Attachment T – Participant Bidding Agreement (PBA) Sample Export

1 Solicitation Information

State of Maryland

Department of Budget and Management (DBM)

Multi-Step Invitation for Bids (MS-IFB)

Pharmacy Benefits Management Services and Purchasing Pool Management

MS-IFB Number BPM039929

See eMMA for State Required Attachments listed in MS-IFB

2 Instructions for Bidders

A. MANDATORY INSTRUCTIONS FOR BIDDERS

Bidder shall complete all applicable sections of the MS-IFB during each phase and provide submissions by the stated deadlines.

Electronic responses and the online Reverse Auction will be facilitated through this platform. Paper submissions, or submissions in any other form or format, shall not be accepted.

Bidders shall submit a Non-Disclosure and Intent to Bid Agreement in order to complete registration and receive login credentials.

Failure to follow these instructions may be grounds for rejection of Bidder response.

B. SUBMISSION PROCESS

The MS-IFB process will be broken out into three (3) phases as follow:

Phase I: Minimum Qualifications

Phase II: Participant Bidding Agreement (PBA)

Phase III: Reverse Auction

Registered Bidders shall receive login credentials to complete Phase I: Minimum Qualifications. After the State has confirmed Bidder meets the minimum qualifications set forth, each qualified Bidder shall be invited to participate in Phase II: PBA responses.

All submissions shall be electronic, using the Milliman RFP360 platform in accordance with the timelines described herein.

Next, minimum qualified Bidders shall respond to Phase II: PBA, which encompasses the technical requirements and terms of the Bidder submission which are not the Reverse Auction. The PBA shall be submitted no later than the specified deadline. **Bidder shall not alter or adjust any answers in the PBA in any way after submission.**

The Reverse Auction phase will contain three (3) rounds of bidding. Bidders that pass both Phase I and Phase II shall be invited to bid via the Reverse Auction.

All Bids will remain valid from the submission deadline until Contract award. A Bidder's disclosure or distribution of submissions other than to the State shall be grounds for disqualification. No more than one (1) Bid per respondent shall be submitted.

The definitions, terms, and statements in the PBA must be satisfied in order for the Bidder to be considered for the State's Pharmacy Benefit Manager. Bidder shall respond ("Agree" or "Disagree") as to whether you agree with the definitions and conditions in the PBA. An "Agree" response indicates that the terms you bid fully comply with the specific requirement. Any other response (e.g., "Disagree") indicates you cannot comply with the specific requirement.

Responses to the PBA apply to both Functional Area 1: Active Employees, non-Medicare Retirees, and State of Maryland Rx Purchasing Pool (Commercial) and Functional Area 2: Medicare Eligible Retirees Employer Group Waiver Program (EGWP) unless explicitly stated.

C. TECHNICAL SUPPORT

All communications except for technical support with Milliman's RFP360 platform shall be directed to the State Procurement Officer as indicated in the MS-IFB Key Information Summary Sheet. Technical support includes user access, navigation help, and system-related response issues. Any questions related to the context of a question shall be directed to the State Procurement Officer ahead of the Phase I process. After Phase I has begun, the only communication with Bidders is limited to technical support of the platform as described herein.

Platform frequently asked questions (FAQs) and support can be found here: Support Home (site.com)

3 Phase I: Minimum Qualifications

To be completed in Phase I. See Attachment P: Minimum Qualifications Sample Export.

4 Phase II: Participant Bidding Agreement

Phase II: PBA encompasses various requirements for the Bidder to consider for review in this Pharmacy Benefit Management (PBM) MS-IFB. The State will review the response to the PBA thoroughly and will determine if the Bidder qualifies for Phase III: Reverse Auction. Bidders are asked to respond to each question with Agree or Disagree utilizing the dropdowns.

4.1 General Definitions

As stated in the Solicitation, Bidder shall agree to all definitions as written. Bidder shall be expected to comply with all Abbreviations and Definitions.

Abbreviations and Definitions

1. **340B Claim** - A Claim identified by the submission of "20" in the Submission Classification Code field 420-DK and/or a Claim submitted by a pharmacy owned by a covered entity, as defined in Section 340B(a)(4) of the Public Health Services Act, whose 340B status is coded as "39" in the NCPDP DataQ database. Claims incurred at a PBM owned, operated, or affiliated mail or specialty pharmacy are not included in this definition.
2. **Acceptable Use Policy (AUP)** - A written policy documenting constraints and practices that a user must agree to in order to access a private network or the Internet.
3. **Access** - The ability or the means necessary to read, write, modify, or communicate data/information or otherwise use any information system resource.
4. **Active Employees** - Employees within the State Personnel Management System, and employees of the Maryland Department of Transportation, Judiciary, and Legislature, including all full and part time employees and contractual employees. Employees of the University of Maryland System are not included under this definition.
5. **Authorized Generic Drug** - Any drug sold, licensed, or marketed under a new drug application (NDA) approved by the Food and Drug Administration (FDA) under section 505(c) of the Federal Food, Drug, and Cosmetic Act (FFDCA) that is marketed, sold or distributed under a different labeler code, product code, trade name, trademark, or packaging (other than repackaging the listed drug for use in institutions) than the brand name drug.
6. **AWP - Average Wholesale Price** - The actual reported "AWP" from Medi-Span for the specific NDC-11 on the Day of Service for all channels (i.e., Retail, Mail, and Specialty). Claims will not use an average AWP or pre-settlement AWP, nor will the AWP be externally calculated, altered, or adjusted. Claims at Mail and Specialty pharmacies will use the AWP of the actual package size and NDC-11 used to dispense (not the package size of the prescription dispensed or alternative package sizes).
7. **Bid** - The Bidder's Bid.
8. **Bidder** - An entity that submits a Bid in response to this MS-IFB.

