder's price offer shall serve as the basis for compensation terms of the resulting contract. Failure to submit pricing as provided in this section may render Bidder's entire offer non-responsive and ineligible for award.

It is understood that if CMS requires a certain benefit level that is superior to what is listed in this RFP, then the CMS benefit should be applied and noted. The premium rate quoted is to cover all services Bidder must provide as described in this RFP.

Cost proposals shall be submitted in the following format:

Bidder's offer will consist of the components as described below and in the Price Proposal instructions.

1. Provide the Fully insured per member monthly premium rates for 2026 (first year of the contract: January 1, 2026 - December 31, 2026) based on the services required as specified in this RFP by completing the Price Proposal - Attachment L.

Bidder is required to break out its premium between claims components and the non-claims components.

2. OSC is considering a partner to provide Medicare Supplement medical and hospital services as a viable long-term solution for their Medicare population. This requires pricing throughout the contract term that recognizes the need for reasonable year over year increases in premiums. Therefore, we are

requesting that Bidders provide annual total premium guarantees, or at a minimum, rate cap guarantees for each succeeding year under the contract. These should be meaningful guarantees not tied to any loss ratio targets.

Subsequent annual premium rates (2027 and 2028) will be based on claims experience of those enrolled in each plan, verified demographics, other documented actuarial factors, and projected health care cost trends. Subsequent annual premium rates will be negotiated annually and reflected in a written amendment to the Contract executed by both parties.

13.5 EGWP PRICING

13.5.1 ADMINISTRATIVE FEE

13.5.1.1 Complete the following Administrative Fee Table. Please offer your administrative fee on PMPM basis. Administrative fees should include all services related to customer service, communications, claims adjudication, dispensing fees, reporting, utilization management, and appeals processing.

	Year 1	**Year 2**	**Year 3**
Administrative Fee	*Dollars.*	*Dollars.*	*Dollars.*

13.5.1.2 List any OPTIONAL services and supplies and their respective fee that are not included in the base administrative fees.

500 words.

13.5.1.3 Complete the following Administrative Fee Table to confirm whether the following items are included in your proposed Administrative Fee or are available at an additional cost:

Broad Retail 30 Network with all retail chains/ Retail 90 at one retail chain/ Non-Exclusive Specialty/ 100% Rebate Pass Through Proposal PROPOSED ADMINISTRATIVE SERVICES	**Are the services included with the proposed Administrative Fee:**	**If not, Indicate the proposed fee amount**
Toll Free Phone Lines	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Monthly Data Feeds to The Plan or Designee(s)	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Prospective /Concurrent DUR	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Standard Reports	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Ad Hoc Reports	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*

COB Program	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Utilization Management Fees	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Dose Optimization Program	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Prior Authorization Program	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Step Therapy Program	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Quantity Limitations	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Overrides	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Custom System Overrides	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Standard 1st level appeals processing	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Standard 2nd level appeals processing	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Urgent appeals processing	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Appeal Services for Utilization Management, formulary and benefit reviews	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Urgent Appeal Service for Utilization Management, formulary and benefit reviews	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Annual EOB Statements	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Retro Termination Letters	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*

Group Coding	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Drug Notification Letters	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Formulary Administration/Management	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
ID Cards (Including new and replacement ID cards)	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Pharmacy Directories and other member materials	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Retail Pharmacy Network Audit Recovery Fees	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Compound Drug Management	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Fraud Waste and Abuse Program	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Opioid Management Program	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Medicaid/Medicare Subrogation Claims	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Paper Claims	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Retrospective DUR	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Prescribing Fees	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Influenza Vaccination Program – Administration Fee	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
Non-Influenza Vaccination Program – Administration Fee	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*
COVID-19 Vaccination Program – Administration Fee	*Single, Pull-down list.* 1: Yes, 2: No	*Dollars.*

Other	*Single, Pull-down list.* 1: Yes, 2: No	*100 words.*

13.5.1.4 List any services and supplies and their respective fee that are not included in the base administrative fees.

500 words.

13.5.1.5 Confirm there are NO additional fees (beyond those outlined in the Financial Section) required to administer the services outlined in this RFP. Any mandatory fees, including clinical and formulary program fees, must be clearly outlined in the Financial Section.

Single, Radio group.
1: Yes,
2: No, please explain: [500 words]

13.5.2 PRESCRIPTION DRUG PRICING

AWP Reimbursement Basis - Complete the following tables using the drug reimbursement that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the contract. Columns marked "AWP Discount" are to be completed using a discount from 100% AWP and dispensing fee logic. All guarantees must be based on the AWP unit cost dispensed and post September 26, 2009 AWP rollback.

