Midwestern Higher Education Compact

Pharmacy Benefit Coalition Program

REQUEST FOR PROPOSAL

Prepared by the
Midwestern Higher Education Compact
Employee Benefits Committee

Announced: June 22, 2010
Submission Deadline: July 30, 2010

The Midwestern Higher Education Compact is a nonprofit regional organization established by compact statute to assist Midwestern states in advancing higher education through interstate cooperation and resource sharing. Member states are: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

MHEC seeks to fill its interstate mission through programs which:
• enhance productivity through reductions in administrative costs
• encourage student access, completion and affordability
• facilitate public policy analysis and information exchange
• facilitate regional cooperation
• encourage quality education programs and services in higher education
• encourage innovation in the delivery of educational services

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Midwestern Higher Education Compact's
Pharmacy Benefit Coalition Program

Introduction

The Midwestern Higher Education Compact (MHEC-pronounced meck) is soliciting proposals from Pharmacy Coalitions to provide Pharmacy Benefit Management (PBM) and additional administrative services for its Midwest[1] member institutions that choose to participate in the program. The contract will not be offered to a brokerage firm. MHEC will contract directly with the Pharmacy Benefit Coalition.

MHEC desires to contract with a Pharmacy Coalition that provides net savings to individual institutions that participate, leveraging its scale purchasing power of PBM services and discounts along with value added services provided by the Pharmacy Benefit Coalition administrative team.

There are approximately 1,000 public and private non-profit institutions in the member states with combined employees of approximately 717,000. Approximately 50% of these institutions are self-funded and eligible for a "carved-out" pharmacy benefit. The table below provides a summary of the range of the employees across the various Midwestern institutions.

Employees	Count
Less than 100	281
100 - 249	184
250 - 499	242
500 - 999	159
1,000 - 2,499	90
2,500 - 4,999	29
5,000 - 9,999	12
10,000+	11

The Pharmacy Benefit Coalition's function is to procure a PBM contract and work with MHEC on recruiting member institutions into the program.

A. The Midwestern Higher Education Compact

The Midwestern Higher Education Compact (MHEC) is an instrumentality of twelve Midwestern states (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin). The Compact was established in 1991 through a common statute enacted into law by each of the member states. The purpose of the Compact is to promote higher education through interstate cooperation and resource sharing.
The Compact is governed by a 60 member Commission composed of five delegates from each state who are appointed by their respective Governors, House Speakers and Senate Presidents. The Commission has been conferred very broad authority to enact solutions and enter into agreements on behalf of its member states. Once a state enacts the necessary legislation to become a member of

[1] Hereafter the Midwest is defined as the twelve member states of the Midwestern Higher Education Compact (MHEC) – Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin.

the Compact, all of the public and private non-profit colleges, institutions, community colleges and technical colleges in the state are automatically accorded membership as well, and are eligible to participate in the solutions established by the Compact. The Commission receives its primary financial support from member state appropriations, grant monies, and administrative service fees.

The primary constituents served by the Midwestern Higher Education Compact are the approximately 1,000 public and private non-profit institutions in the member states whose combined enrollments total over 4 million students.

One of the Compact's top priorities is to establish public-private relationships to improve services to higher education, and reduce administrative costs for both providers and institutions. Over the past 18 years, the Compact has engaged in several highly successful initiatives in cooperation with leading corporations. These relationships have been quite innovative, and have produced financial benefits for all of the involved parties.

1. The Midwestern Higher Education Compact's Employee Benefits Committee

The President of MHEC travels to the 12 member states on an annual basis, meeting with key higher education and legislative leaders. In these visits, the President repeatedly receives requests from the state to look at ways to reduce costs to institutions in the areas of energy and health insurance. As a result of these requests, MHEC put together a grant application to explore these areas. Thanks to the generous support of Lumina Foundation for Education, MHEC has established the Pharmacy Benefit Coalition Program.

2. Pharmacy Benefits

Health care costs are spiraling for most employers, higher education and governmental entities are no exception. The fastest growing component of medical trend is pharmacy benefits. Many employers see double digit percentage increases annually and there is no end in sight. Institutions are looking for ways to control medical trend, making pharmacy medical benefits more affordable in these challenging economic times.

By utilizing the unique structure of the Compact, MHEC is looking for the Pharmacy Benefit Coalition Program to provide its Midwestern colleges and institutions with a lower cost prescription drug benefit with cost-savings that could only be achieved by working collaboratively. Furthermore, because institutions have differing size and pharmacy benefit plan designs, the Pharmacy Coalition Program must be designed with enough flexibility to meet those varying needs.

MHEC believes that the services and scalability of the Pharmacy Benefit Coalition Program will offer unique advantages and benefits to participating colleges and institutions and their employees that cannot be readily achieved through individual actions. Mega-group participation will enable significant streamlining of marketing and administration functions; additional services; and cost savings to institutions and their individual scenarios. In order for the Pharmacy Benefit Coalition Program to be successful, it must be profitable for both the Coalition and the institutions. MHEC is committed to making that happen.

3. The MHEC Request for Proposal (RFP) Process

1. Point of Contact

This Request for Proposal (RFP) is issued by the Midwestern Higher Education Compact, this is the sole point of contact for MHEC during the selection process. The person responsible for managing the procurement process is Ms. Jennifer Dahlquist (612/626-1602 or jenniferd@mhec.org).

2. Objective

The objective of the RFP process is to provide interested parties with information to enable them to prepare and submit a proposal which would allow MHEC to:

1. Obtain formal agreements for the Pharmacy Benefit Coalition Program;
2. Assure that MHEC, its member institutions and their employee are receiving state of the market programs and services;
3. Select a Pharmacy Benefit Coalition with the resources and experience to allow MHEC to offer the Pharmacy Benefit Coalition Program to institutions of higher education.

4. Schedule of events

The following schedule lists meetings and deadlines related to this Request for Proposal (RFP) on the selection of a Pharmacy Benefit Coalition for the Pharmacy Benefit Coalition Program. Deadline dates are as indicated unless otherwise changed by MHEC. In the event that MHEC finds it necessary to change any of the dates or activities listed in this calendar, it will do so by issuing an amendment to the RFP to prospective Providers.

Event	Target Completion Date
Advertisements of RFP	June 22, 2010
Effective Issue Date of RFP	June 22, 2010
Mandatory Pre-proposal Teleconference	July 12, 2010 1:00-2:30 CDT
Final Questions Due	July 16, 2010
Answers to Questions Sent to Intended Responders	July 21, 2010
Deadline for Submission of RFP	July 30, 2010
Identification and Notification of Finalists	TBD
Interviews with Finalists	Week of August 16 (tentative)
Selection of Coalition	TBD
Contract Award and Assignment	TBD
Effective Date of Contract	January 1, 2011

5. Selection Process

The selection process will be guided by an evaluation of the range and quality of PBM and Pharmacy Benefit Coalition administrative services offered, and the cost of those services, along with pharmacy discounts that produce net savings for institutions of the Midwestern Higher Education Compact and the potential members of its Pharmacy Benefit Coalition Program. The evaluation of

responses will be performed by MHEC staff and its consultants. Its findings and recommendations will be submitted to the MHEC President for approval.

6. Instructions to Respondents

    1. Request for Proposal (RFP) Document

    Respondents are expected to examine the complete RFP document and all appendices. The failure to do so is at the respondent's risk. It is the respondent's responsibility to ask questions, request clarifications, or otherwise advise MHEC if any language, specification or requirement of the RFP appears to be ambiguous, contradictory, and/or arbitrary, or appears to inadvertently restrict or limit the requirements stated in the RFP to a single source.

    All questions with regard to the submission of proposals should be made in writing and directed to Jennifer Dahlquist, Assistant Vice President for Cost Savings and Chief Financial Officer, at jenniferd@mhec.org. Only information supplied by MHEC in writing through Jennifer Dahlquist or this RFP or amended RFP should be used as a basis for the preparation of Provider responses.

    2. Evaluation and Award

    Any clerical errors, apparent on its face, may be corrected by MHEC before Contract award. Upon discovering an apparent clerical error, MHEC may contact the respondent and request clarification of the intended proposal. The correction shall be incorporated in the notice of award. MHEC reserves the right to request clarification of any portion of the respondent's response in order to verify the intent. The respondent is cautioned, however, that its response may be subject to acceptance or rejection without further clarification.

    MHEC reserves the right to make an award to the respondent who meets the terms, conditions, and specifications of the RFP and whose proposal is considered to best serve MHEC's interest. In determining responsiveness and the responsibility of the Respondent, the following shall be considered when applicable: the ability, capacity, and skill of the respondent to perform as required; whether the respondent can perform promptly, or within the time specified without delay or interference; the character, integrity, reputation, judgment, experience and efficiency of the respondent; the quality of past performance by the respondent; the previous and existing compliance by the respondent with related laws and regulations; and the sufficiency of the respondent's financial resources.

    MHEC reserves the right to accept or reject any or all proposals and to waive any technicality or informality. Any protest must be made to the MHEC President within ten working days following notice of award. The decision of the MHEC president shall be final and binding.

3. Mandatory Pre-Proposal Teleconference

A mandatory pre-proposal teleconference will be held on July 12, 2010 from 1:00 PM CDT to 2:30 PM CDT. Responses to the RFP from respondents that fail to attend the pre-proposal teleconference will not be accepted. To access the teleconference, dial 1-866-740-1260 and enter code 6261602.

The RFP document and any appendices constitute the complete set of specifications and proposal response forms. Final questions must be submitted in writing via email to Jennifer Dahlquist (jenniferd@mhec.org) by July 16, 2010. All questions and responses will be shared with all firms that have requested a copy of the RFP and attended the pre-bid teleconference.

No verbal or written information that is obtained other than through this RFP or its addenda shall be binding on MHEC. No employee of MHEC is authorized to interpret any portion of this RFP or give information as to the requirements of the RFP in addition to that contained in or amended to this written RFP document or any formal written responses to submitted questions. In case of any doubt or difference of opinion as to the true intent of the RFP, the decision of MHEC's president shall be final and binding on all parties.

Proposals will be subject to the terms and conditions shown in Appendix B.

4. Contract Award and Assignment

The successful respondent shall, within ten (10) days after the receipt of formal notice of program award and assignment of the contract, enter into contract negotiations with MHEC. The Contract Documents shall include the RFP and any appendices, any addenda to the RFP, Respondent's Proposal, and Letter of Award. The Contract will be awarded by at date yet to be determined.

The contract to be awarded and any amount to be paid there under shall not be transferred, sublet, or assigned without the prior approval of MHEC. MHEC will enter into a master agreement for three (3) years with two (2) optional three-year renewals at MHEC's discretion.

5. Book of Business

MHEC does not guarantee a book of business or premium volume. Institutions participate in MHEC's programs of insurance at their election and are free to make other choices they may deem to better serve their employees.

6. Contract Termination for Cause

In the event the Coalition violates any provisions of the contract, MHEC may serve written notice upon the Coalition setting forth the violations and demanding compliance with the contract. Unless within ten (10) days after serving such notice, such violations shall cease and satisfactory arrangements for correction be made, MHEC may terminate the contract by serving written notice upon the Coalition; but the liability of Coalition for such violation;

and for any and all damages resulting there from, as well as from such termination, shall not be affected by any such termination.

7. Contract Termination for Convenience

MHEC reserves the right, in its best interest as determined by MHEC, to cancel the contract by given written notice to the Coalition thirty (30) days prior to the effective date of such cancellation.

8. Accounting Practice

The Coalition shall maintain, during the term of the contract, all books of account, accounting records, reports, and records in accordance with generally accepted accounting practices and standard for records directly related to this contract. The Coalition agrees to make available to MHEC, member states, and participating institutions, during normal business hours, all books of account, reports and records relating to this contract for the duration of the contract and retain them for a minimum period of six (6) years beyond the last day of the contract term.