9. **Bid Price Form or Bid Form -** The Reverse Auction (see definition of "Reverse Auction" below).
10. **Billed Amount Due** - The total cost for a Covered Product on a paid Claim in accordance with the Plan excluding the Copayment.
11. **Biosimilar or Biosimilar Product** - A FDA-approved type of biological product that is highly similar to and has no clinically meaningful differences in terms of safety and effectiveness from its respective FDA-approved biological reference product, under Section 351(k) of the Public Health Service Act, as added by the Biologics Price Competition and Innovation Act of 2009.
12. **Brand Drug** - For adjudication purposes, a drug that is approved by the U.S. Food and Drug Administration (FDA) and is distributed under an FDA Application Type of new drug application (NDA) or biologic license application (BLA), and which is not an Authorized Generic and which is not a House Generic. In instances where the Brand or Generic status of a drug, as determined by the Contractor relying on an independent published source, differs from this definition, the Contractor may rely on its standard drug classification system for operational purposes of claim adjudication. All Brand Pricing Guarantees will be reconciled based on Medi-Span multi-source code field M, N, or O, excluding House Generics, as defined herein.
13. **Business Day(s)** - The official working days of the week to include Monday through Friday. Official working days excluding State Holidays (see definition of "Normal State Business Hours" below).
14. **Change of Control** - One or a series of transactions related to a) sale of assets of a party exceeding fifty percent (50%); b) any merger, takeover, consolidation, or acquisition of a party with, by, or into another corporation, entity, or person; or c) a transfer of a party's issued and outstanding shares exceeding fifty percent (50%).
15. **Claim** - A Covered Product that is processed and paid through PBM's adjudication system or otherwise transmitted/processed by the PBM in accordance with State's applicable benefit plan design. Bidder agrees its financial bid is based on approved and paid Claims only and will exclude all rejected, withdrawn, denied and/or reversed Claims.
16. **Clinical Services Account Manager** - The individual assigned by the Contractor (identified as Key Personnel in MS-IFB Section 3.10) to provide administrative clinical services to the State.
17. **CMS** - Centers for Medicaid and Medicare Services.
18. **COMAR** - Code of Maryland Regulations, available on-line at https://dsd.maryland.gov/Pages/COMARHome.aspx.
19. **Compound Prescription** - A medication that requires compounding by pharmacists because it is not available from a pharmaceutical manufacturer in the prescribed form or strength. Compound drugs consist of two or more solids, semi-solids, or liquids where at least one of which is a Covered Product.
20. **Contract** – The Contract awarded to the successful Bidder pursuant to this MS-IFB. The Contract will be in the form of **Attachment M**.
21. **Contract Commencement** – The date the Contract is signed by the Department following any required approvals of the Contract, including approval by the Board of Public Works, if such approval is required.
22. **Contract Manager (CM)** – The State representative for this Contract who is primarily responsible for Contract administration functions, including issuing written direction, invoice approval, monitoring this Contract to ensure compliance with the terms and conditions of the Contract, monitoring MBE and VSBE compliance, and achieving completion of the Contract on budget, on time, and within scope. The Contract Manager may authorize in writing one or more State representatives to act on behalf of the Contract

Manager in the performance of the Contract Manager's responsibilities. The Department may change the Contract Manager at any time by written notice to the Contractor.

23. **Contractor** – The selected Bidder that is awarded a Contract by the State.
24. **Contractor Account Executive** – The individual assigned by the Contractor (identified as Key Personnel in **MS-IFB Section 3.10**) to oversee all work performed under the Contract and who is the day-to-day Contract contact.
25. **Contractor Account Service Representative** – The individuals assigned by the Contractor (identified as Key Personnel in MS-IFB Section 3.10) to provide service to EBD staff.
26. **Contractor Personnel** – Employees and agents of prime contractor and subcontractor employees and agents performing work at the direction of the Contractor under the terms of the Contract awarded from this MS-IFB.
27. **Contractual Employee** – A non-permanent employee of the State of Maryland as defined in COMAR 17.04.13.03.
28. **Coordination of Benefit Claim (COB Claim)** - A Claim subject to coordination of benefits under the applicable Benefit Plan, regardless of whether State is the primary or the secondary payer.
29. **Copayment or Copay** - The portion of the charge for each Covered Product dispensed to an enrollee that is the responsibility of such enrollee (e.g., copayment, coinsurance, cost sharing, and/or deductibles under initial coverage limits and up to annual out-of-pocket thresholds) as provided under the Benefit.
30. **Coverage Gap** - The stage of the benefit between the initial coverage limit and the catastrophic coverage threshold, as described in the Medicare Part D prescription drugs program administered by the United States federal government.
31. **Coverage Gap Discount** - The manufacturer discounts available to eligible Medicare beneficiaries receiving applicable, covered Medicare Part D drugs while in the Coverage Gap.
32. **Coverage Gap Discount Program** - The Medicare program that makes manufacturer discounts available to eligible Medicare beneficiaries receiving applicable, covered Medicare Part D drugs while in the Coverage Gap.
33. **Covered Product(s)** - The prescription drugs, supplies, and other items that are covered under the Planor treated as covered pursuant to a coverage determination appeal.
34. **Data Breach** - The unauthorized acquisition, use, modification or disclosure of State Data, as that term is defined below, or other Sensitive Data, as that term is defined below.
35. **DAW** - Dispense as written.
36. **DBM or Department** – The Maryland Department of Budget and Management.
37. **Dependent** - An eligible Spouse, Domestic Partner, or Dependent Child, as those terms are defined in COMAR 17.04.13 in connection with establishing eligibility for coverage in the State Employee and Retiree Health and Welfare Program and Plan.
38. **Dependent Child** - An eligible person as defined in COMAR 17.04.13.01(B)(3).
39. **DESI** - Drug Efficacy Study Implementation. DESI refers to drugs identified by the Food and Drug Administration as lacking substantial evidence of effectiveness. DESI drugs, as with all other drugs that do not meet the definition of either Brand Drug, as that term is defined above, or Generic Drug, as that term is defined below, shall be excluded from Bid Price Form (Attachment B) pricing guarantees and reconciliation of those guarantees for FA 1 and FA 2, but will be subject to the Transparent and Pass-Through Pricing requirements of MS-IFB Section 2.3.2.1.

40. **DHHS** - The United States Department of Health and Human Services.
41. **Direct Pay Enrollee** - An individual in the State Plan who is billed directly by the Department for selected State benefits, including but not limited to Consolidated Omnibus Budget Reconciliation Act (COBRA) Participants, Leave of Absence Participants, Contractual Employees and Part-Time Employees.
42. **Discount(s)** - The percentage decrease from AWP. For example, AWP = $100: Price = $80; (AWP 100 - Price 80) / AWP 100 * 100% = 20 % Discount
43. **Dispensing Fee(s)** - The pharmacy professional fee incurred at the point of sale to pay for costs in excess of the Ingredient Cost for the filling of a single Covered Product for a Member.
44. **Domestic Partner** – A relationship between two individuals who:

    1. Are at least 18 years of age;
    2. Are not related to each other by blood or marriage;
    3. Are not married or in a civil union of domestic partnership with another individual;
    4. Are the sole domestic partner of the other person and have been so for the immediately preceding 12 months; and
    5. Agree to be in a relationship of mutual interdependence in which each individual contributes to the maintenance and support of the other individual and the relationship.
45. **Drug Classification** - The agreed upon methodology to classify Brand Drugs and Generic Drugs as set forth in this Bid.
46. **Drug Therapy Management** - The overall management of medication therapy by pharmacists or other trained healthcare professionals following clinical protocols to maximize therapeutic outcomes and value.
47. **Drug Utilization Review or DUR** - A collection of programs designed to ensure the safe, efficient and cost-effective use of drugs.
48. **EBD** – The Employee Benefits Division of the Department of Budget and Management.
49. **EDI** - Electronic Data Interface.
50. **EGWP Benefit** – The Employer Group Waiver Plan (EGWP) Benefit, which serves as the State's Medicare Part D prescription drug plan administered for eligible retirees.
51. **EGWP Member** - Each Part D Eligible Retiree who is enrolled in the EGWP Benefit State Plan.
52. **EGWP Plus** - The prescription drug benefit plan that provides coverage beyond the standard Part D benefit and is defined by CMS as other health or prescription drug coverage, and as such, the Coverage Gap Discount is applied before any additional coverage beyond the standard Part D benefit.
53. **EGWP Services** - The Employer Group Waiver Prescription Drug Plan (PDP) services that are described in the Agreement that will support State's participation in the PDP Program as an employer providing a CMS-approved EGWP. Services include, but are not limited to: (1) the adjudication of eligible claims through a contracted retail pharmacy network, and the Mail Order and specialty pharmacies at specified discounted rates, (2) the billing of such adjudicated claims, (3) customer service relating to retail pharmacy, mail order and specialty pharmacy claims; and (4) all CMS required filings and reporting.
54. **eMMA** - eMaryland Marketplace Advantage (see MS-IFB **Section 4.2**).
55. **Enterprise License Agreement (ELA)** - An agreement to license the entire population of an entity (employees, on-site contractors, off-site contractors) accessing a software or service for a specified period of time for a specified value.
56. **FMLA** – The Family and Medical Leave Act.
57. **Formulary** - The list of clinically appropriate Covered Products covered by the State, organized into different tiers or levels indicating potential member cost share for each Covered Product.

58. **FTE** - Full-time equivalent. A State employee who is FTE or who works at least 50% of a normal workweek of 40 hours may be eligible for State subsidy of the State Plan's premium.
59. **Functional Area** - A contracted service requirement outlined within the MS-IFB and subject to award.
60. **Generic Code Number (GCN)** - A standard number assigned by a drug pricing service called First DataBank. The GCN identifies each strength, formulation, and route of administration of a drug entity. Each drug has its own unique GCN.
61. **Generic Drug** - For adjudication purposes, a drug that is approved by the U.S. Food and Drug Administration (FDA) and is distributed under an FDA Application Type of abbreviated new drug application (ANDA), or which is an Authorized Generic or which is processed as a House Generic. In instances where the Brand or Generic status of a drug, as determined by the Contractor relying on an independent published source, differs from this definition, the Contractor may rely on its standard drug classification system for operational purposes such as claim adjudication. All Generic Pricing Guarantees will be reconciled based Medi-Span multi-source code filed of Y or House Generic, as defined herein.
62. **Go-Live Date** - The date when coverage for Participants under the Plan is scheduled to begin.
63. **GPI or GPI-14** - The Generic Product Identifier reported by Medi-Span. It is a 14-character hierarchical classification that identifies drugs from their primary therapeutic use down to the unique interchangeable product regardless of manufacturer or package size.
64. **Gross Drug Cost or Gross Cost** - The total discounted Ingredient Cost plus and applicable Dispensing Fee, sales tax, or other tax for a Covered Drug under a Claim.
65. **HIPAA** – The Health Insurance Portability and Accountability Act and its corresponding regulations, including HITECH.
66. **House Generic** - A drug with the multi-source code field in Medi-Span of O when there is a DAW code of 5.
67. **Information Technology (IT)** - All electronic information-processing hardware and software, including: (a) maintenance; (b) telecommunications; and (c) associated consulting services.
68. **Ingredient Cost** - The total cost for a Covered Product on a Paid Claim, excluding Administrative Fees, Copayment, Dispensing Fees, POS Rebates, government-imposed service fees, and taxes, in accordance with the terms of the Plan.
69. **Key Personnel** - All Contractor Personnel identified in the solicitation as such that are essential to the work being performed under the Contract. See MS-IFB **Section 3.10**.
70. **LAW** - Leave of absence without pay. An unpaid leave of absence elected by a permanent employee who is not eligible for State subsidy of benefits during such leave but is eligible to participate in certain benefits provided by the State of Maryland while on the unpaid leave of absence.
71. **LEP** - Late Enrollment Penalty. The financial penalty incurred under the Medicare Drug Rules by Medicare Part D beneficiaries who have had a continued gap in creditable coverage of sixty-three (63) days or more after the end of the beneficiary's initial election period, adjusted from time to time by CMS.
72. **Limited Distribution Drug (LDD)** - A Covered Product that is available for distribution through a limited number of pharmacy providers, as determined by the pharmaceutical manufacturer or the Food and Drug Administration (FDA).
73. **Local Time** - Time in the Eastern Time Zone as observed by the State of Maryland. Unless otherwise specified, all stated times shall be Local Time, even if not expressly designated as such.

74. **Lower of Member Cost Logic** – The methodology used to calculate the Member cost share prior to dispensing a Covered Product to the Member in accordance with the Plan. A Member's cost share shall be the lowest of the Copay under the Member's Plan or Lower of Pricing Logic.
75. **Lower of Pricing Logic** - The methodology used to calculate the Ingredient Cost, which shall equal the lowest of the following: submitted Usual and Customary Price or U&C, AWP Discount (and/or alternative metrics such as MAC, WAC, NADAC, AAC, etc.) + Dispensing Fee, and if allows, submitted Ingredient Cost + Dispensing Fee.
76. **MAC** - Maximum allowable cost.
77. **Mail Order Pharmacy** - A pharmacy where prescriptions are filled and delivered to Members by regular mail or delivery service.
78. **Manufacturer Administrative Fees** - Those fees received by Bidder or Bidder's Affiliate(s) from pharmaceutical manufacturers or intermediaries pursuant to a contract between Bidder or Bidder's Affiliate(s) and a drug manufacturer to manage placement of Covered Products on Bidder's Formulary and administering, invoicing, allocating and collecting Rebates that are attributable to Covered Products dispensed to Members.
79. **Manufacturer Payments** - Has the meaning in Md. Ann. Code, Insurance Art. § 15-601 (i), as amended. Manufacturer payments include:
    1. payments received in accordance with agreements with pharmaceutical manufacturers for Formulary placement and, if applicable, drug utilization;
    2. Rebates, regardless of how categorized;
    3. market share incentives;
    4. commissions;
    5. fees under products and services agreements; and
    6. administrative or management fees.

    Manufacturer Payments do not include purchase discounts based on invoiced purchase terms when the PBM is operating in the capacity of a pharmacy that is purchasing stock.
80. **Market Assessment** - An evaluation of prescription drug pricing based on recent market benchmarks, as defined by the State. Should data not be available as defined by the State, benchmarking will be based on existing market pharmacy benefits manager agreements from comparable plans.
81. **Market Check** – A technology-driven evaluation of prescription drug pricing based on benchmarks derived from pharmacy benefits manager's reverse auction processes conducted in the United States over the immediately preceding 12 months (State Personnel and Pensions Article, Section 2-502.2). In the event market data for reverse auction processes conducted in the United States over the immediately preceding 12 months is not available or complete, benchmarking will be based on existing market pharmacy benefits manager agreements from comparable plans.
82. **Maryland Rx Program** - The pharmacy and prescription drug benefits purchasing pool established by the Department, including the State Employee and Retiree Health and Welfare Benefits Program and other entities made eligible by Maryland law.
83. **Maximum Aggregate Base Administrative Fee** - The Contractor's maximum charges billed to the State for administrative services included in Section 4.6.3 of the Participant Bidding Agreement, excluding any optional services and/or programs subsequently selected by the State after contracting.