ONLY FULL PASS THROUGH RETAIL PRICING WITH 100% PASS THROUGH REBATES PROPOSALS WILL BE ACCEPTED

Notes:

1. Brand Pricing must include both single source and multi-source brands.
2. Post September 26, 2009 AWP rollback
3. Generic Pricing must include single-source generics.
4. Bids must be 100% Rebate Pass Through Quotes

13.5.2.1 **Year 1**

Retail 30 Network with All Retail Chains Included (List any major Retail Chains Excluded)/ Retail 90 Network / Non-Exclusive Specialty/ 100% Rebate Pass Through	**AWP Discount Retail 30 (1 – 83 Days' Supply)**	**AWP Discount Retail 90 (84+ Days' Supply)**	**AWP Discount Mail (1 – 90+ Days' Supply)**
Brand Drugs			
Discount Guarantee from AWP for all brands	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Guarantee Per Rx	*Dollars.*	*Dollars.*	*Dollars.*
Generic Drugs			
Discount Guarantee from AWP for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Guarantee Per Rx	*Dollars.*	*Dollars.*	*Dollars.*
Rebates			

All Current Plan Designs – Minimum Guaranteed Rebate per Brand Prescription with 100% Pass Through of any additional rebates beyond the Minimum Rebate Guarantee	*Dollars.*	*Dollars.*	*Dollars.*

13.5.2.2 **Year 2**

Retail 30 Network with All Retail Chains Included (List any major Retail Chains Excluded)/ Retail 90 Network / Non-Exclusive Specialty/ 100% Rebate Pass Through	**AWP Discount Retail 30 (1 – 83 Days' Supply)**	**AWP Discount Retail 90 (84+ Days' Supply)**	**AWP Discount Mail (1 – 90+ Days' Supply)**
Brand Drugs			
Discount Guarantee from AWP for all brands	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Guarantee Per Rx	*Dollars.*	*Dollars.*	*Dollars.*
Generic Drugs			
Discount Guarantee from AWP for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Guarantee Per Rx	*Dollars.*	*Dollars.*	*Dollars.*
Rebates			
All Current Plan Designs – Minimum Guaranteed Rebate per Brand Prescription with 100% Pass Through of any additional rebates beyond the Minimum Rebate Guarantee	*Dollars.*	*Dollars.*	*Dollars.*

13.5.2.3 **Year 3**

Retail 30 Network with All Retail Chains Included (List any major Retail Chains Excluded)/ Retail 90 Network / Non-Exclusive Specialty/ 100% Rebate Pass Through	**AWP Discount Retail 30 (1 – 83 Days' Supply)**	**AWP Discount Retail 90 (84+ Days' Supply)**	**AWP Discount Mail (1 – 90+ Days' Supply)**
Brand Drugs			
Discount Guarantee from AWP for all brands	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Guarantee Per Rx	*Dollars.*	*Dollars.*	*Dollars.*
Generic Drugs			
Discount Guarantee from AWP for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Guarantee Per Rx	*Dollars.*	*Dollars.*	*Dollars.*
Rebates			
All Current Plan Designs – Minimum Guaranteed Rebate per Brand Prescription with 100% Pass Through of any additional rebates beyond the Minimum Rebate Guarantee	*Dollars.*	*Dollars.*	*Dollars.*

13.5.2.4 Please complete the tables below for claim count projections for pricing exclusions.

Drug Category	Claim Count	AWP Discount Exclusion	Rebate Guarantee Exclusion
340b	*Integer.*	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No
Drug Category 2	*Integer.*	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No
Drug Category 3	*Integer.*	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No
Drug Category 4	*Integer.*	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No
Drug Category 5	*Integer.*	*Single, Pull-down list.* 1: Yes, 2: No	*Single, Pull-down list.* 1: Yes, 2: No

13.5.2.5 Please also provide projections of claims counts, gross cost, and estimated rebates, by year.

Claim Count Projections					
Drug Channel	**Drug Type**	**Base Claims Data**	**Year 1**	**Year 2**	**Year 3**
Retail 30	Brand	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Retail 30	Generic	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Retail 90	Brand	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Retail 90	Generic	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Specialty	Brand	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Specialty	Generic	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Biosimilars	Brand	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Biosimilars	Generic	*Integer.*	*Integer.*	*Integer.*	*Integer.*
LDD	Brand	*Integer.*	*Integer.*	*Integer.*	*Integer.*
LDD	Generic	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Excluded	Brand	*Integer.*	*Integer.*	*Integer.*	*Integer.*
Excluded	Generic	*Integer.*	*Integer.*	*Integer.*	*Integer.*