9. Disclaimer

This Request for Proposal is not an offer to purchase. It is a request for administrative services product information and cost to assist MHEC in development and growth of the Pharmacy Benefit Coalition Program. Brokerage firms will not be awarded a contract. MHEC, nor potential members of its Pharmacy Benefits Coalition Program assumes any financial responsibility for the cost of preparation of proposals by vendors, nor does MHEC make any commitment to enter into a contract for service based on responses to this Request for Proposal.

MHEC makes no guarantee that any institution or number of institutions will participate in Pharmacy Benefit Coalition Program. MHEC will not be liable for the failure of any institution to make any payment or for the breach of any term or condition by an institution under any agreement.

7. Pharmacy Benefit Program Services

Questions have been broken into two parts: questions for the Coalition's PBM to answer; and questions for the Coalition.

8. PBM Requirements

General Administration

1. Pharmacy benefit services to be provided for two populations
    a. Active employees and their covered dependent
    b. Medicare eligible disabled employees and retirees and their covered dependents

2. Describe your ability to provide integrated pharmacy services for these distinct populations and how you allow for seamless transition in terms of eligibility and prescription history as members move from one group to the next.
3. Attach details of the specific performance guarantees you are offering, including information on how performance will be measured and how your organization is set-up to facilitate the institution auditing your performance. Define the penalty to be assessed for each service performance guarantee if the proposed standard is not achieved. Define the penalty as a percent of administration fees and estimate the total dollar value equivalent of the penalty.
4. Provide a copy of your standard PBM administration contract between the institution and the PBM.
5. Provide a copy of the standard service agreement between PBM and network pharmacies. Include any special contract terms for a 340B qualifying entity.
6. Indicate the site or sites from which the PBM will perform the relevant tasks listed in this proposal. This should be provided with along with the transmittal forms. Specifically identify where the following activities will take place:
    a. Claims processing;
    b. Member and provider services;
    c. Project/Account Management;
    d. Prior Authorizations;
    e. Mail Order Pharmacy Services;
    f. Specialty Pharmacy Services
7. Describe your ability to offer Client access and custom plan design and the security level that would allow system access as stated below:
    a. Access to on-line PBM system in live time for inquiry and report generation
    b. Real time access to PBM database for eligibility updates
8. Discuss your ability to provide the following:
    a. Dedicated group call center with a dedicated customer service toll free number
    b. Web access for forms, formulary, network access, refills, member questions, cost comparison information (generics versus brand, brand versus brand) and general prescription drug information
    c. Member communication materials and identification cards available via web access
    d. ID cards and packets for Open Enrollment and Routine Enrollment
    e. Replacement ID's as needed
    f. Medicare Annual Notice of Change and other Medicare documents to satisfy CMS requirements
9. Describe your ability to integrate with the medical benefit administrators such as health plans and flexible spending debit card providers and other outside vendors as requested by institutions.
10. Describe your procedures for development and maintenance of data reporting to comply with CMS requirements and updates for the Medicare prescription drug plan.
11. The ownership of claims data is retained by the institution. Does your company provide for full ownership of claims data by the institution? Will your company provide a copy of SAS 70 annually upon request?
12. Describe your options to handle the transmission of eligibility data from the institution to the PBM and from the PBM to CMS (if applicable).

Account Management/Account Services

MHEC desires an Account Management Administrative Service that is proficient in coordinating resources and services to meet all contract requirements and performance guarantees and is responsive to Institution requests for support and coordination.

1. Show the organization of the account service team proposed for MHEC in chart format, including titles. Also, include the geographical location of each of the account service team members. Please indicate which members are dedicated to MHEC and which are not.
2. Discuss your ability to provide the following required services:
    a. Account management services available to ensure personalized services, provide periodic review of plan performance and provide periodic updates of emerging plan specific programs and annual updates on industry trends,
    b. Assignment of a specific account manager to this account to help assure client specific pharmacy benefit management services,
    c. Access to a toll-free number for administration questions (separate from general consumer access toll-free-number),
    d. Direct line for account manager access,
    e. Annual on-site meetings at institutions with PBM account manager and PBM clinical pharmacist.
3. Describe the account servicing approach in regards to the following:
    a. Responsibilities of day-to-day contact
    b. Problem resolution process
    c. Title/level with problem resolution authority
    d. Mid-Year and Year-end plan performance analyses
    e. Monitoring account service satisfaction
4. Discuss any Internet capabilities that you currently offer or are developing to support the account management function.
5. Describe the training to be provided to the Employee Benefits staff at institutions on the PBM Client systems.
6. Provide a description of the resources (both pre and post implementation) dedicated to member communications. Provide examples of printed materials, booklets, directories, forms, etc. Please indicate any additional charges that might be incurred by institutions for such.
7. Summarize the administrative problems expected to be most challenging with respect to the plan described in this RFP and offer a brief action-plan for overcoming each of these problems.
8. Indicate your willingness to provide implementation of benefit design and plan parameters test results to institutions for review both during the implementation process and throughout the life of the contract as new benefit implementations arise. How will issues be resolved?
9. Describe the formal process by which system changes are tested and approved by the client, prior to implementation, into the production environment.
10. How will the PBM provide support to the Client to manage eligibility and other administrative tasks?
11. How will the PBM assist the Client in monitoring plan performance?
12. Please answer all of the questions below.

PBM Background Information and Qualifications	
Question Statement (attach necessary explanations and/or deviations)	**Yes or No**
13. Is PBM licensed in the MHEC states to provide the services proposed?	
14. PBM complies with all applicable federal and state laws including but not limited to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and will assist institutions in keeping current with legal and tax mandates as they relate to the health care and prescription drug benefit programs and the health care management program.	
15. PBM will not to sell or lease the client's protected health information to a third party in the course of administering this contract or after the contract has terminated.	
16. Has the company had any mergers and/or acquisitions that have occurred within the last 24 months?	
17. Has there been any material litigation brought against you in the past 24 months?	
18. Are you currently or have you ever been under investigation by a government entity or regulatory body?	
19. Is your company URAC certified?	
20. Do your organization and/or subsidiary monitor for or file for participation in class action lawsuits on behalf of your clients?	
21. Security features are in place to ensure confidentiality with individually-identifiable health information.	
22. Do PBM's employees receive HIPAA training?	
23. Has PBM experience an accidental or inappropriate security breach in the past 24 months?	

MHEC expects the Project/Implementation Team to be committed full-time during the development and implementation and is/are accessible to institutions during work hours during the development and implementation phases. The PBM must also identify one individual who will be the primary contact person. This individual must be authorized to commit the resources of the PBM in matters pertaining to performance of the contract. The PBM must confirm that this Individuals' sole responsibility will be managing the institution account during the implementation.

MHEC desires an Account Management Administrative Service that is proficient in coordinating resources and services to meet all contract requirements and performance guarantees and is responsive to Institution requests for support and coordination.

Implementation, Support and Account Management	
Question Statement (attach necessary explanations and/or deviations)	**Yes or No**

24. Will the institution have flexibility in customization of communication materials?	
25. Will you distribute printed materials to all institution sites?	
26. If there is a charge for personalization?	
27. Will you conduct training sessions for institution Employee Benefits offices prior to plan effective dates?	
28. The PBM will provide designated experienced subject matter experts for each contracted Administrative Service in sufficient numbers for the size and complexity of this account.	
29. The PBM will indicate who the primary contact is for each institution.	
30. The PBM will prepare, print and furnish to the institution an administrative manual containing all information of a substantive nature concerning all aspects of administering this program. This manual shall be updated and the update provided to institution within one month of any change in practice or procedure affecting the administration of the plan.	
31. The PBM will provide training on the PBM system to the Employee Benefits staff as mutually determined.	
32. The PBM will have a work order process to document program changes and services requested by the institution, and a method for tracking work orders.	
33. The PBM agrees to designate an Account Executive who is experienced, knowledgeable, and readily accessible to institution plan management.	
34. The PBM will designate account leads for enrollment, billing, claims, IT, medical review, and medical policy that are experienced, knowledgeable, and readily accessible to the institution. Leads will coordinate all aspects of the service delivery in their areas of responsibility and have decision-making authority sufficient for prompt response to institution questions and concerns.	
35. The PBM will assure that account management team members respond to Institution calls and emails within 24 hours / 48 hours /in the same day, unless received after 2 p.m. in which case response will be made by 10 a.m. the following business day.	
36. The PBM will provide a list of which team members are assigned to institution accounts, with an organization chart. The PBM will keep that list up to date with phone numbers and e-mail addresses for all designated and dedicated account team members.	
37. The PBM will inform the institution Human Resources Director of any planned change in the designated account team's key personnel by phone and in a written notice at least 14 days prior to the effective date, including the reason for the personnel change. The replacement personnel will undergo the same level of training on institution's accounts as that provided to PBM's personnel during the initial implementation.	
38. The PBM will hold account management meetings with institutions at a mutually determined frequency no less frequently than quarterly. All members of the account team will participate by phone or in-person meetings as requested by institutions.	
39. Indicate your willingness to provide a dedicated account management representative to address Employee Benefit staff needs both pre and post implementation.	

40. As new benefit implementations arise, benefit design and plan parameter test results are made available to the institution for review.	
41. System changes are tested and approved by the client, prior to implementation, into the production environment.	
42. Internet capabilities are available to support the account management function.	
43. Can the client update in real time via the Internet?	
44. The PBM's hotline staff shall have complete on-line access to all computer files and databases that support the system for applicable pharmacy benefit programs.	

Performance Standards and Penalties

MHEC expects superior service and will determine the PBM's service in part by the extent to which the PBM agrees to put a portion of its fees/premiums at risk for failing to meet MHEC's standards for service. The following chart shows MHEC's proposed minimum categories for performance standards. Please complete the chart and include any additional categories guaranteed.

How measured: (service performance reporting)

Clearly indicate whether a report is currently available, must be modified, has been developed ad-hoc, or will have to be developed to report results for each service performance area. Provide an example of the recommended report, a description of the changes to existing sample reports to be modified, or a description of the format and layout of reports to be developed. Clearly explain how the report to be used demonstrates satisfaction of the guaranteed performance standards and highlight the example report.

Penalty if Standard Not Met: (dollars or % of administration fees)

Define the penalty to be assessed for each service performance guarantee if the proposed standard is not achieved. Define the penalty as a percent of administration fees and estimate the total dollar value equivalent of the penalty. State your willingness to permit the institution to redistribute the total penalty and explain any conditions.