84. **Medi-Span®** - The organization producing drug databases that provide clinicians, pharmacists, payers, and pharmaceutical companies with consistent drug information.
85. **Medical Records Act** - The Maryland Confidentiality of Medical Records Act, Annotated Code of Maryland, Health-General Article, Title 4, Subtitle 3.
86. **Medicare Formulary** - The list of prescription drugs and supplies developed, implemented, and maintained in accordance with the Medicare Drug Rules for the EGWP benefit.
87. **Medicare Rebate Program** - The Contractor's manufacturer Rebate program under which the Contractor contracts with pharmaceutical manufacturers for Rebates payable on selected Covered Products that are reimbursed through Medicare Part D, as such program may change from time to time.
88. **Member** - An employee, former employee, or retiree (including Satellite and Direct Pay) who is eligible to participate in the Program pursuant to COMAR 17.04.13.03A, as amended from time to time, inclusive of that individual's Dependents. One "Member" includes the eligible employee, former employee, or retiree and that eligible individual's Dependents.
89. **Minority Business Enterprise (MBE)** - Any legal entity certified as defined at COMAR 21.01.02.01B (54) which is certified by the Maryland Department of Transportation under COMAR 21.11.03.
90. **Multi-Step Invitation for Bids (MS-IFB)** - This Multi-Step Invitation for Bids issued by the Department of Budget and Management (Department) with the Solicitation Number and date of issuance indicated in the Key Information Summary Sheet, including any amendments thereto.
91. **NDC or NDC-11** - The unique National Drug Code, as reported by First Databank (FDB) or Medi-Span.
92. **New-to-Market** - A drug or product that is newly introduced for sale by pharmaceutical manufacturers and made available for dispense at pharmacies after the Effective Date.
93. **Non-Participating Pharmacy** - Any out-of-network Retail Pharmacy, Mail Order Pharmacy, Specialty Pharmacy, or other pharmacy type that has not entered into a pricing agreement with Bidder to dispense Covered Products to members.
94. **Normal State Business Hours** - Normal State business hours are 8:00 a.m. - 5:00 p.m. Monday through Friday except State Holidays, which can be found at: https://dbm.maryland.gov/employees/pages/employeeshome.aspx- - Please see bottom left side of the webpage for current year State Holidays.
95. **Notice to Proceed (NTP)** - A written notice from the Procurement Officer that work under the Contract, project, Task Order or Work Order (as applicable) is to begin as of a specified date. The NTP Date is the start date of work under the Contract, project, Task Order or Work Order. Additional NTPs may be issued by either the Procurement Officer or the Contract Manager regarding the start date for any service included within this solicitation with a delayed or non-specified implementation date.
96. **NTP Date** - The date specified in an NTP for work on Contract, project, Task Order or Work Order to begin.
97. **Ongoing Claims Review** - An automated process to receive and review claims files underlying each PBM invoice.
98. **Participant** - Each individual covered by the family unit of a Member enrolled in a plan (Members and Dependents).
99. **Participant Bidding Agreement (PBA)** - A Bidder's response to the solicitation requirements of this MS-IFB. A Bidder's Participant Bidding Agreement will be determined acceptable prior to qualifying for the Reverse Auction phase. The PBA must include 1) Common definitions; 2) Prescription drug classifications; 3) Rules that may include retail pricing rules such as maximum allowable cost price lists

and dispensing fees; and 4) any other contract terms the Department determines are necessary to further the intent of the General Assembly as established in Md. Ann. Code, State Personnel and Pensions Art. § 2-502.2(b).

100. **Participating Pharmacy** - An in-network Retail Pharmacy, Mail Order Pharmacy, Specialty Pharmacy, or other pharmacy type that has entered into a pricing agreement with Bidder to dispense Covered Products to members.

101. **Part D or Medicare Part D Eligible Retiree** - The individual who is (a) eligible for Part D in accordance with the Medicare Drug Rules, (b) not enrolled in a Part D plan (other than the EGWP Benefit), and (c) eligible to participate in Program benefits.

102. **Part-Time Employee** - A permanent employee who works less than 50% of the standard workweek and is not eligible for State subsidy of benefits but is eligible to enroll in the State of Maryland Employee and Retiree Health and Welfare Benefits Program.

103. **Pass-Through** - Bidder shall invoice the State the same amounts reimbursed by Bidder to retail Participating Pharmacies for any Covered Product dispensed from such retail Participating Pharmacy. This pricing model will bill the State the exact Ingredient Cost, Dispensing Fee and taxes paid less member copay and potential POS Rebates to the Participating Pharmacy. Bidder receives no other revenue and derives no other value from any Paid Claim adjudicated at the Participating Pharmacy, either directly or indirectly, in the aggregate or otherwise, except for the fee(s) charged by Bidder to a Participating Pharmacy for administrative services related to dispensing Covered Products to Members

104. **PMPM** - Per Member Per Month. The Contractor's administration fee for each employee and family unit, or retiree and family unit on a monthly basis.

105. **Personally Identifiable Information (PII)** - Any information about an individual maintained by the State, including (1) any information that can be used to distinguish or trace an individual identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.

106. **Pharmacy Benefit Management (PBM) Services** - Provided in Md. Ann. Code, Insurance Article, §15-1601(p)(l), as amended. Pharmacy Benefit Management Services includes:

1. the procurement of prescription drugs at a negotiated rate for dispensation within the State to beneficiaries;
2. the administration or management of prescription drug coverage provided by a purchase for beneficiaries; and
3. any of the following services provided with regard to the administration of prescription drug coverage:

    a. mail service pharmacy;

    b. claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to beneficiaries;

    c. clinical Formulary development and management services;

    d. rebate contracting and administration;

e. patient compliance, therapeutic intervention, and Generic substitution programs; or

f. disease management programs

Pharmacy benefits management services does not include any service provided by a nonprofit health maintenance organization that operates as a group model, provided the service:

1. is provided solely to a member of the nonprofit health maintenance organization; and
2. is furnished through the internal pharmacy operations of the nonprofit health maintenance organization.

107. **Plan** - The State's self-funded pharmacy and prescription benefits plan offered through the State Employee and Retiree Health and Welfare Benefits Program. The Plan is a Purchasing Pool Participant (see 113. Below).

108. **PPPM** - Per Participant per month. The Contractor's administration fee for each Medicare eligible enrolled retiree and family member in the EGWP drug program charged on a monthly basis.

109. **PPACA** - Patient Protection and Affordable Care Act.