13.5.2.6 Please complete the table below on total cost projections.

Total Cost Projections				
	Base Claims Data	**1/1/2026-12/31/2026**	**1/1/2027-12/31/2027**	**1/1/2028-12/31/2028**

(+) Discounted Ingredient Cost	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
(+) Dispensing Fees	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
(+) Admin Fees	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
(-) Member Cost	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
(-) Rebates	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*
Total Net Plan Cost	*Dollars.*	*Dollars.*	*Dollars.*	*Dollars.*

13.5.2.7 Using the most current CMS related data available, provide an estimated end of year subsidy for benefit plan years 1, 2, and 3.

1000 words.

13.5.2.8 Confirm that pricing will not include any taxes unless accompanied by proof that OSC is subject to the tax. If necessary, bidders may request OSC's tax exemption number and federal tax exemption information.

Single, Radio group.
1: Confirmed, explain [500 words] ,
2: Not confirmed, explain [500 words]

13.5.3 SPECIALTY PHARMACY PROGRAM PRICING

13.5.3.1 Provide an AWP-based pricing list **in Excel** of all specialty pharmaceuticals, including biosimilars plus Limited Distribution Drugs **that the PBM has access as well as those that the PBM does not have access**, that your company dispenses and distributes to providers and patients for your proposed specialty pharmacy program. Your pricing must include adequate supplies of ancillaries such as needles, swabs, syringes, and containers. The following items must be included in your list:
a. Product Name
b. Therapeutic Group/Therapeutic Category
c. NDC
d. Guaranteed Minimum AWP Discount and Dispensing Fee for all specialty pharmacy program prescriptions for the specialty arrangement
e. Limited Distribution Drug Designation/ Exclusive Distribution with Access
f. Limited Distribution Drug Designation/ Exclusive Distribution without Access
g. Biosimilar Designation.

Single, Pull-down list.
1: Attached,
2: Not provided

13.5.3.2 Confirm you provided the most recent Limited Distribution Drug Indicator and Exclusive Distribution Indicator in the attachment for the previous question. Confirm you have indicated whether you have access or do not have access to distribute those Limited Distribution Drugs/ Exclusive Distribution Products in the attachment of the previous question. If not, please provide your proposed Limited Distribution Drug List and Exclusive Distribution List as well as an indicator determining whether you have access or do not have access to dispense those products with NDC-11 in an Excel File that will be in place.

500 words.

13.5.3.3 Confirm that all specialty pharmacies that can dispense an LDD will be part of the specialty drug participating pharmacy network.

Single, Radio group.
1: Yes,
2: No, please explain: [Unlimited]

13.5.3.4 Confirm you provided the most recent Biosimilar Indicator in the attachment for the previous 13.4.3.1 question. If not, please provide your proposed Biosimilar Drug List with NDC-11 in an Excel File that will be in place.

500 words.

13.5.3.5 Complete the following table: **EGWP**

Specialty Drugs Dispensed at Participating Retail Pharmacies under the Open Specialty Pharmacy Program (30 days' supply)	**Year 1**	**Year 2**	**Year 3**
Overall Effective Discount (OED) Guarantee for Specialty Brand Drugs (excluding Biosimilars)	*Percent.*	*Percent.*	*Percent.*
Overall Effective Discount (OED) Guarantee for Specialty Generic Drugs (excluding Biosimilars)	*Percent.*	*Percent.*	*Percent.*
Overall Effective Discount (OED) Guarantee for Biosimilars (including New to Market Biosimilars)	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Guarantee - Per Prescription (including Limited Distribution Drugs with Access and without Access, Biosimilars and New to Market products)	*Dollars.*	*Dollars.*	*Dollars.*
Administrative Fee Guarantee - Per Prescription (if not included in the proposed Administrative Fee)	*Dollars.*	*Dollars.*	*Dollars.*
Minimum Rebate Guarantee – Per Brand Prescription (Passed Through at 100%)	*Dollars.*	*Dollars.*	*Dollars.*
Minimum Rebate Guarantee – Per Biosimilar Prescription (Passed Through at 100%)	*Dollars.*	*Dollars.*	*Dollars.*
If Limited Distribution and Exclusive Distribution Drugs are not included in the above Minimum Rebate Guarantee, then please indicate the separate Limited Distribution and Exclusive Distribution Drug Rebate Guarantee (including those that the PBM has access and does not have access). As a reminder, the PBM may be disqualified if Limited Distribution Drugs that the PBM has access and does not have access are not included in the overall minimum rebate guarantees.	*Dollars.*	*Dollars.*	*Dollars.*