Performance Category	Performance Criteria	Performance Standard	How Measured	Penalty if Standard Not Met
Enrollment / Eligibility	timeliness of eligibility loading, ID card distribution accuracy of ID Card			
	accuracy of ID cards			
Customer Service: Member accessibility though phone	call answering time			
	call abandonment rate			

calls				
Participant Satisfaction Survey	satisfaction of members calling customer service			
	satisfaction of members with retail program			
	satisfaction of members with mail service program,			
Client Satisfaction	client service meetings and plan performance reports			
Mail Service Claims Processing Time	business days measured from date Rx received by vendor to date mail order shipped (mail, fax, internet)			
Mail Service Claims Processing Accuracy	overall dispensing accuracy			
Network Pharmacy Management	desk audits			
	on-site audits			
Point-of-Sale Network System	vendor's claim processing system			
Claim Payment	compliance with applicable state law relative to claims payment legislation			Any fine or assessment as a result of violation is paid by the PBM, not by the institution
One-time Service Performance: Implementation	Key implementation milestones are met. Vendor agrees to work with the institution to develop a mutually acceptable set of			

	milestones and associated penalties.			
Other Service Performance Guarantees	Indicate your willingness to offer service performance guarantees to satisfy other performance objectives of the institution			
Reporting / Record keeping				
Account Management	(call returned, problem resolution, member inquiries, appeals, etc)			
Clinical Management Programs / DUR				
Financial accuracy				
Maximum amount at Risk				

Claims Processing and Systems

1. MHEC desires a Claim Services Administrative Service with the capability to:
    a. Adjudicate all U.S. prescription claims for retail, mail-order, and specialty pharmacy claims for all health plan members.
    Describe your ability to provide services for the above.
2. Verify that the PBM can provide the following:
    a. An operational POS electronic adjudication process that shall be in compliance with all Federal and State regulations and mandates, as described herein, which include (but are not limited to): eligibility verification; POS edits and drug monitoring; audits; pharmaceutical manufacturer liaison; prior authorization; Drug Utilization Review; billing and reimbursement; e-prescribing, and reporting. This must be real time on-line adjudication twenty-four (24) hours per day, seven (7) days per week.
3. Provide current data layout including all data elements and data dictionary. This includes eligibility formats, billing files, and paid claim files.

4. Provide a full description of your systems environment including technical platform, software, back-up procedures, staff, overall capacity, and security. Include your system disaster recovery plan and the last test date of such.
5. Describe in detail your pre and post implementation testing environment. Is this a stand-alone system from your production/operation system and if so, does it completely mirror the production environment?
6. Describe your ability to support e-prescribing (etc). What e-script services are currently being utilized and how do you support the CMS required e-prescribing communications.
7. The PBM will be expected to pre-load a one-year history file from each institution, including claims and prior authorizations. Describe your experience and capabilities in this regard.
8. Describe the period of time detailed claim history is kept on-line before archiving.
9. Provide a complete description of your adjudication system including hardware, operating system, software, number of sites processing claims, etc.
10. Provide an overview of the claims processing process from the time the request for service is obtained at the participating pharmacy until the process is complete. Include the systems that are used and how the managed care and reporting systems are accessed. Include a comprehensive narrative and flow chart detailing your claims adjudication process for each:
    a. Participating pharmacy (mail, retail, Internet)
    b. Non-network pharmacy
    c. Paper claims
11. Describe any episodes of claim system downtime scheduled and/or non-scheduled and the subsequent resolutions of the non-scheduled downtime during the past year. Include the established procedures to be followed during system downtime.
12. Describe the data that pharmacists will be required to input to identify a member in your claims system. Provide a sample payer sheet for a retail pharmacy.
13. Describe the instances in which an EOB will be generated and forwarded to participants and include a copy of a sample EOB.
14. The PBM will be required to administer a complete, comprehensive audit program that will include both desk and on-site audits. The PBM will be required to manage the audit and compliance programs for its own network(s). This includes appropriate sanctions and recoveries. Describe the formal audit program administered by the PBM.
15. Please answer all of the questions in below:

MHEC desires a Claims Services Administrative Service with the capability to:

Question Statement (attach necessary explanations and/or deviations)	**Yes or No**
Claim System	
16. Can you adjudicate all U.S. prescription claims, for retail, mail-order, and specialty pharmacy claims, for all coalition health plan members?	
17. Can you adjudicate foreign prescription claims subsequent to Institution verification and approval?	
18. Will you support Institution strategic initiatives and demonstration projects?	
19. Will you perform other claims-related functions necessary to provide a complete scope of service?	

20. Do you provide a claims subrogation service / provide prescription data needed for subrogation agent?	
21. Do you provide fraud awareness, detection, and recovery services?	
22. Will you work with the institution and the prior PBM provider to load appropriate claims history as needed to facilitate transition of service (existing refills in mail service, prior authorization, step therapy, etc)?	
23. Upon termination of this contract, PBM will pay claims incurred prior to contract termination for up to 12 months.	
24. Will you make benefit revisions during the year with 90 days notice from the institution?	
25. The PBM will pay providers no later than the close of business on the business day after institutions transfer funds to the PBM.	
26. PBM will provide a periodic (probably annual cycle) data feed for the administration of institution's health and wellness program.	
27. The selected PBM will provide recurring data feed for the administration of institutions flexible spending programs and other benefit programs.	
28. Is there a stand-alone test environment system separate from your production/operation system that completely mirrors the production environment?	
29. Provide your formal process by which system changes are tested and approved by institution prior to implementation into the production environment. Can institution test in this process?	
30. The PBM has an operational POS electronic adjudication process that shall be in compliance with all Federal and State regulations and mandates. not limited to): eligibility verification; POS edits and drug monitoring; audits; pharmaceutical manufacturer liaison; prior authorization; Drug Utilization Review; billing and reimbursement; e-prescribing, and reporting. This must be real time on-line adjudication twenty-four (24) hours per day, seven (7) days per week.	
31. The PBM has an operational POS electronic adjudication process that provides:	
a. Eligibility verification	
b. POS edits and drug monitoring	
c. Drug Utilization Review	
d. Prior Authorization	
e. E-Prescribing	
f. Real time on-line adjudication 24 hrs/day, 7 days/week	
Claims Administration (Complete below to provide information on your organization's claims administration.)	
32. Turnaround time of prescription claim payments to network providers	
33. Turnaround time of prescription claim payments to members (paper claims)	
34. Financial accuracy for 2008 and 2009	
Prescription Claims Processing and Data	
35. Prescribers will be able to view on line formulary information	
36. Prescribers will be able to view on line medication history reports	
37. Prescribers will be able to view prior authorization status	

38. Are you fully compliant with 2009 CMS regulations for e-prescribing, specifically prescription benefit and prescription history?	
39. The PBM will pre-load a one-year history file, including claims and prior authorizations.	
40. PBM can process paper claims from member	
41. PBM can process Universal Claim Form from provider	
42. Do you own the software used by pharmacies to submit claims to your processing system?	
43. Is there a single payment and enrollment system in use nationally as opposed to multiple systems accessed by location?	
44. Is coordination of benefits tracked and administered?	
45. Can diagnosis be captured on prescription claims data to support determination of claim payment based on diagnosis?	
46. Can your system accept ICD-9 diagnosis codes?	
47. Designated Institution employees, through connectivity to your claims processing system, will have the security required to:	
a. Add, update and terminate members (both major or minor);	
48. Can your system accept CPT codes for claims processing?	
49. Can your system accept HCPCS codes for claims processing?	
50. Do claims submitted with DAW=5 calculate into the generic dispensing rate?	
51. Does your system process compounded Rxs using multi-ingredient method?	
52. Can your system process compounded Rxs using primary ingredient method?	
53. Can your system track formulary compliance?	
54. Do you require that prescriber identification be collected for all prescriptions dispensed?	
55. Do you validate the prescriber identification against an existing file? How frequently is this file updated?	
56. How frequently is this provider file updated?	
57. Does your prescriber identification method identify prescriber specialty?	
58. Do you have a research and development (R&D) program as part of your Information Systems department?	
59. Do you provide member EOBs?	
60. Will the PBM agree to reimburse on an immediate basis any overpayments that are the result of error, negligence, reckless or willful acts of omissions by the administrator, agents, officers, or employees?	
61. Describe the process used for document record retention. If imaging, do the accounting and customer service representatives that will support this account have on-line access to these images?	

62. Which of the following plan provisions are handled automatically by your system?

Plan Provision	Yes	No	Barriers to this service
Individual out of pocket maximums			
Deductibles			

Coordination of Benefits with Medicare plans			
COB with other governmental Rx plans			
COB with other non-governmental Rx plans			
Prior authorizations			
90 day at retail limitations			
90 day at mail service limitations			
Trial dose programs (fill at 30 day prior to fill at 90 day)			

63. Discuss the timetable, charges and barriers to system edit changes such as:

System Edit Issue	Implementation Timetable	Associated Costs	Discuss Barriers to Implementation
Gender edits			
Day supply edits			
Rolling days supply edits			
Age edits			
Age of claim edits (claim too old)			
Product limitations			
Dosage limitations			
Product exclusions			
Formulary changes			
Benefit Design changes			
New drug review - subsequent addition and/or deletions			
Step-therapy protocols on-line (provide current samples)			
Pre-edit, pro-active on-line messaging to pharmacy network for any and all of the above changes			

Answer the following questions about the PBM's audit program:

64. Describe the formal audit program
65. Describe the frequency and type of audits
66. Who performs the audits?
67. Are there written audit guidelines and/or procedures?
68. Is there a random audit program? If so, what percentage of claims is audited? Explain if and how this percentage varies by pharmacy or pharmacy network.
69. How are records of audit results recorded and maintained?

70. Describe the recovery process.

Customer Service

1. MHEC requires the PBM to provide customer, provider, and client service through telephone support for its prescription benefit. The PBM must provide toll-free telephone access to support system (technical) operations. Provide detailed explanations how telephone support will operate in order to respond to claims, inquiries, questions and problems regarding operations, including if internal or outsourced.
2. Supply a sample menu and script for your Voice Response Unit.
3. Describe the electronic/Internet access available to Institution members, providers, prescribers, and client. Address compliance with HIPAA standards for security, accessibility and privacy.
4. Describe the customer service features available to members utilizing the PBM's website.
5. Specify the types of information available for download from website by members, prescribers, providers, and client.
6. Describe the drug pricing information available to members on your website. Can members calculate savings between preferred and non-preferred drug products? What type of on-line pricing and messaging is available to members for those medications requiring step therapy or prior authorization?
7. Provide an attachment to describe in detail all resources that will be made available to institutions for Annual Enrollment and how you will structure enrollment, communications, and enrollment data entry.
8. Provide a sample Prescription ID Card and indicate where customization is available by institutions. Indicate if there is additional charge for customization.
9. Explain what type of historical eligibility information is retained and viewable by Institution staff (e.g. past and future eligibility changes). Is this same information viewable by retail pharmacies?
10. Provide examples of member education and communication materials and indicate what is available at no charge. Specifically address the same relative customization of the aforementioned materials and lead time to prepare and distribute the same.
11. How do you monitor and measure participant satisfaction. Furnish a copy of the survey instrument and the results of your latest survey.
12. Describe how you track and resolve member complaints and the established grievance procedure for persons experiencing problems with provision of services.
13. Describe in detail your appeals process and the internal decision-making system to handle member appeals.
14. Please answer all of the questions described below:

MHEC requires the PBM to provide customer, provider, and client service through telephone support for its prescription benefit. The PBM must provide toll-free telephone access to support system (technical) operations.

Member, Provider and Client Phone Support	
Question Statement (attach necessary explanations and/or deviations)	**Yes or**

	No
15. The PBM shall supply all required information systems, telecommunications, and personnel to perform the above referenced telephonic operations.	
16. The PBM shall appropriately staff its systems hotline, with positions such as a manager, hotline team leaders, and hotline representatives, all of whom shall be extensively trained.	
17. PBM has a separate toll-free telephone access for institution's Employee Benefits staff.	
18. PBM provides single front-end toll-free telephone number with touch-tone routing (if necessary) to respond to member requests, including but not limited to, for pharmacy locations, eligibility issues, claim or provider inquiries, and complaints about pharmacist practices and services, replacement ID cards, etc.	
19. PBM provides prescribers with toll-free telephone access to support provider needs, including but not limited to clinical programs like prior authorization, prescription faxes.	
20. PBM provides retail pharmacy providers with toll-free telephone access to support point of sale needs, including but not limited to, advice pertaining to the proper use of prescription drugs, consistent with Prospective Drug Utilization and other clinical standards, as they apply to each member's unique needs and medical conditions.	
21. PBM has Voice Response Unit and procedures for calls after normal business hours.	
22. Can you track and report on call volume, average speed of answer (ASA) and Abandonment Rate?	
23. Are call volume statistics reported on a client specific basis?	
24. Are telephone call records maintained for content and type of inquiry?	
25. Are URAC standards are met or exceeded for customer service, communications and disclosure?	
26. Is there a separate call center for the mail order service?	
27. Does this require a separate phone number for members to call mail order service, or are the two call centers telephonically linked?	
28. Will mail service customer service representatives have access to the same on-line plan/beneficiary information that is used by as retail customer service representatives?	
29. Is there a separate call center for the specialty pharmacy service? Does this require a separate phone number for members to call, or are the two call centers telephonically linked?	
30. Does this require a separate phone number for members to call for specialty pharmacy, or are the two call centers telephonically linked?	
31. Will specialty pharmacy customer service representatives have access to the same on-line plan/beneficiary information that is used by retail customer service representatives?	
32. What is the ratio of customer service representatives to covered lives in your PBM's programs?	