110. **Pricing Guarantee(s)** - The network Discounts, claim adjudication rates, specialty drug Discounts, Dispensing fees, Rebates, and minimum Rebate guarantees.

111. **Pricing Guarantee Period -** Means each six (6) month period (i.e., bi-annual) for Discounts, Dispensing Fees, and Rebates, commencing with the Go-Live Date of the Agreement.

112. **Procurement Officer** - Prior to the award of any Contract, the sole point of contact in the State for purposes of this solicitation. After Contract award, the Procurement Officer has responsibilities as detailed in the Contract (**Attachment M**) and is the only State representative who can authorize changes to the Contract. The Department may change the Procurement Officer at any time by written notice to the Contractor.

113. **Protected Health Information (PHI)** - Information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) that identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

114. **Purchasing Pool Participant (PPP), Purchasing Pool Member, Pool Member, or Pool Participant** - An entity that participates in the pharmacy benefits purchasing for its own self-insured plan.

115. **Rebate** - All pharmaceutical Manufacturer Payments or revenue, including indirect and direct remuneration, as a result of the State's Program, paid to the Contractor.

116. **Rejected Claim** - A prescription drug claim or transaction submitted by a pharmacy to the PBM in a Billing Transaction and subsequently rejected, as indicated in the PBM's response transmission.

117. **Repacked NDCs** - A medication taken from its original packaging and placed into a smaller, safer, and simpler type of packaging.

118. **Retail Pharmacy** - A pharmacy establishment acting as a retail store at which Covered Products are dispensed by a registered pharmacist under the laws of each state.

119. **Retiree** – As Defined in COMAR 17.04.13.03:

(7)Retired employees who began State service on or before June 30, 2011, or who began State service on or after July 1, 2011 and are retirees of the Judges' Retirement System, and who qualify in accordance with §§A(7)(a) and (b) of this regulation. Neither service as a faculty member, teacher, or staff member for a community college or a local board of education prior or subsequent to State service, nor membership in the Teachers' Pension or Retirement Systems, shall in itself disqualify a former State employee who is otherwise eligible under §A(7)of this regulation. The only retired employees eligible for benefits under §A(7) of this regulation are those who:

(a) Receive a retirement allowance pursuant to State Personnel and Pensions Article, Division II, Annotated Code of Maryland, and who have:

(i) Retired directly from State service with a State retirement allowance on or after July 1, 1984, provided that the employee had at least 5 years of creditable service;

(ii) Terminated State service with 16 years or more of creditable service;

(iii) Terminated State service before July 1, 1984; or

(iv) Terminated State service with 10 years of creditable service and within 5 years of normal retirement age; or

(b) Receive a periodic distribution of benefits from the Maryland Optional Retirement Program under State Personnel and Pensions Article, Title 30, Annotated Code of Maryland, and who have:

(i) Ended service with a State institution of higher education with at least 10 years of service and were at least age 57;

(ii) Ended service with a State institution of higher education with at least 16 years of service; or

(iii) Retired directly from and had at least 5 years of service with a State institution of higher education on or after July 1, 1984;

(8) Retired employees who began State service on or after July 1, 2011, and who qualify in accordance with §§ 8(a) and (b) of this regulation. Neither service as a faculty member, teacher, or staff member for a community college or a local board of education prior or subsequent to State service, nor membership in the Teachers' Pension or Retirement Systems, shall in itself disqualify a former State employee who is otherwise eligible under §A(8) of this regulation. The only retired employees eligible for benefits under §A(8) of this regulation are those who:

(a) Receive a retirement allowance pursuant to State Personnel and Pensions Article, Division II, Annotated Code of Maryland, and who have:

(i) Retired directly from State service with a State retirement allowance provided that the employee had at least 10 years of creditable service;

(ii) Terminated State service with 25 years or more of creditable service; or

(iii) Terminated State service with 10 years of creditable service and within 5 years of normal retirement age; or

(b) Receive a periodic distribution of benefits from the Maryland Optional Retirement Program under State Personnel and Pensions Article, Title 30, Annotated Code of Maryland, and who have:

(i) Ended service with a State institution of higher education with at least 10 years of service and were at least age 57;

(ii) Ended service with a State institution of higher education with at least 25 years of service; or

(iii) Retired directly from and had at least 10 years of service with a State institution of higher education on or after July 1, 2011;

120. **Reverse Auction** - An automated bidding process conducted online that starts with an opening bid from all participants and allows qualified bidders to view the blinded, high-level bids (Total Projected Cost) of other participants and counteroffer a lower price for multiple rounds of bidding.

121. **Reversed Claim** - A previously paid claim that was submitted by the pharmacy to the PBM in a Billing Transaction requesting a reversal of the previously paid Transaction and processed as an accepted Reversed claim, as indicated in the PBM's response transmission**.**

122. **Satellite Account Employee or Retiree** - An employee or retired employee of a political subdivision, agency, commission, or organization that is permitted by Maryland law to participate in the Program.

123. **Security Incident** - A violation or imminent threat of violation of computer security policies, Security Measures, acceptable use policies, or standard security practices. "Imminent threat of violation" is a situation in which the organization has a factual basis for believing that a specific incident is about to occur.

124. **Security or Security Measures** - The technology, policy, and procedures that a) protects and b) controls access to network, systems, and data.

125. **Sensitive Data** - Means PII; PHI; other proprietary or confidential data as defined by the State, including but not limited to "personal information" under Md. Code Ann., Commercial Law § 14-3501(e) and Md. Code Ann., St. Govt. § 10-1301(c) and information not subject to disclosure under the Public Information Act, Title 4 of the General Provisions Article; and information about an individual that (1) can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; or (2) is linked or linkable to an individual, such as medical, educational, financial, and employment information.

126. **SLEOLA** - State Law Enforcement Officers Labor Alliance.

127. **Software** - The object code version of computer programs licensed pursuant to this Contract. Embedded code, firmware, internal code, microcode, and any other term referring to software that is necessary for proper operation is included in this definition of Software. Software includes all prior, current, and future versions of the Software and all maintenance updates and error corrections. Software also includes any upgrades, updates, bug fixes or modified versions or backup copies of the Software licensed to the State by Contractor or an authorized distributor.

128. **Specialty Drug** - For FA-1 Commercial, Specialty Drug means a biologic, biosimilar, biogeneric, biobetter, or non-biologic pharmaceutical that meets one or more of the following conditions: 1) is used to treat complex, chronic conditions, 2) requires special handling and storage, or 3) involves a significant degree of patient education, monitoring, and management. For FA-2 EGWP, a Specialty Drug is determined in accordance with applicable CMS regulations and guidance.