13.5.3.6 Complete the following table: **EGWP**

Confirm Limited Distribution and Exclusive Distribution Specialty Drugs that the PBM has access will be included in the above OED guarantees	*Yes/No.*		
Confirm Limited Distribution and Exclusive Distribution Specialty Drugs that the PBM does not have access will be included in the above OED guarantees	*Yes/No.*		
If Limited Distribution Specialty Drugs are not included in the above OED guarantees, then please indicate the Limited Distribution and Exclusive Distribution Drug Brand Guarantee for those products the PBM has access and are dispensed at a Participating Retail Pharmacy	*Yes/No.*		
If Limited Distribution Specialty Drugs are not included in the above OED guarantees, then please indicate the Limited Distribution and Exclusive Distribution Drug Generic	*Yes/No.*		

Guarantee for those products that that the PBM has access and are dispensed at a Participating Retail Pharmacy			
If Limited Distribution Specialty Drugs are not included in the above OED guarantees, then please indicate the Limited Distribution and Exclusive Distribution Drug Brand Guarantee for those products that the PBM does not have access and are dispensed at a Participating Retail Pharmacy	*Yes/No.*		
If Limited Distribution Specialty Drugs are not included in the above OED guarantees, then please indicate the Limited Distribution and Exclusive Distribution Drug Generic Guarantee for those products that the PBM does not have access and are dispensed at a Participating Retail Pharmacy	*Yes/No.*		
Confirm The Plan will receive 100% of rebates related to Biosimilar Products, if any.	*Yes/No.*		
Confirm any Exclusions from Minimum Rebate Guarantees. List Drugs and Provide Separate Guarantees.	*Yes/No.*		
Confirm New to Market Specialty Drugs, New to Market Limited Distribution Drugs and New to Market biosimilars will be included in their respective OED guarantees	*Yes/No.*		
	Year 1	***Year 2***	***Year 3***
If not, then please indicate the New to Market Specialty Drug Discount Guarantee	*Percent.*	*Percent.*	*Percent.*
If not, then please indicate the New to Market Limited Distribution Drug Discount Guarantee	*Percent.*	*Percent.*	*Percent.*
If not, then please indicate the New to Market Biosimilars Discount Guarantee	*Percent.*	*Percent.*	*Percent.*

13.5.3.7 Complete the following table: **EGWP**

Specialty Drugs Dispensed at the PBM's Specialty Pharmacy under the Open Specialty Pharmacy Program	**Year 1**	**Year 2**	**Year 3**
Overall Effective Discount (OED) Guarantee for Specialty Brand Drugs (excluding Biosimilars)	*Percent.*	*Percent.*	*Percent.*
Overall Effective Discount (OED) Guarantee for Specialty Generic Drugs (excluding Biosimilars)	*Percent.*	*Percent.*	*Percent.*
Overall Effective Discount (OED) Guarantee for Biosimilars (including New to Market Biosimilars)	*Percent.*	*Percent.*	*Percent.*
Dispensing Fee Guarantee - Per Prescription (including Limited Distribution Drugs with Access and without Access, Biosimilars and New to Market products)	*Dollars.*	*Dollars.*	*Dollars.*
Administrative Fee Guarantee - Per Prescription (if not included in the proposed Administrative Fee)	*Dollars.*	*Dollars.*	*Dollars.*
Minimum Rebate Guarantee – Per Brand Prescription (Passed Through at 100%)	*Dollars.*	*Dollars.*	*Dollars.*
Minimum Rebate Guarantee – Per Biosimilar Prescription (Passed Through at 100%)	*Dollars.*	*Dollars.*	*Dollars.*
If Limited Distribution and Exclusive Distribution Drugs are not included in the above Minimum Rebate Guarantee, then please indicate the separate Limited Distribution and Exclusive Distribution Drug Rebate Guarantee (including those that the PBM has access and does not have access). As a reminder, the PBM may be disqualified if Limited Distribution Drugs that the PBM has access and does not have access are not included in the overall minimum rebate guarantees.	*Dollars.*	*Dollars.*	*Dollars.*