Eligibility Maintenance	
Question Statement (attach necessary explanations and/or deviations)	**Yes or No**
33. Confirm that institutions will be able to access the eligibility database for inquiry	

purposes.	
34. Confirm that institutions will be able to access the eligibility database for data entry (real time / emergency enrollment).	
35. Is historical eligibility information retained and viewable by institution staff (for example past and future eligibility changes). What about retail pharmacy providers?	
36. Is historical eligibility information retained and viewable by retail pharmacy providers?	
37. Do you comply, upon enrollment and throughout your service to institutions, with the Americans with Disabilities Act with respect to accommodating employees who have sight, hearing, and other disabilities?	
38. When a dependent child reaches the institutions Medical Benefit Plan's age limits and is no longer eligible for coverage, will the plan's system notify the institution?	
39. What portion of the fees will be put at risk if ID cards are not distributed timely? (NOTE: see section for Performance Standards and Penalties.)	
40. Can the Prescription ID card be customized as required by the institution?	
41. Is there an additional charge for the customization of prescription ID cards?	

The PBM will be required to issue prescription ID cards and other member materials to recipients covered by the institution. The PBM will be required to provide electronic / internet access to Institution members and providers. The PBM must meet or exceed HIPAA standards for security, accessibility, and privacy.

Member, Provider, Client Self-Service	
Question Statement (attach necessary explanations and/or deviations)	**Yes or No**
42. Prescription ID cards will adhere to NCPDP specifications	
43. PBM will perform all mailing of member materials to recipients covered by institution health plans.	
44. Are there any differences in cost and/or availability for communication / education pieces for (1) new client activities, (2) annual open enrollment activities, and (3) routine activities?	
45. Will you provide each covered family member with an ID card issued to participants' homes within two weeks after receipt of eligibility data?	
46. Confirm that your ID card can be customized as required by institution (institution decal or imprint).	
47. Confirm that your toll-free number will be placed on the ID cards.	
48. Does the PBM provide a customizable member preview site for new client use?	
49. Does the PBM provide a customizable member preview site for annual use at open enrollment?	
50. The following information can be downloaded or printed by members, prescribers, and providers (for example manual claim forms, drug list, prior authorization requirements / forms, medication history).	
a. Manual claim forms	
b. Formulary drug list	
c. Prior Authorization forms	

d. Medication History	
e. Step Therapy Requirements	
51. Can members submit inquiries to customer service via internet or e-mail?	
52. If your website has a demonstration site, please indicate the URL and any necessary passwords.	
54. Is there 24 hour customer service for members without online access but who need critical information?	
55. Is there 24 hour nurse or clinical pharmacist available for members without online access but who need critical information?	
56. Do you provide on-line provider directories?	
57. Are your online services ADA compliant.	
58. Can members view EOB and claim history on line?	
59. Attach a description of all services and information available on your web site.	
Which of the following are included in the PBM's online services?	
60. A searchable up-to-date provider directory.	
61. Provider directory with driving instructions.	
62. Downloadable forms.	
63. Tools to support personal health management.	
64. Tools to support informed decision-making / cost comparison.	
65. Secure access to personal claims history.	
66. Secure email to/from customer service.	
67. Member can check eligibility	
68. Member can order replacement ID card	
69. Member can print replacement ID card	
70. Videos / training manuals / information	
71. Payor sheets for network pharmacies	
72. Member can check claim status	
73. Provider can verify in "real-time" the eligibility status of members	

Customer Survey/Satisfaction

74. How do you monitor and measure participant satisfaction? Furnish a copy of the survey instrument and the results of your latest survey.
75. Who administers the survey and collates the results? How frequently and what guidelines are followed?
76. Describe how you track and resolve member complaints.
77. What kind of grievance procedure is there for persons who experience problems with services provided?
78. List any of your customer service functions that are outsourced.
79. Describe the training process for your customer service representatives.
80. Describe your compliance with HIPAA. Include in your response details on your organizations policies on privacy, security (including physical safeguards), and electronic data interchange requirements.
81. What other services or programs do you offer that set you apart from your competitors?

Customer Service Area	PBM Response
82. Number of grievances per 1,000 members resulting in the highest level of arbitration in calendar year 2008	
83. Hours of operation of customer service units	
84. Number of customer service representatives assigned to MHEC service units	
85. Customer service employee turnover rate for 2008 and 2009 (year-to-date)	
86. Member satisfaction rating in most recent member satisfaction survey	
87. Average hold time in seconds and average abandonment rate for calls in 2008 and 2009 (year-to-date)	
88. Will there be a dedicated toll free customer service unit for Institution employees and retirees? Same number or different for Medicare and non-Medicare members?	

Member Printed Communications

MHEC desires a Member / Enrollee Printed Communications Administrative Service that works in collaboration with Employee Benefits customer services staff. It must provide effective and efficient communications with institution health plan members / enrollees and potential enrollees to enable them to make informed decisions in selecting a benefit plan, appropriately utilize available benefits, and actively engage in managing their health.

The PBM will print and distribute a welcome packet for new enrollees to include:	
Question Statement (attach necessary explanations and/or deviations)	**Yes or No**
89. Drug List.	
90. Cover letter.	
91. Notice of Privacy Practices.	
92. Web services promotional piece.	
93. Mail order and specialty pharmacy services	
94. Pharmacy listing (optional)	
95. The PBM is able to prepare and distribute (online, paper) Explanation of Benefits.	
96. The PBM will reissue identification cards to all institution health plan members when significant information changes are requested by institution.	
97. The PBM will do all the following:	
a. Submit enrollee identification card design for approval, in advance, to the institution.	
b. Issue replacements for lost cards at no charge to the enrollee or institution.	
c. Distribute member materials to persons enrolled prior to plan effective dates.	
98. The PBM will obtain approval from institutions for all mass mailed enrollee communications prior to mailing.	

99. All communications will be ADA compliant.	

Appeals
MHEC desires an Appeals Administrative Service to administer, document, and track appeals, complaints, and related issues and to process associated correspondence in compliance with all applicable laws for patient privacy and promptness.

Question Statement (attach necessary explanations and/or deviations)	**Yes or No**
100. The PBM will customize standard appeals related materials as directed by institutions.	
101. What percentage of denied claims processed in 2009 were appealed?	
102. What percentage of appealed claims was approved?	
103. Is any part of the appeals function delegated or outsourced?	
104. Do you send documentation to participants with notification of outcome of appeal?	

Pharmacy Network
105. Describe the network(s) the PBM will use to manage the pharmacy benefit for MHEC. Identify any major chains not participating in this network.
106. Describe the network pharmacy audit program, including the selection process for desk and on-site audits, frequency of such, and how settlements are calculated.
107. Explain your procedures for tracking compliance with usual and customary price provision.
108. Please answer all of the questions in described below:

Pharmacy Distribution Channels: Pharmacy Network	
Question Statement (attach necessary explanations and/or deviations)	**Yes or No**
Quality Management, Provider Selection and Credentialing	
109. Are network pharmacies required to complete a credentialing process?	
110. How frequently are pharmacies reviewed / credentialed once they are a part of the provider network?	
111. Have any pharmacy network providers been terminated based on results of the review process?	
112. Are there established procedures for removing a pharmacy from the network?	
113. Are any incentives provided to pharmacies to encourage the use of generics or formulary drugs?	
114. Are there quality parameters in place to measure and/or compensate pharmacy performance?	
115. Is there quality parameters in place to measure and/or penalties imposed for pharmacy poor performance?	
Provider Contracting	

116. Do you have multiple pharmacy retail network alternatives available to our organization? Provide detailed summary of differences of major terms and conditions along with sample contracts for each network.	
117. Do you have separate 90 day at retail pharmacy network alternatives available to our organization? Provide detailed summary of differences of major terms and conditions along with sample contracts for each network.	
118. Will you add retail network pharmacies at institution's request? What requirements must be met for you to consider expanding your network?	
119. Are pharmacy provider changes communicated to members?	
120. If a pharmacy provider is terminated, are members who have used that provider notified?	
121. What is the minimum requirement in liability coverage for network pharmacies (per occurrence and in aggregate)?	
122. Do you require documentation of network pharmacy policy and training on fraud, waste, and abuse prevention?	
123. Provide a detailed description of any and all point of sale transaction fees charged to the pharmacy network providers or directly to institutions. Include in this description whether these transaction message fees are levied from the pharmacy network to the vendor and/or the message back from the vendor to the pharmacy network provider.	
124. Describe your void/repay process for pharmacy claims that may require adjustments.	
125. Do you track complaints about network providers?	
Pharmacy Network Auditing	
126. How often do audits occur?	
127. How the audit department staffed, including the credentials of the staff.	
128. Are audit functions outsourced to another vendor?	
129. What percentage of pharmacies receives desk audits?	
130. What percentage of pharmacies receives on-site audits?	
131. What parameters trigger a desk audit?	
132. What elements are reviewed during the desk audits?	
133. Do you audit for the accuracy of dispense as written (DAW) use and DAW overrides?	
134. What criteria discovered in a desk audit will result in an on-site audit?	
135. For on-site audits:	
a. Who conducts the audits?	
b. What records are reviewed?	
c. What advance notice is provided to pharmacy	
136. Will audits identify and address partial fill and under stocked drugs?	
137. Will audits identify Rxs not picked up and dispensed are reversed in timely manner?	

138. Describe PBM's policies with respect to audit recoveries. How are these recoveries shared with the PBM's clients?
139. Describe your process for assuring that network providers respond to your DUR on-line messages.
140. Describe any education provided to network providers following an audit to correct problems from recurring.