129. **Specialty Pharmacy -** A pharmacy that focuses on dispensing Specialty Drugs to Members.
130. **Spouse** - An individual who is lawfully joined in marriage to an employee or retired employee, as defined in COMAR 17.04.13.01(B)(3), as amended from time to time.
131. **SPS** - State Personnel System.
132. **Standard Broad Formulary** - The Bidder's standard list of Covered Products with minimal exclusions. Covered Products may be subject to different copay amounts based on their Formulary placement and State's benefit design. Bidder's formulary should focus on promoting the placement of low WAC products within therapeutic categories (i.e., Biosimilars, Insulins).
133. **State** - The State of Maryland.
134. **State Prescription Drug Data** - The Contractor's standard Claims data in National Council for Prescription Drug Programs ("NCPDP"), X12 835, or other mutually agreed upon formats as well as all pricing information utilized by Contractor in the adjudication of pricing or Pricing Guarantee calculations for Paid Claims including but not limited to MAC Lists, Specialty Lists, Formulary Lists, etc. State Prescription Drug Data shall not include Participating Pharmacy agreements or Supplier agreements with pharmaceutical manufacturers including without limitation agreements for Manufacturer Derived Revenue.
135. **Tax** - Any applicable federal, State, or local government levied amount currently in existence or hereafter enacted, calculated either on gross revenues or by transaction, whether such tax is designated a sales tax, gross receipts tax, retail occupation tax, value added tax, health care provider tax, transaction privilege tax, assessment, pharmacy user fee, wholesale distributor tax, or charge otherwise titled or styled, and whether or not the bearer of the tax is the retailer or consumer.
136. **Technical Safeguards** - The technology and the policy and procedures for its use that protect State Prescription Drug Data and control access to it.
137. **Third Party Software** - Software and supporting documentation that: 1) are owned by a third party, not by the State, the Contractor, or a subcontractor; 2) are included in, or necessary or helpful to the operation, maintenance, support, or modification of the Solution; and 3) are specifically identified and listed as Third Party Software in the Bid.
138. **TIN** - Taxpayer Identification Number.
139. **Total Projected Cost (TPC)**- The Bidder's total price for goods and services in response to this solicitation, as calculated through the Reverse Auction platform - Attachment B.
140. **TrOOP** - True Out-of-Pocket Costs. The costs incurred by an EGWP Member or by another person on behalf of an EGWP Member, such as a deductible or other cost-sharing amount, with respect to Covered Products, as further defined in the Medicare Drugs Rules.
141. **TTY/TDD** - A telephone-text device used by hearing impaired individuals whereby they communicate via telephone connected to a keyboard and screen.
142. **Unforeseen Market Event** - An unanticipated change which occurs after the time of Agreement execution which may materially alter the ability of the PBM to meet its financial obligations with regard to Rebates. An Unforeseen Market Event may include: pharmaceutical manufacturer significantly dropping list price of a medication, a product with material utilization being removed from the market by the Food and Drug Administration (FDA) due to safety concerns, or changes to any law or regulation which would materially alter the intent or financial arrangement of this agreement. An Unforeseen Market Event is not: a Brand Drug medication becoming available generically, a Biosimilar product being launched or

approved by the FDA, a Brand Drug losing rebates when a brand over generic strategy (DAW9) is used by the PBM, or a new to market product being approved by the FDA.

143. **URAC** - The independent, non-profit organization that provides accreditation and certification services for pharmacy benefit managers (formerly known as the Utilization Review Accreditation Commission).

144. **Usual and Customary Price or U&C** - The actual retail price charged by a Participating Pharmacy for a specified drug if purchased in a cash transaction on the date the drug is dispensed, as reported to Supplier by the Participating Pharmacy.

145. **Veteran-owned Small Business Enterprise (VSBE)** - A business that is verified by the Center for Verification and Evaluation (CVE) of the United States Department of Veterans Affairs as a veteran-owned small business. See Code of Maryland Regulations (COMAR) 21.11.14.

146. **WAC** - Wholesale acquisition cost.

147. **Zero Balance Due Claim or ZBD Claim** - Any Claim for which the Member is responsible under the applicable Benefit Plan for the full amount of the Claim's Gross Drug Cost and the State is responsible for no portion of the Claim's Gross Drug Cost.

1. Contractor shall comply with all stated Abbreviations and Definitions above and any applicable amendments.

4.2 General Requirements

1. Bidder agrees to support both Functional Area 1 (Commercial) and Functional Area 2 (EGWP) lines of business.

2. Bidder agrees to provide financial bids that are independent for each Functional Area (cannot provide rates for combined Functional Area 1 (Commercial) and Functional Area 2 (EGWP)) and cannot be contingent on one another and cannot offset from one another.

3. For avoidance of doubt, Bidder agrees that should the State terminate one Functional Area, Contractor shall not be allowed to adjust rates on other Functional Area.

4. Bidder agrees that they are currently an approved CMS-contracted prescription drug plan sponsor for an EGWP prescription drug plan in accordance with applicable CMS rules, regulations and requirements.

5. Bidder agrees they have implemented policies and procedures designed to manage, adhere and ensure compliance with all CMS regulations regarding compliance, formulary submission, fraud, waste and abuse, and transition fills.

6. Contractor shall directly administer EGWP benefit for EGWP Members and all administrative services in accordance with Medicare Drug rules, regulations, and requirements, and will not use an external subcontractor to administer EGWP benefit.

7. Bidder shall be compliant with all CMS requirements and manage coverage determinations, re-determinations, appeals and grievance procedures.

8. Bidder agrees that Functional Area 2 (EGWP) bid will cover 100% of the drugs covered by the active non-Medicare eligible plan.

9. Contractor shall pass 100% of all associated EGWP and CMS subsidies (e.g. low-income subsidies, direct subsidies, federal reinsurance and coverage gap discounts) to State within ten (10) Business Days of receipt.

10. Bidder agrees that the responses herein and during the Reverse Auction are based on the plan design and State-specific requirements stated in the MS-IFB Section 2, Contractor Requirements: Scope of Work.

11. Bidder agrees the State shall own their Claims detail (State Prescription Drug Data) and receive up to five (5) detailed claims files on a daily basis, or other mutually agreed upon intervals, at no additional charge. Claims detail shall be in NCPDP, D.0 file format including all transactions, and at minimum a unique pharmacy identifier, NDC-11, ingredient cost, Dispensing Fee, and member cost-share or other mutually agreed upon format.

12. Contractor shall fully cooperate in ongoing invoice and claims review. This includes providing all required data for the invoice and claims review process, including but not limited to a claims detail file with financial details as well as Specialty, LDD, Biosimilar, Preferred Formulary, and Formulary Exclusion Lists all at the NDC11 level and to support discrepancy resolution.

13. Contractor shall allow the State to conduct a Market Assessment before the first contract year to analyze the competitiveness and financial terms of the awarded contract. If Contractor's awarded pricing is greater than one percent (1%) behind market, Contractor shall negotiate improved terms with the State.

14. Contractor shall allow the State to conduct annual Market Checks during the contract term, including optional periods, to preserve the competitiveness and financial terms of this Contract.