13.5.3.8 Complete the following table: **EGWP**

Confirm Limited Distribution and Exclusive Distribution Specialty Drugs that the PBM has access will be included in the above OED guarantees	*Yes/No.*		
Confirm Limited Distribution and Exclusive Distribution Specialty Drugs that the PBM does not have access will be included in the above OED guarantees	*Yes/No.*		
If Limited Distribution Specialty Drugs are not included in the above OED guarantees, then please indicate the Limited Distribution and Exclusive Distribution Drug Brand Guarantee for those products the PBM has access and are dispensed at a Participating Retail Pharmacy	*Yes/No.*		
If Limited Distribution Specialty Drugs are not included in the above OED guarantees, then please indicate the Limited Distribution and Exclusive Distribution Drug Generic Guarantee for those products that that the PBM has access and are dispensed at a Participating Retail Pharmacy	*Yes/No.*		
If Limited Distribution Specialty Drugs are not included in the above OED guarantees, then please indicate the Limited Distribution and Exclusive Distribution Drug Brand Guarantee for those products that the PBM does not have access and are dispensed at a Participating Retail Pharmacy	*Yes/No.*		
If Limited Distribution Specialty Drugs are not included in the above OED guarantees, then please indicate the Limited Distribution and Exclusive Distribution Drug Generic Guarantee for those products that the PBM does not have access and are dispensed at a Participating Retail Pharmacy	*Yes/No.*		
Confirm The Plan will receive 100% of rebates related to Biosimilar Products, if any.	*Yes/No.*		
Confirm any Exclusions from Minimum Rebate Guarantees. List Drugs and Provide Separate Guarantees.	*Yes/No.*		
Confirm New to Market Specialty Drugs, New to Market Limited Distribution Drugs and New to Market biosimilars will be included in their respective OED guarantees	*Yes/No.*		
	Year 1	***Year 2***	***Year 3***
If not, then please indicate the New to Market Specialty Drug Discount Guarantee	*Percent.*	*Percent.*	*Percent.*
If not, then please indicate the New to Market Limited Distribution Drug Discount Guarantee	*Percent.*	*Percent.*	*Percent.*
If not, then please indicate the New to Market Biosimilars Discount Guarantee	*Percent.*	*Percent.*	*Percent.*

13.5.4 ALLOWANCES

13.5.4.1 Please complete the following table: EGWP

Allowance	Description	Response
a Implementation	Provide the $ (dollar) Per Member amount or the flat dollar ($) amount you are offering The Plan.	*500 words.*
b. Annual Audit	Provide the annual dollar ($) Per Member amount or the flat dollar ($) amount you are offering The Plan to be used annually to verify The Plan are receiving discounted costs and major services as contracted as well as 100% of rebates.	*500 words.*

c. General Pharmacy Program Management	Provide the $ (dollar) Per Member amount or the flat dollar ($) amount you are offering The Plan for general expenses related to the management of the pharmacy benefits program such as pharmacy claim and rebate audits, communication expenses, clinical programs, consulting fees or be used as a credit against claim invoices.	*500 words.*

13.6 PERFORMANCE GUARANTEES

13.6.1 Please complete the table below.

Performance Category	Standard	Proposed level and Penalty (% of aggregate premium)
Prior Authorizations	The rate of denial for lack of documentation shall be equal to or less than __%	*500 words.*
Prior Authorizations	For medical services in which an initial denial is appealed the appeal overturn rate shall be equal to or less than __%	*500 words.*
Prior Authorizations	For pharmacy services in which an initial denial is appealed an appeal overturn shall be equal to or less than __%	*500 words.*
Customer Satisfaction	A minimum of a 60 NPS score as measured on an annual survey sent to all members in the fall of each plan year	*500 words.*
Quality	Ensure that the plan in which the state and Partnership members are enrolled earns 4.5 stars in each plan year applicable to the proposal	*500 words.*

13.6.2 OSC is interested in negotiating performance standards and monetary guarantees with the selected Bidder to encourage superior performance. Bidders are encouraged to propose performance guarantees and may offer traditional performance guarantees or unique guarantees that meet the objectives of this RFP proposal.If you are proposing Performance Guarantees, please include with your proposal.

Single, Radio group.
1: Confirmed and attached,
2: Not confirmed/not attached, explain [500 words]

14 BID EXCEPTIONS AND DEVIATIONS

14.1 If your bid does not fully comply with the specifications in this RFP, please upload and complete the Bid Exceptions and Deviations Document - Attachment B.

Single, Radio group.
1: Bid does not fully comply - Document Attached,
2: Bid does fully comply - Document Not Attached

Attached Document(s): RFP Attachment B - Bid Exceptions and Deviations Form.docx