The PBM must provide mail order services. However, it is not mandatory for MHEC health plan members to use home delivery. The PBM must describe all of the following:

Pharmacy Distribution Channels: Pharmacy Mail Order Service	
Question Statement (attach necessary explanations and/or deviations)	**Yes or No**
141. Is MAC pricing is used at mail order?	
142. Is mail order MAC price the same as retail MAC price? If no, is it higher or lower?	
143. If several MAC lists are available in your proposed retail networks, describe how the mail order MAC compares to the retail MAC (same drugs, more drugs, and fewer drugs)?	
144. Are you willing to guarantee that MAC pricing will be used for all generics dispensed through mail service?	
145. Briefly explain the general reasons or circumstances that have resulted in incorrectly dispensed drugs and what was done to correct the errors. Should this happen to institutions, would institutions receive compensation for any incorrectly dispensed drugs?	
146. Can you "file" a prescription submitted to mail order and hold for future request?	
147. Is there a hotline or customer service line that can telephonically connect a mail order consumer to a pharmacist?	
148. Does the caller have the ability to speak to a live customer service representative or pharmacist at any time during a call?	
149. Can members purchase over the counter products from the mail service facility?	
150. Can member use mail service while confined to a nursing home?	
151. Are procedures in place to ship to one time temporary address?	
152. Are there procedures in place to refill prescriptions where members may be traveling out of country? Extended leave (greater than 6 months)?	
153. Do you have overnight delivery available?	
154. Who pays the overnight delivery costs? (Member, PBM, Client?)	
155. Describe the timeframe and process of locating "lost" shipments and the facilitation of member pick up of this "lost" medication at a local pharmacy.	
156. Can the customer service representative determine the status of a mail order claim at any point during the filling and mailing the prescription?	
157. Are all mail and retail claims visible in the claims processing system to the mail	

order customer service representative?	
158. Can the member access on-line tracking of the prescription through the mail? Service facility until delivery?	
159. What payment options are available to members utilizing mail service?	
160. Credit card	
a. Bill member after shipment sent	
b. Payment required prior to shipment	
161. Will formulary compliance be maintained through your mail service facility?	
162. Can your mail service facility be set up to function as any other pharmacy does in your network?	
163. Can you process an e-script at mail service?	
164. Provide references of clients using the proposed mail order facility including the following information:	
165. Disclose the number of incorrectly filled, dispensed, labeled, shipped, etc. drugs (for whatever reason) generated out of the recommended facility during 2008 and 2009.	

Client	Length of Service	Number of Employees	Contact Name/Tel. #

Pharmacy Distribution Channels: Specialty Pharmacy Service	
Question Statement (attach necessary explanations and/or deviations)	**Yes or No**
166. Does the facility provide oral medications?	
167. Does the facility provide blood products?	
168. Does the facility provide limited distribution medications?	
169. Indicate the dispensing facility recommended for this account and briefly explain the reasons for this recommendation. Where is it located?	
170. What is your financial and vendor relationship with this specialty pharmacy?	
171. What is your turn-around time, based on both total days from receipt of order to delivery?	
172. Provide the number of current clients utilizing the Specialty Pharmacy service you are proposing.	
173. Provide a copy of the specialty pharmacy formulary and formulary options.	
174. Are there safeguards are in place to screen medication requests and authorization process for the medical versus pharmacy benefit (reimbursements	

and patient cost-sharing)?	
175. Is the specialty pharmacy claims processing system integrated with the retail/mail service claims processing system?	
176. Can the Customer Service Representative at the PBM and Client view the claims?	
177. Is the specialty pharmacy clinical management system integrated with the retail/mail service clinical management system?	
178. Can the Customer Service Representative at the PBM and Client view the approvals/denials?	
179. Are specialty pharmacy clinical management program administered separately from the retail / mail service programs?	
180. Are there safeguards are in place to ensure next day receipt of specialty medications?	
181. Are programs are in place to avoid waste?	
182. Is eligibility data coordinated between the PBM's retail / mail programs and the Specialty Pharmacy Provider's programs?	

183. Describe the process to be used when a member has an immediate need for a specialty medication (e.g., post discharge).
184. Describe any ancillary services offered, including but not limited to care management programs, special packaging, and free supplies.
185. Discuss your current member satisfaction with distribution, administration, and efficiency.
186. Provide references of clients using the proposed Specialty Pharmacy facility including the following information:

Client	**Length of Service**	**Number of Employees**	**Contact Name/Tel. #**

187. Disclose the NUMBER of incorrectly filled, dispensed, labeled, shipped, etc. drugs (for whatever reason) generated out of the recommended facility during 2008 and 2009.
188. Describe the process for notification of the client of the addition of a new drug product to the Specialty Drug List and how coverage or exclusion of such is determined.

Cost

Services Included in Fees		
Verify that the following services have been included in the quoted fees:	**Yes**	**No***

Services Included in Fees		
Verify that the following services have been included in the quoted fees:	**Yes**	**No***
1. Maintenance of comprehensive eligibility data for all eligible participants including name, social security number, date of birth, relationship, coverage option, coverage level, coverage effective date, coverage termination date, and COB data.	☐	☐
2. Adjudication and issuance of payments to providers	☐	☐
3. Maintenance and provision of accounting of claims (paid, reversed, adjusted, and denied) and expenses including reimbursement invoices and monthly reimbursement reconciliation.	☐	☐
4. In compliance with state and federal legislation relative to claims payment, the PBM will be responsible for any fine or assessment resulting from lack of compliance on its part.	☐	☐
5. Production of eligibility, claims and utilization reports as outlined in this RFP.	☐	☐
6. Provision of certificates of coverage in accordance with the Health Insurance Portability and Accountability Act.	☐	☐
7. Provision of health information to enrollees both written and via the Internet.	☐	☐
8. Pharmacy Audits	☐	☐

Complete the financial proposal which is found in Appendix C.

Plan Design

1. The PBM will be required to work closely with institution's Employee Benefits staff in the actual plan design. This process must have the flexibility to adjust to changes in criteria or procedures as required by institutions. MHEC requires that agreement with URAC standards are in place to assure that formulary decisions are based primarily on therapeutic practices before financial consideration of rebates. Member dissatisfaction and member disruption must be an important consideration in formulary design. Discuss your ability to comply and your company's philosophy toward such an approach.
2. Describe the PBM's current P&T Committee make up and outline procedures for approval of a new drug and default Formulary placement for new agents
3. Describe the different formulary options available to institutions. Provide a copy of the formulary or formularies the PBM is proposing and indicate if any major changes are anticipated within the next year.

4. Does the PBM have the ability to support numerous group numbers and various levels of benefits for both active employees and retirees?
5. The PBM will be required to assist individual Institutions in production of financial models for rate setting for annual plan premium and member cost sharing changes. Describe the process for providing modeling and trending.
6. Outline clinical management programs, including but not limited to outreach and education, physician profiling, retrospective and prospective Drug Utilization review, prior authorization, step therapy, drug coverage management predictive modeling, and disease state management programs.
7. Please answer all of the questions below:

General	
Question Statement (attach necessary explanations and/or deviations)	**Yes or No**
8. Institutions will reserve the right to audit, either directly or through its authorized agent(s), the vendor's compliance with the terms of the contract. If any costs are associated with audits, please include cost in your responses to the financial section.	
9. The vendor will be adequately accredited and will monitor affiliated health care providers, in accordance with the current URAC standards, and all other applicable and appropriate criteria relating to provider selection and quality management.	
10. The vendor will act promptly in response to complaints made by covered employees, retirees, and their eligible dependents. The vendor will maintain records of such complaints, and make complaint details available to the Client.	
11. The vendor will act promptly in response to appeals made by covered employees, retirees, and their eligible dependents. The vendor will maintain records of such appeals according to the Appeals Process resulting from this contract, and make appeal details available to the Client.	
12. The vendor will maintain an employee, retiree, and dependent eligibility system. Initial enrollment/eligibility file will be furnished electronically from institutions. The vendor must accept updates at a frequency mutually agreed upon containing additions, deletions, and status changes affecting enrollment from an electronic file produced by institution. The vendor must furnish a proposed file format and agree to work with institutions on a file format and transmission that is acceptable to both parties.	
13. The vendor and any subcontractors must process eligibility updates (new enrollments, demographic changes, coverage terminations, etc.) within 48-72 hours of receipt of an electronic file from institutions.	
14. The vendor will have the ability to support numerous group numbers and various levels of benefits for both active employees and retirees.	
15. Ninety-five percent of ID cards for initial enrollment will be accurate and mailed by the vendor in advance to the appropriate plan participants and received no later than the effective date.	

16. The vendor must produce a customized document or other printed employee communication describing benefits coverage to be made available no later than 30 days prior to the effective date of the plan.	
17. The vendor must assist the Client in production of financial models for rate setting for the Client's annual plan premium and member cost sharing changes.	
18. The vendor must use commercially reasonable efforts to facilitate use of debit card technology for flexible spending claims. The PBM must maintain a contractual relationship with Institution selected debit card vendor and provide the vendor with access to prescription claims information necessary to verify that the member incurred an eligible expense and the amount of the expense.	

MHEC requires that URAC standards are in place to ensure that formulary decisions are based primarily on therapeutic practices before financial consideration of rebates. Member dissatisfaction and member disruption must be an important consideration in formulary design.

Clinical / Formulary Management	
Question Statement (attach necessary explanations and/or deviations)	**Yes or No**
19. Are there different formulary options available?	
20. Can institutions edit the formulary? For example, institutions may want to change the tier of a particular drug.	
21. Does the PBM utilize an evidence-based formulary?	
22. Is the formulary readily available on the Internet for providers and members to access?	
23. Can the prescriber and member easily identify utilization restrictions, or formulary alternatives for non formulary or high cost formulary products?	
24. How do you communicate formulary changes / decisions to institutions, to providers and to plan members?	
25. Members (and their prescribers) receive notification from PBM when formulary changes directly impact them (covered drug changes tier status, covered drug becomes non-covered, etc).	
26. Is there an exceptions process in place, if a member / provider requests coverage of a non-covered drug?	
27. Have you provided value-based insurance design to other clients?	

Aggressive prescription management programs such as prior authorization, step therapy and quantity limits (PA, ST, QL), might provide savings to the Plan, without degrading quality of care. Through this RFP, MHEC is asking the PBM to propose integrated PA, ST, and QL programs. Such recommendations will be reviewed and approved based on institutions' discretion.

Utilization Review	
Question Statement (attach necessary explanations and/or deviations)	**Yes or No**
28. Does PBM offer Point of Sale Drug Utilization Review?	
29. Will mail service, specialty pharmacy, and retail pharmacies access a common database for DUR?	
30. Is a common patient profile (retail and mail service, specialty pharmacy) accessed when DUR is conducted?	
31. Does the PBM provide Basic DUR services? Describe	
32. Does the PBM provide Enhanced DUR services? Describe	
33. Does the PBM provide concurrent DUR services? Describe	
34. Does the PBM provide DUR focused on the needs of the retiree market place?	
35. Describe your tracking system for early refills that tracks both current and cumulative usage.	
36. Do you report soft edit overrides by individual network pharmacies?	
37. Are there circumstances where concurrent DUR edits indicate that Rx should not be filled? When will claim payment be denied?	
38. Are there circumstances where concurrent DUR edits will result in claim payment denial?	
39. Does the PBM provide Step Therapy point of sale messaging?	
40. Are processes in place for the PBM's ST process used to ensure a first line medication is not processed to allow a second line medication to process, but then the first line medication is reversed at the pharmacy? Describe	
41. Are notifications sent to members (and their prescribers) when formulary changes directly impact them (prior auth)?	
42. Are consumers informed in writing of the reasons for clinical decisions (written to member and prescriber)?	
43. Who will contact the prescriber if services are denied (e.g., prior authorization)?	
44. Does the PBM provide Care / Disease / Medication Management? Provide list of available programs.	
45. Are incentives offered in other employers' plans to encourage participation in the disease management programs?	
46. Are members provided with brochures to describe health promotion programs? Is there an additional cost? Provide samples of the brochures.	
47. If the PBM provides a pharmacist or nurse advice line, is it staffed 24 hours a day? If so, indicate if there is an additional cost.	
48. Are there designated internal process for handling appeals, exceptions and prior authorizations through the retail pharmacies, mail service pharmacy and specialty pharmacy	
49. Is there coordination of clinical programs for non-Medicare members as they transfer into the Medicare product?	
50. Are there clinical programs and guidelines for step-care therapy? Provide list of available programs and associated costs	

51. Are there clinical programs and guidelines for quantity limits? Provide list of available programs and associated costs	
52. Are there clinical programs and guidelines for prior authorization? Provide list of available programs and associated costs	
53. Do individual institutions have flexibility for selection of specific clinical programs for own institution?	
54. Are any guarantees tied to participation in specific clinical programs?	