15. Contractor shall agree that State reserves the right to perform annual Market Checks, and if savings is greater than one percent (1%), Contractor shall negotiate improved terms with the State.

16. Bidder agrees that in the case of any conflicting terms or conditions between the final Contract and the responses to this PBA, the terms and conditions most favorable to the State shall prevail.

17. Bidder agrees State shall receive a Contract with an Initial term of three (3) years, plus up to two (2) additional optional renewals all subject to Market Check provisions.

18. State shall be allowed to terminate for any cause or no cause, which shall incur no fees or penalties of any kind to the State. For the avoidance of doubt, Contractor may not retain any earned Rebates, require administration fees through the term of the original agreement, or require repayment of any implementation/setup fees or credits.

19. If State elects to terminate the Agreement, all then-current contract provisions, terms, and guarantees shall remain in effect through the date of termination. In the event that termination results in a partial plan year, all Rebate and Pricing Guarantees set forth shall be honored without penalty, and calculated pro-rata for Claims processed during the period of time that the Plan was in force.

20. Bidder pricing submission must adhere to required definitions and benchmarks for network adjudication and guarantees, such as AWP discount.

21. Bidder must demonstrate financial stability by submitting: a) Vendor’s most recent financial report; b) the most recent independent auditor’s report; and c) SSAE 16, SAS-70, or equivalent external audit of Vendor’s operations. Please attach proof of financial stability meeting this requirement.

22. Bidder agrees that if awarded, responses to the PBA and Reverse Auction will become part of the contract.

23. The Reverse Auction submission is to be signed and dated, where requested, by an individual who is authorized to bind the Bidder to the prices entered during the Reverse Auction.

24. Bidder must certify that if qualified for the Reverse Auction phase, the pricing submitted in Section 11.1 and 11.2 applies to the duration of the Agreement and that any proposed changes to pricing will only be warranted for an Unforeseen Market Event as defined in Section 4 and be mutually agreed upon between the State (or designated representative) and Contractor.

4.2.1 Administrative Requirements

1. Please indicate your acceptance that the State reserves the right to change any aspect of the plan design including, drugs to which Drug Utilization Review (DUR) is applied, the list of specialty medications in the Specialty Drug Management Program, changes to member cost share structure, list of drugs eligible for the zero copay generics and prior authorization requirements, without a contract modification.

2. Contractor shall agree that member cost share structure and plan design may be changed by the State without contract modification, but by written direction to the Contractor. The Contractor shall absorb the costs of programming these, or any, benefit changes.

3. Contractor shall permit all eligible participants, as determined by the State, to obtain prescription drug coverage.

4. Contractor shall not allow administrative functions required under this contract to be performed offshore.

5. Contractor shall assign a designated (but not necessarily dedicated) Contractor Account Executive for each Functional Area per solicitation section 3.10. The State of Maryland reserves the right to accept or decline assigned personnel for any reason at any time.

6. Contractor shall assign a designated (but not necessarily dedicated) Clinical Services Account Manager for the State per solicitation section 3.10. The State of Maryland reserves the right to accept or decline assigned personnel for any reason at any time.

7. Contractor shall assign a dedicated Contractor Account Service Representative for each Functional Area per solicitation section 3.10. The State of Maryland reserves the right to accept or decline assigned personnel for any reason at any time.

8. Contractor shall assign a designated (but not necessarily dedicated) customer service team for the State. The State of Maryland reserves the right to accept or decline assigned contacts for any reason at any time.

9. Contractor shall assign a designated (but not necessarily dedicated) eligibility representative for the State. The State of Maryland reserves the right to accept or decline assigned contacts for any reason at any time.

10. Contractor shall review drafts of the plan description contained in the State's annual benefits guide within five (5) Business Days of a request from the State.

11. The Contractor shall agree to offer support for the 2025 open enrollment period (fall of 2024) and all subsequent open enrollments during the contract term.

12. The Contractor shall attend all quarterly meetings at the State offices in MD (or virtually as required). The discussion will include plan administration, operational performance, performance guarantees, customer service issues, claims utilization trends and any other concerns the State may have.

13. Contractor shall share the expenses for printing and mailing all open enrollment materials (including virtual open enrollment expenses), such as the benefits guide, universal enrollment forms, and other notices or information included in the enrollment kits. The cost will be shared equally among all benefit plans, including medical, dental, prescription drug, flexible spending accounts, life insurance, and accidental death and dismemberment. The total cost will be shared equally among all benefit plans. The 2023 plan year's total cost per plan was $23,929 but may fluctuate year over year.

14. Contractor shall assume a share of the cost of an annual State-conducted Participant satisfaction survey on its health plan.

15. Contractor shall establish and provide a state-of-the-art customer service operation (including a dedicated toll-free phone number) available to plan Participants (both in-state and out-of-state) 24/7, staffed by live customer service representatives during the core hours, 7 am – 11 pm Eastern Time, seven days a week at no additional charge. This may be the same operation as that provided for State employees, retirees and dependents under another active contract, if applicable.

16. During call center live hours, the automated voice-response answering system will be an automatic system that picks up within 30 seconds and directs Participants into a queue to be serviced, including the option for Participants to opt out and connect to a live representative at any time during the call.

17. The customer service operation must include the following:
a. Integrated member support for retail, mail order, and specialty pharmacy claims.
b. Knowledgeable staff available to answer questions on plan eligibility, plan benefits, and claims procedures specific to the State Plan.
c. The ability to assist participants who contact member services with only their name and/or Social Security number.
d. The ability to access eligibility data that identifies eligible Participants and supporting demographic information regarding Participants.
e. A procedure for handling emergency requests.
f. Adequate and appropriate access to the customer service system for individuals with disabilities (e.g. TTY and online access for deaf, full-service phone access for blind).
g. The Contractor shall provide a member website that provides, at a minimum, the ability for the participant to locate a pharmacy, price a prescription specific to the State's plan design, and the pricing with the State for brand and generic at retail and mail, be offered savings opportunities, be offered a chance to communicate with a pharmacist or customer service representative, order a mail order refill, track a mail order shipment, and order a replacement card.

18. Contractor shall have in place a State of Maryland specific website and corresponding mobile app by October 1, 2024, through which members can access and view plan benefits, pharmacy, and formulary information online. This website will be linked to the State's internet home page.

20. Contractor shall provide, upon request of the State, a description of each drug utilization review (DUR) program available to the State, the protocols for each program, a complete list of medications subject to these programs and the additional cost to the State, if any, for the implementation of any such programs.

21. Contractor shall provide clinical resources to the State to help in interpreting pharmacy data and developing cost management strategies at no additional cost.

22. Contractor shall market the Maryland Rx Purchasing Pool program to potential Purchasing Pool participants.

23. The contractor shall produce and mail Identification (ID) cards to the homes of each Member. ID cards must be in the member's possession at least ten (10) Business Days before the program's initial effective date and throughout the contract term for new members within three (3) Business Days of notification by the State.