Special Pharmacy Requirements

55. Does this PBM develop prescriber profiles? If so, please include a copy of any available formats.
56. What tools are available to the prescriber for access to clinical programs (for example, prior authorization information)?
57. How do you reimburse decimal packages (e.g., 2.5 ml ophthalmic products)? Do you allow rounding-up of these sizes? Do you audit for decimal quantity?
58. How do you reimburse drugs needed by physicians for administration in the physician's office? Do you have a specialty pharmacy arrangement for procurement and billing? How do you discern medical benefit versus prescription benefit?
59. Is it mandatory that specialty medications be filled by mail at the Specialty Pharmacy? If so, is there a first fill at retail available?
60. How frequently will your system dump claims to the institution's TPA for a spend-down consumer-driven health plan?
61. What type of services do you offer for over the counter medications?
62. Discuss a trial dose program for chronic medications (for example, requiring 30 day fill at retail before 90 day fill approved).
63. Define the policy regarding coverage for employees, spouses and/or dependent children
    a. Compounded prescriptions
    b. Emergency situations
    c. Out of country travel
    d. Nursing home / extended care facility

Reporting

1. Please provide description and examples of the PBM's standard reporting package. This should include the monthly utilization and financial reports, quarterly reporting mechanism and the annual review. Also, provide timelines for production and receipt schedule, and define the length of time data is available to client before archiving. Provide a sample of each standard report available
2. Describe the reporting tool that institutions can use to generate their own reports, the training for such, and number of users allowed access.
3. Describe the process for generation of ad hoc reports and data elements available for ad hoc reporting and any charges for generation of such.

Report categories, at a minimum, should include reports on performance measures, clinical management, drug utilization / drug mix, financial reporting, generic utilization, generic utilization, financial & clinical trending, and ad hoc reporting unique to plan.

4. Have you submitted samples of other claims reports formats and management reporting systems available to institutions?
5. State specifically which reports are automatically included in your proposed costs, and which are not. For reports not automatically provided, separately state the additional cost.
6. Have you stated which of the available claims reports and other management reporting systems you are including within the costs of your proposal?
7. Which of these reports available in real-time?

Standard Reporting

Please provide description and examples of the firm's standard reporting package. This should include the monthly utilization and financial reports, the quarterly reporting mechanism and the annual review. Also, provide timelines for production and receipt schedule.

8. Provide layout of data elements available on standard reports.
9. Describe customization parameters and barriers of standard reports.
10. Describe your reporting tool that institutions can use to generate their own reports.
11. Discuss reporting available that will identify members and provide drug detail at the member level.
12. Discuss tracking rejected and/or reversed claims and available reporting on these claims for clients.
13. Discuss reporting available that will identify groups and lines of business and provide drug detail at the group level.
14. What individual member reports do you provide?

Ad-hoc Reporting

15. Provide description and examples of ad-hoc reports. Also, provide timelines for production and receipt schedule.
16. Provide layout of data elements available on ad-hoc reporting.
17. Describe customization parameters and barriers, if any, of ad-hoc reports.
18. Describe your charges for customized and ad hoc reporting.
19. Describe your reporting tool that the institution can use to generate its own reports.

On-Line/Query Tool Reporting

20. Provide detailed information on any on-line reporting/querying product available, claims updating schedule and any costs associated with this product. Include information pertaining to client system requirements, the level of training you provide and the time required for product installation, and any computer system support required. Also include number of users allowed and costs associated by number of users.
21. The PBM must provide institution access to a web-based application to be used for on-line ad-hoc and administrative reporting and tracking no later than 45 days after implementation. The PBM must provide training, support, and on-going consultation in the use of this application. The

application must be compliant with all federal and state privacy and security requirements. Any costs for establishing connectivity with the PBM must be borne by the PBM.

22. The institution may require that both claims processing system access and querying tools be installed and functioning prior to any potential "go-live" date. Indicate your willingness to meet this potential requirement.
23. Which reports are on-line via the Internet – what is the time relationship or lag time of the data? (for example, end of month reports are available 10 days after month end; member profiles are real-time)
24. Provide timetable for scheduled downtime for on-line reporting/querying product and description of any non-scheduled downtime and the subsequent resolutions of these situations.
25. Describe customization parameters and barriers, if any, of on-line/Query reporting tool.
26. How many months of current data are available for online reporting?
27. How are per unit costs of drugs reported to members? How is this calculated for online viewing by member? By client?
28. The PBM shall provide the following capabilities:
    a. On-line access to paid claims history (real-time);
    a. On-line access to the drug file;
    b. On-line access to the eligibility files;
    c. Ability for the institution Employee Benefits staff to enter or update eligibility;
    d. Ability to request a new ID card;
    e. Plan coverage elements, such as copays and plan limits;
    f. Rejected and reversed claims;

Financial Reporting

29. Provide description and examples of financial standard report package. Also, provide timelines for production and receipt schedule.
30. Provide layout of data elements available on ad-hoc reporting.
31. Describe customization parameters and barriers of financial reports.

Financial Reporting	
The PBM's system shall provide, online / electronically, a complete package of monthly, quarterly, or yearly management and utilization reports that shall be mutually agreed upon by THE INSTITUTION and the PBM, to include the following information, at a minimum:	**Yes or No**
32. Total number of paid and denied claims	
33. Total number of claims and associated dollars by eligibility type	
34. Top 1000 drugs by dollars	
35. Top 100 indications by dollars	
36. Prior authorization (PA) reports: requests, approvals, denials, renewals	
37. Detail of PA denial - online	
38. Total number of denied requests on appeal;	

39. Management reports	
40. Annualized savings and basis for savings;	
41. Annualized savings per drug category and management type;	
42. Average time/range for adjudication of claims by mode of processing;	
43. Average time/range for prior authorization approval/denial;	
44. Number of prior authorizations not resolved within twenty-four (24) hours;	
45. Reasons for prior authorizations resolved in greater than twenty-four (24) hours	
46. Triangle lag report	

47. The PBM shall provide institution quarterly, semiannual, and annual reviews, including but not limited to, information that shall be useful to identify ongoing cost savings and institution plan performance.

I. Coalition Requirements

General

1. Show the organization of the account service team proposed for MHEC in chart format, including titles. Also, include the geographical location of each of the account service team members. Please indicate which members are dedicated to MHEC and which are not.
2. Describe any value added services and programs the coalition provides above and beyond those provided by the PBM.

Contracting

3. What is the minimum number of years MHEC institutions must contract with your Coalition?
    a. If more than one year, is there an option to give notice and sever the contract at the end of that year?
4. Since some institutions may have a plan year different than the contract year with your PBM (e.g. July-June instead of January-December), please explain how an institution with less than a full year contract with the "old PBM" will be treated as the Coalition moves to a "PBM" in the middle of an institution's contract.
5. MHEC has hundreds of thousands of potential covered lives that can be added to your current PBM contract. What is the trigger point (number of new covered lives) that allows you to receive additional discounts from your new PBM?
6. When does your current PBM contract end? Are there any renewal options? Are there any financial incentives built into the current contract that kick in with future years or do these have to be renegotiated at the end of the current contract? Please describe.

Account Management

7. Describe your approach to supporting MHEC members who decide to become a part of this group purchasing arrangement.
8. Will each individual MHEC member that participates in the program be assigned an individual Account Manager at the PBM?
9. Will MHEC members receive clinical support from a clinical pharmacist employed by the PBM?

10. Will MHEC members receive clinical support from a clinical pharmacist employed by the partner organization?
11. Confirm your ability to handle a potentially large influx of new business through the MHEC partnership. What staff will you potentially need that you don't have today? How will you handle filling those open positions?
12. Will MHEC have a single point of contact within your organization responsible for the partnership? Please identify this individual.
13. Will your organization provide support during meetings with MHEC members and the PBM vendor? If yes, in what capacity?
14. Describe how you would handle a dispute that is unresolved between a MHEC member and the PBM vendor.
15. How will you include MHEC staff as a key member of the team delivering value back to MHEC members?
16. Will MHEC staff be copied on communications (e.g. generic marketing materials) from the PBM or your organization to MHEC members?

Value-Added Services

17. Describe other group purchasing initiatives or other products that would align well with MHEC members.
18. Describe how your organization uses pharmacy data from your group purchasing program to engage local physicians and change prescribing behaviors to the lowest cost, most efficacious drugs. What programs do you do around adherence? Are these programs driven by the PBM or your organization? Include metrics used to measure the results of these programs and cite specific results when possible.
19. How will you allocate resources to support value-added services for MHEC members?
20. What other value-added services are available to MHEC members as a part of your organization?

Program Growth

21. What are your specific growth goals for your program this year? What is the likelihood that you reach those goals?
22. Describe how you will support MHEC in growing this program within the MHEC membership as it relates to:
    a. Marketing materials including the MHEC logo
    b. General Presentations to the MHEC membership
    c. Conference Call and Meeting Support for interested MHEC members
    d. Evaluating MHEC members' data for program savings opportunities
    e. Responses to MHEC members' RFP's
    f. Participation in Finalist Meetings
    g. Other support materials
    22. How do you currently interact with your PBM vendor's sales team?
    23. Who is (are) the primary contact(s) within your organization that MHEC would work with to secure new business in the program?

J. Submission Deadlines

The deadline for submission of proposals and related information is 4 p.m. CDT on

July 30, 2010. All proposals must be submitted with the signature page (see Appendix A), and should be typed in single-sided MS Word format. Proposals should be organized and presented in a manner that addresses all of the RFP provisions and requirements.
The outside envelope should be sealed and clearly marked:

"Proposal for Pharmacy Benefit Coalition Program"

Six (6) bound original and one (1) unbounded identical copy of the Response plus an electronic copy on CD/DVD (the electronic copy files are limited to the following document formats: MS Word, MS Excel, or PDF) The Provider should designate one (1) person as its principal contact with respect to this RFP.

The proposal should be addressed, mailed and/or delivered to the following address:

Midwestern Higher Education Compact
Attn: Jennifer Dahlquist
Assistant Vice President for Cost Savings and Chief Financial Officer
1300 South Second Street, Suite 130
Minneapolis, MN 55454-1079

To receive consideration, proposals must be received, at the above address, prior to the July 30, 2010, 4 p.m. CDT RFP deadline. Respondents assume full responsibility for the actual delivery of proposals during business hours at the specified address.

Unless otherwise specifically stated in the RFP, all specifications and requirements constitute minimum requirements. All proposals must meet or exceed the stated specifications or requirements. Pricing (Appendix C) must be presented in one sealed envelope separately of the response to the RFP.

L. Submission of Proposals

Respondents shall furnish information required by the solicitation in the form requested. MHEC reserves the right to reject proposals with incomplete information or which are presented on a different form. All proposals shall include a completed signature page (Appendix A), signed in the appropriate location, by a duly authorized representative of the respondent's organization. Signature on the proposal certifies that the respondent has read and fully understands all proposal specifications, plans, and terms and conditions.

By submitting a proposal, the respondent agrees to provide the specified services in the RFP, at the prices quoted, pursuant to all requirements and specifications contained therein. Furthermore, the respondent certifies that: (1) the proposal is genuine and is not made in the interest of or on behalf of any undisclosed person, firm, or corporation, and is not submitted in conformity with any agreement or rules of any group, association, or corporation; (2) the proposal has been arrived at independently, without consultation, communication or agreement with any competitor for the purpose of restricting competition, (3) the respondent has not directly or indirectly induced or solicited any other respondent to submit a false or sham proposal; (4) the respondent has not solicited or induced any person, firm, or corporation to refrain from responding; (5) unless otherwise required by law, the offer cited in this proposal has not been and will not be knowingly

disclosed by the vendor prior to opening directly or indirectly to any other vendor; and (6) the respondent has not sought by collusion or otherwise to obtain any advantage over any other respondent or over MHEC.

Modifications or erasures made before proposal submission must be initialed in ink by the person signing the proposal. Proposals, once submitted, may be modified in writing prior to the exact date and time set for the proposal submission deadline. Any such modifications shall be prepared on company letterhead, signed by a duly authorized representative, and state the new document supersedes or modifies the prior proposal. The modification must be submitted in a sealed envelope marked "Proposal Modification" and clearly identifying the RFP title, proposal submission deadline, time and date. Proposals may not be modified after the proposal submission deadline closing time and date. Telephone and facsimile modifications are not permitted.

Proposals may be withdrawn in writing, on company letterhead, signed by a duly authorized representative and received at the designated location prior to the submission deadline. Proposals may be withdrawn in person before the proposal closing upon presentation of proper identification. Proposals may not be withdrawn for a period of sixty (60) days after the scheduled closing time for the receipt of proposals.

In addition to addressing requested services, all proposals must address the information requested in the sections that follow.

1. Pharmacy Coalition and PBM's Financial Condition

   Submit your company's and current PBM's most recent audited financial statements (i.e. balance sheet, and profit and loss statement) and credit rating from nationally respected rating agency.

2. Disclosure/Transparency Policies

   Provide copies of compensation disclosure policy and a sample of documents to be issued when submitting quotations.

3. References

   Provide at least three references from current customers that participate in your Pharmacy Benefit Coalition. Provide at least one reference from a customer to which you no longer provide service. Please include any higher education references.

4. Pricing

   Initially, MHEC will consider proposals with compensation based solely on administrative fees, pharmacy discounts and rebates. The contract is to be awarded for three (3) years with two (2) three-year optional renewal periods exercised solely by MHEC. You must disclose the pricing for each year.

If responder is to earn any additional fees as the result of being appointed as the Coalition for the Pharmacy Benefit Coalition Program, they must be fully disclosed as to the nature of the fees and the amount of the fees.

Complete Appendix C for the financial proposal.

5. Limits of Insurance

   Address how your firm will meet the insurance requirements stated in section 7 of Appendix B – General Terms and Conditions.

M. Coalition Selection Criteria

Appropriate weights will be given to the following factors to be used in the evaluation of proposals (the factors are not listed in any particular order of importance):

- General Administration
- Claims Service/Administration
- Customer Service
- Pharmacy Discount Channels/Networks
- Cost
- Plan Design
- Reporting
- Optional Services

Financial Offer

- Mandatory Services
- Optional Services
- Alternative Pricing
- Responsiveness – Form and Content of RFP

N. Selection of Finalists and Best and Final Offers from Finalists

MHEC will select and notify the finalist on June 17, 2010. Only finalists will be invited to participate in the subsequent steps of the procurement. Prospective Coalition finalists may be asked to submit revisions to their proposals for the purpose of obtaining best and final offers to be considered during the interviews with finalists to be held the week of August 16-17-18, 2010 in Minneapolis, MN.

O. Conflict of Interest

By submitting a proposal, the vendor certifies that no relationship exists between the vendor and the Midwestern Higher Education Compact or its consultants that interferes with fair competition or is a conflict of interest, and no relationship exists between the vendor and other persons or firms that constitutes a conflict of interest that is adverse to the Midwestern Higher Education Compact.

P. Public Information

After the contract is awarded and the contract document is executed, all proposals and documents pertaining to the proposals will be open to the public. If the prospective provider submits information in response to this RFP that it believes to be trade secret materials as defined by the laws of the MHEC member states, the prospective provider must:

1. Clearly mark all trade secret materials in its response at the time the response is submitted;
2. Include a statement with its response justifying, with particularity, the trade secret designation for each item; and
3. Defend any action seeking release of the materials it believes to be a trade secret, and indemnify and hold harmless MHEC, its Commissioners, agents and employees from any judgments awarded against MHEC in favor of the party requesting the materials, and any and all costs connected with the defense. This indemnification survives MHEC's award of a contract. In submitting a response to this RFP, the prospective provider agrees that this indemnification survives as long as the trade secret materials are in possession of MHEC.

In the event a request is made for information which the prospective provider has identified as trade secret, MHEC agrees to notify prospective provider of said request and provide its determination as to whether disclosure is legally required, in addition to anticipated disclosure dates, if any, and to allow the prospective provider an opportunity, in its discretion and at its sole expense, to seek a protective order or otherwise protect the confidentiality of the information.

Q. Illegal Conduct

All responses must include a statement as to whether or not the responding firm has been convicted of bribery or attempting to bribe a public official, barred from contracting with a unit of local or state government as a result of bid rigging, or been convicted of a felony.

R. Organization and Format

Six (6) bound original and one (1) unbounded identical copy of the response plus an electronic copy on CD/DVD (the electronic copy files are limited to the following document formats: MS Word, MS Excel, or PDF) should be forwarded to the following address prior to the deadline. Proposals should be typed in single-sided MS Word format. Pricing must be presented in one sealed envelope separately of the response to the RFP.

S. Contacting MHEC

For further information about the Midwestern Higher Education Compact and its programs and services you are referred to the Compact web site at:
http://www.mhec.org.
Ms. Jennifer M. Dahlquist
Assistant Vice President for Cost Savings and Chief Financial Officer
Midwestern Higher Education Compact
1300 South Second Street, Suite 130
Minneapolis, MN 55454-1079
Phone: 612/626-1602

Fax: 612/626-8290
E-mail: jenniferd@mhec.org
Web Site: http://www.mhec.org

Appendix A – Signature Page

Midwestern Higher Education Compact's
Pharmacy Benefit Coalition Program

Supplementary material on any of the questions below may be attached to this questionnaire. Note: this form may be either filled in or reproduced on your word processing system, however, please reproduce in the same order as it exists.

General information about your office

____
Name of Firm

____
Street Address

____
City State Zip Code

____
Name of Contact Person in Connection with this Proposal

____
Title

____
Telephone Number

____
E-mail Address Organization's Website Address

____
Date submitting office was established

Also, please list subsidiary or associate companies of your firm which you wish to utilize in servicing the MHEC account.

____

____

____

____

If a subsidiary/branch/franchise of a national agency, provide the following information on the parent organization

____

Head Office

____

Date established

____

Number of offices in the U.S

The person signing below authorizes that:

1. He or she is the person in the respondent's firm responsible for the decision to offer the proposal in response to the RFP for Pharmacy Benefit Coalition Program; or

2. He or she is not the person in the respondent's firm responsible for the decision to offer, but has been authorized in writing to act as agent to quote the persons responsible for such decisions.

____

Name

____

Title

____

Organization

____

Date

Appendix B – General Terms and Conditions

Midwestern Higher Education Compact's
Pharmacy Benefit Coalition Program

1. Purpose: The purpose of these specifications is to require the furnishing of the highest service in accordance with the specifications. These documents and any subsequent addenda constitute the complete set of specification requirements and proposal response forms.

2. Governing Laws and Regulations: Any contract issued as a result of this RFP shall be construed according to the laws of the State of Minnesota. Additionally, the Coalition shall comply with all local, state, and federal laws and regulations related to the performance of the contract to the extent that the same may be applicable.

3. Taxes: The Pharmacy Coalition and PBM shall assume and pay all taxes and contributions including, but not limited to, State, Federal and Municipal which are payable by virtue of the furnishing and delivery of item(s) specified herein.
Materials and services furnished to MHEC are not subject to either Federal Excise Taxes or Minnesota Sales Tax.

4. Equal Opportunity and Non-Discrimination: In connection with the furnishing of services under the contract, the Coalition and all subcontractors shall agree not to discriminate against any recipients of services, or employees or applicants for employment on the basis of race, color, religion, national origin, sex, age, disability, or veteran status. The Coalition shall comply with federal laws, rules and regulations applicable to subcontractors of government contracts including those relating to equal employment of minorities, women, persons with disabilities, and certain veterans. Contract clauses required by the United Sates Government in such circumstances are incorporated herein by reference.

5. Applicable Laws and Regulations: The Coalition shall comply with federal laws, rules and regulations applicable to subcontractors of government contracts including those relating to equal employment opportunity and affirmative action in the employment of minorities (Executive Order 11246), women (Executive Order 11375), persons with disabilities (29 USC 706 and Executive Order 11758), and certain veterans (38 USC 4212 formerly [2012]) contracting with business concerns with small disadvantaged business concerns (Publication L. 95-507) and the Health Insurance Portability and Accountability Act (HIPPA) of 1996. Contract clauses required by the Government in such circumstances are incorporated herein by reference.

6. Inventions, Patents, and Copyrights: The Coalition shall pay for all royalties, license fees, patent or invention rights, or copyrights and defend all suits or claims for infringements of any patent or invention right or copyrights involved in the items furnished hereunder. The Coalition shall defend, protect, and hold harmless the Midwestern Higher Education Compact (MHEC), its officers, agents, servants and employees against all suits of law or in equity resulting from patent and or copyright infringement concerning the Coalition's performance or products produced under the terms of the contract.

Copyrights for any item developed for MHEC shall be the property of MHEC and inure to its benefit and the Coalition shall execute such documents as
MHEC may require for the perfection thereof.

7. Insurance: The Coalition will be required to provide certificates of insurance evidencing the following coverages and minimum limits of liability:

General Liability: Bodily injury and property damages
$10,000,000 per occurrence

Errors and Omissions: Professional liability
$2,000,000 per claim

Workers Compensation and Employers Liability
Statutory limits in state of hire

Commercial Automobile Liability: owned, non-owned and hired vehicles
$2,000,000 combined single limit for bodily injury and property damage

The insurance must be maintained throughout the term of the contract, except that any claims made policy must be maintained for 3 years following the last year of the contract. MHEC must be named as an additional insured on the broker's general liability policy on a primary and non-contributory basis.

Appendix C - Pricing

A. PBM Administrative Fees

Complete the administrative cost questionnaire below:

Administrative Fees Table	Proposed Fees	Is this an Estimate (E) or a Guarantee (G)?	Length of Guarantee (Years)
1. Administrative Fee (Specify PEPM or PMPM)			
2. Network Electronic Claims Processing (please specify basis: for example, paid or paid & denied, PMPM, etc)			
3. Out of Network and Paper Processing Charge			
4. Mail Order Claims Processing			
5. Basic Concurrent DUR (point of sale)*			
6. Retrospective DUR*			
7. Prospective DUR*			
8. Other DUR programs (list by name)*			
9. Formulary Management/Intervention*			
10. Physician Profiling and Interventions*			
11. Pharmacist Profiling and Education*			
12. Prior Authorization*			
a. Administrative Override			
b. Clinical Review			
13. Disease Management*			
14. Case Management*			
15. Compliance Programs*			
16. Data Reporting:			
a. Standard			
b. Custom or Ad-Hoc			
c. On Line Access			
17. Customer Service			
18. Toll-Free Number			
19. Claim Forms			
20. Participant Communication Materials:			
a. Camera-Ready Art			
b. Production Cost			
21. ID Cards			
a. Initial			

b. Replacement			
22. COB Administration			
23. Clinical Program costs (Step, PA, QL)			
24. Appeals – clinical and non-clinical			
25. Audits			
26. Other mandatory/required fees or costs not included in the above			

27. Explain any financial guarantees that the PBM is offering.
28. What is the preferred method of claims payment?

B. Funding and Contracting

1. Describe the claim funding process and address the following points:
    a. Payment options
    b. Billing frequency
    c. Due dates
    d. Grace period
    e. Late payment procedures
    f. Interest penalties
2. Describe the administration fee billing process and address the following points:
    a. Payment options
    b. Billing frequency
    c. Due dates
    d. Grace period
    e. Late payment procedures
    f. Interest penalties
3. Are administrative fees bundled with incurred claims costs or are they billed separately?
4. Will you offer a one-time implementation credit to support the cost with implementation or renewal activities?
    a. What expenses qualify for the credit?
    b. The amount PMPM.
    c. How can the funds be used?
    d. When will it be paid to the institution?
    e. What type of documentation is required?

C. Prescription Cost

Please answer the following questions for each proposed pharmacy network offered to the Institutions:

1. What is the name of the network(s)?
2. How many U.S. pharmacies are in the network(s) as of January 1, 2010?
3. Which major chains do not participate in any given network?
4. Describe any differences between available networks. If a single network describe how this network differs from your traditional network and address the following points:
5. Network performance objectives
6. How performance-based reimbursement is measured and paid
7. Target benchmarks to be achieved by the pharmacy network
8. Technology and processes used to achieve compliance
9. How performance will be reported
10. Estimate the savings under proposed network(s) and identify by type of savings (e.g. higher generic utilization, compliance with DUR messages, etc.).
11. What amount is collected from the member when the copay is greater than the eligible charge but less than the UCR price?

Brand Name Drugs
Assume AWP Prices have been rolled back per the AWP Settlement

12. Please complete one of the following formulas for billing the plan sponsor:
    a. A rate billed to the institution of the lower of AWP - ___% + $______ dispensing fee or UCR
    b. A rate billed to the institution of AWP - ___% + $_____ dispensing fee
    c. A pass-thru of contracted rates with an overall guarantee of AWP - ___% + $_____ dispensing fee
    d. A pass-thru of contracted rates with an overall guarantee of the lower of AWP - ___ % + $_____ dispensing fee or UCR
    e. A pass-thru of contracted rates with an overall estimated average of the lower of AWP - ___ % + $_____ dispensing fee or UCR
    f. Other: please specify
13. Is this formula guaranteed?
14. For how many years?
15. Are guarantees reconciled at the institution level or MHEC group level?
16. How often are guarantees reconciled?
17. What are the discount arrangements you are able to provide MHEC for retail and mail service prescriptions?
18. Are the above discount arrangements the same arrangements that are in place between the pharmacies and the prescription drug vendor? If not, explain the reimbursement arrangement between the vendor and the pharmacies.
19. What is the penalty if the guarantee is not satisfied and when is the penalty paid? Indicate any aggregate maximum on financial performance penalties.
20. Please provide a sample report that will be provided to the plan sponsor to demonstrate satisfaction of this guarantee and/or calculate the penalty owed. How frequently is this reconciliation done?
21. How does this billing formula differ from the actual retail pharmacy reimbursement formula?
22. Does the guarantee proposed in Question 8 include any multi-source brand drugs included on the MAC list?

23. If retail pharmacies are reimbursed at a lower of UCR pricing, provide the following:
    g. The estimated % of brand name prescriptions where the UCR price is lower than the reimbursement formula
    h. The estimated impact of UCR pricing as a % of brand name eligible charges
    i. Examples of any reports available to demonstrate/validate the impact of UCR pricing

Generic Drugs

Assume AWP Prices have been rolled back per the AWP Settlement

24. Please complete one of the following formulas for billing the plan sponsor:
    j. A rate billed to the plan sponsor of the lower of AWP - ___% or MAC + $______ dispensing fee or UCR
    k. A rate billed to the plan sponsor of the lower of AWP - ___% or MAC + $_____ dispensing fee
    l. A pass-thru of contracted rates with an overall guarantee of the lower of AWP - ___% or MAC + $_____ dispensing fee
    m. A pass-thru of contracted rates with an overall guarantee of the lower of AWP - ___ % or MAC + $_____ dispensing fee or UCR
    n. Other: please specify
25. Is this formula guaranteed?
26. For how many years?
27. Are guarantees reconciled at the institution level or MHEC group level?
28. How often are guarantees reconciled?
29. What is the penalty if the guarantee is not satisfied and when is the penalty paid? Indicate any aggregate maximum on financial performance penalties.
30. Please provide a sample report that will be provided to the plan sponsor to demonstrate satisfaction of this guarantee and/or calculate the penalty owed. How frequently is this reconciliation done?
31. How does this billing formula differ from the actual retail pharmacy reimbursement formula?
32. If retail pharmacies are reimbursed at a lower UCR pricing, provide the following:
    o. The estimated % of generic prescriptions where the UCR price is lower than the reimbursement formula
    p. The estimated impact of UCR pricing as a % of generic eligible charges
    q. Examples of any reports available to demonstrate/validate the impact of UCR pricing

Specialty Products

33. List the criteria for classification of a drug as "Specialty"
34. Are specialty products reimbursed with the same formula as detailed above? If not, what is the formula for pricing these claims? Please provide the pricing for all products that have specialty pricing. How is this pricing determined? Will this specialty pricing formula require an exclusive Specialty Pharmacy network? If so, list pricing for both exclusive network and open Specialty network. Is there a specialty fee?
35. Is this formula guaranteed?
36. For how many years?

37. What is the penalty if the guarantee is not satisfied and when is the penalty paid? Indicate any aggregate maximum on financial performance penalties.
38. Please provide a sample report that will be provided to the plan sponsor to demonstrate satisfaction of this guarantee and/or calculate the penalty owed. How frequently is this reconciliation done?
39. How does this billing formula differ from the actual retail pharmacy reimbursement formula?

Effective Discount Formula

40. Propose an effective discount on total brand name and generic spending including the impact of MAC and UCR pricing within the following formula, as well as discount guarantees individually on Brand and Generic drugs:
    Overall effective rate of AWP - ____%
    Generic effective rate of (Network Pharmacy) AWP - __%
    Brand effective rate of (Network Pharmacy) AWP- __%
    Generic effective rate of (Mail Order Pharmacy) AWP___ %
    Brand effective rate of (Mail Order Pharmacy) AWP -__ %
41. Provide the calculation methodology for this formula.
42. Is this formula guaranteed?
43. For how many years?
44. What is the penalty if the guarantee is not satisfied and when is it paid? Indicate any aggregate maximum on financial performance penalties.
45. Please provide a sample report that will be provided to the plan sponsor to demonstrate satisfaction of this guarantee and/or calculate the penalty owed. How frequently is this reconciliation done?

D. MAC Pricing

1. Describe how your MAC program is developed and maintained and how frequently it is updated.
2. For each MAC list that you maintain, disclose the following as of July 1, 2002:

Name of MAC List				
a. Check (✓) the MAC list proposed for MHEC				
b. Number of GCNs on the MAC list				
c. Estimated % of retail generic* Rxs that will be MAC'd				
d. Estimated % of retail generic* AWP that will be MAC'd				
e. For those drugs on the MAC list, what is the average or effective discount off the generic AAWP				

(weighted by dollars)				
f. Does the MAC list include any multi-source brand drugs?				
g. If yes, provide a list:				

* Defined as generic drugs + multi-source brand drugs on the MAC list

3. Disclose any exceptions or differences in how MAC pricing is administered from pharmacy to pharmacy.

E. Mail Order Reimbursement

1. Complete the following table:

	Proposed Pricing	**Is this an Estimate (E) or a Guarantee (G)**	**Length of Guarantee (Years)**	**Amount at Risk**
a. Brand Discount % off AWP				
b. Brand Dispensing Fee per Rx				
c. MAC Pricing (Yes or No)				
d. For those drugs on the MAC list, what is the average or effective discount off the generic AAWP (weighted by dollars)				
e. Estimated % of mail order generic* Rxs that will be MAC'd				
f. Estimated % of mail order generic* AWP that will be MAC'd				
g. Non-MAC Generic Discount % off AWP				
h. Generic Dispensing Fee per Rx				
i. Postage-Paid Return Envelopes				

*Defined as generic drugs + multi-source brand drugs on the MAC list

2. Provide the following information regarding the AWP source and pricing:
   a. Source document or service providing AWP
   b. Frequency of updates to AWP file
   c. Use of manufacturer's full 11-digit NDC code to determine AWP
   d. Package size basis for typical book of business AWP formula

e. Use of acquisition package size AWP in pricing determination

3. Are specialty products reimbursed with the same formula as detailed above? If not, what is the formula for pricing these claims? Please provide the pricing for all products that have specialty pricing. How is this pricing determined?
4. If mail order pricing is based upon the actual dispensed package size, provide an estimate to demonstrate the value compared to discounts based on fixed package size of 100s or pints.
5. Are shipping costs included in the mail order dispensing fee? If not, define the additional cost. Indicate whether the proposed mail order dispensing fees are subject to increases in postal/shipping rates during the contract term.
6. What amount is collected from the member when the copay is greater than the eligible charge?

F. Formulary Rebates

1. What is your definition of rebates?
2. What role do rebates play in the placement of drugs on the formulary?
3. Explain how the PBM's Pharmacy & Therapeutics process integrates with formulary and rebate development and negotiations?
4. How does the PBM integrate Prior Authorizations and Step Therapy into this process?
5. What type(s) of rebate agreements do you offer?
6. What is the minimum average dollar amount per claim (brand + generic) that you will guarantee for all claims?
   a. 30 day retail claims
   b. 90 day mail order claims
7. What other services are included in the rebate contract – for example, fees, compensation and discounts?
8. How can the rebate agreement be audited?
9. Who is the party responsible for generating rebates and include the name of the vendor if this is outsourced?
10. Explain your organization's rebate invoicing, accounting and payment processes including distribution of funds and reports outlining dollars projected and received. Please provide a sample rebate report.
11. Describe in detail the existing relationships with pharmaceutical manufacturers and clearly define the term "manufacturer rebates" with respect to "rebates" that will be shared with our Institution. Include all such revenue sources, both direct and indirect, including but not limited to drug spend rebates and manufacturer administrative fees.
12. Does the vendor generate rebate dollars or any other pharmaceutical manufacturer revenue that are not shared with the client? If yes, describe in detail.
13. How are rebates calculated for the client and reported? Are rebates paid on all drugs (retail, mail order, specialty, brand, generic, paper claims)? What is the time frame for distribution of rebates? Is there any difference in the rebates for those using the discount card?
14. What other payments do you get from drug manufacturers besides rebates?
15. Define the total rebate pool (including specialty drug and mail) with regard to the client's share.
16. Provide samples of rebate reports the PBM provides to self-funded clients.
17. Describe the time line for reporting and receiving of rebates.
18. We may require the right to a client or an independent client-specific consultant group audit

of records and manufacturer contracts for compliance with the terms of both formulary and rebate guarantee. Indicate your willingness to meet this requirement.

G. Pharmacy Benefit Coalition Pricing

1. What is the monthly fee that is paid directly to the pharmacy benefit coalition for administrative services, which is separate from the PBM administrative fee (if applicable)? Please indicate whether Per Employee per Month (PEPM) or Per Member per Month (PMPM)).
    a. If a flat amount, is it the same for all institutions or does it vary? Please describe.
    b. If it is a percentage, is the percentage the same for all institutions or does it vary? Please describe.
    c. Is there a monthly or annual cap on this fee?
    d. Is there a rebate if the coalition achieves certain efficiencies or economies to scale?

2. Are there additional fees for MHEC members to take advantage of any of the additional programs and services you've described in this proposal? Please cite specifics.
3. Are there any additional fees or charges that are not reflected in the questionnaire for the PBM or the Pharmacy Benefit Coalition questions above? If so, please indicate the fee or charge category and the corresponding cost and indicate the frequency of the expense.
4. Will your organization derive revenue from MHEC members who participate in this program? If so, please disclose all sources of revenue.
5. Is there an opportunity to provide MHEC with an administrative fee to compensate MHEC for promoting the PBM group purchasing program?