24. The contractor shall produce ID cards which are compliant with current NCPDP standards, and include the following information:

i. the name of the entity administering the pharmacy benefits;
ii. the group number applicable to the employee/retiree;
iii. the name, an identification number for the employee/retiree, which is not the employee or retiree's SSN;
iv. the bank identification number necessary for electronic billing;
v. the effective date of the coverage evidenced by the card; and,
vi. any appliable plan deductible and out-of-pocket maximum under the plan.

4.2.2 Reporting Requirements

1. Contractor shall comply with all reporting requirements referenced in section 2.3.12 of the solicitation and Attachment Q.

2. Contractor shall provide, on a monthly basis, a full file of all claim activity to the State's data warehouse vendor. This file will include member Social Security numbers and will be in the format specified in Attachment Q–100 Character File Layout.

3. Contractor shall provide, on a daily basis, a full file of all State Prescription Drug Data activity to the State's Ongoing Claims Review consultant. This file will NOT include member Social Security numbers.

4. Contractor shall deliver the required management information reporting in a format specified by the State that provides utilization, claims reporting, rebates, and administrative services data by subgroup to the State of Maryland. The required subgroups are: Active, Satellite, Direct Pay, State retirees under 65, and State retirees 65 and over. The Contractor also agrees to provide monthly claims and enrollment in these specified subgroups.

5. Contractor shall cooperate fully with any health management vendor under contract by the State, including coordination of care management activities and transmission of data to and from the medical plan vendor in a mutually acceptable format, at no additional cost.

6. Contractor shall provide reporting and share required data with the State and its Contractors to support plan management; and with development and support of wellness and disease management programs, as well as any future strategic initiatives.

7. Contractor shall share claims and eligibility data on Participants with the State as determined by the State.

8. Contractor shall provide ad-hoc reporting at no additional charge.

9. Contractor shall provide online access to all standard reports to the State and its Consultants at no additional charge.

10. Contractor shall provide the required disclosures and reports as specified in Md. Ann. Code, Insurance Art. § 15-1623 and § 15-1624.

4.2.3 Communication Requirements

1. Contractor shall use a unique identification number (that is not a Social Security number) on all Participant communications; examples include membership cards, EOBs, etc. The Contractor shall maintain a crosswalk between the Participant's Social Security number and the unique identifier.

2. Contractor shall assist the State as requested in the development of benefit summaries and other communication materials for participants.

3. All mass communications materials shall be coordinated with and approved by the State prior to distribution, including paper claims form(s) as necessary.

4. Contractor shall, with prior approval from the State, provide ongoing communications to participants on issues pertinent to the pharmacy benefits program.

5. Contractor shall ensure network pharmacies provide free information to members on general health information such as adverse drug events, medication safety and storage, poison control and child safety.

6. The Contractor agrees to have a process for resolving participant complaints in place and operable on the date of contract commencement. The State expects that an expeditious, written resolution will normally be mailed to the participant within ten (10) Business Days of receipt of the complaint.

4.2.4 HIPAA (Business Associate Agreement)

Terms herein shall have the meaning provided in 45 CFR, Parts 160, 162 and 164.

1. Contractor shall comply with HIPAA security regulations, 45 CFR Part 164, subpart C.

2. Contractor shall comply with HIPAA privacy standards, 45 CFR Parts 160 and 164.

3. Contractor shall comply with 45 CFR 164.508(a)(4) and §13405(d)(1) and (2) of the HITECH Act as if it were a covered entity in connection with the benefit plan administered by the Contractor pursuant to this MS-IFB and Contract. Contractor shall prohibit its business associates, agents, and subcontractors who receive, use, disclose, create, retain, maintain, or transmit PHI from receiving remuneration in exchange for PHI on the same terms.

4. Contractor shall comply with limitations on marketing and fundraising communications provided in 45 CFR 164.508(a)(3) and §13406 of the HITECH Act as if it were a covered entity in connection with the benefits plan.

4.2.5 Breaches of Unsecured PHI

1. A breach shall be treated as discovered in the terms described in 45 CFR §164.410.

2. Notice to the Department:
(1) Contractor shall promptly notify the Department of a breach of unsecured PHI in its possession following the first day on which Contractor (or Contractor's employee, officer, agent or subcontractor) knows of such breach or following the first day on which Contractor (or Contractor's employee, officer, agent or subcontractor) should have known of such breach. Such notice shall occur without unreasonable delay and in no event more than 30 days following discovery of the breach. Such notice shall occur if the breach impacts the State's participants and/or data even if the breach is not of a Member of the State Plan.
(2) In the event Contractor determines that there is a no risk of an unauthorized access, acquisition, use, or disclosure compromises the security or privacy of the protected health information of a member, Contractor shall promptly notify the Department of the event and the basis for that determination. Such notice shall occur as soon as is reasonable but in no event more than 30 days following discovery of the unauthorized access, acquisition, use, or disclosure of PHI of a Participant. Such determination shall be in writing and signed by an appropriate officer or employee of Contractor.
(3) Contractor's notice to the Department pursuant to this section concerning breaches shall include, at a minimum:
(i) The total number of individuals overall affected by the breach and the number of Participants in the State Plan affected by the breach;
(ii) If applicable, the identification of each State Plan Participant whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, disclosed, or otherwise the subject of the breach;
(iii) A description of what happened, the date of the breach, if known, and the date of the discovery of the breach;
(iv) A brief description of the types of unsecured PHI that were involved in the breach (such as name, social security number, date of birth, claims or healthcare services information, etc.);
(v) Identification of an individual who can provide additional information concerning the breach; and
(vi) A brief description of the steps Contractor is taking to mitigate the breach, investigate the breach, and to protect against further breaches.
(4) Contractor's notice to the Department pursuant to this section may be provided on a rolling basis, with information provided to the Department as it becomes available.

3. Notice to Participants:
(1) Contractor shall provide notice to affected members and to the media in the form, content, manner, method, and timing required to meet the requirements of §§13400-13402 of the HI TECH Act and 45 CFR §§164.404 and 164.406, applied as if Contractor were a covered entity in connection with the group plan(s) administered by Contractor pursuant to the Underlying Agreement.
(2) The notice(s) required by this section may not be issued until the Department has reviewed and approved the notice(s). Such approval may not be unreasonably delayed or withheld.

4. Contractor may delay the notice(s) required pursuant to sections 164.404(b) and 164.406(b) only if permitted pursuant to 45 CFR §164.412.

5. In the event of an unauthorized use or disclosure of PHI or a breach of Unsecured PHI, Contractor shall use reasonable efforts to mitigate any harmful effects of said disclosure that are known to it.

6. Notices to DHHS:
(1) In the event of a breach described in 45 CFR §164.408(b), Contractor shall provide to Department all information required by that subsection to be submitted to the Secretary of DHHS. The information shall be provided without unreasonable delay and in no event more than 30 days following discovery of the breach. Upon request, Contractor shall submit the required breach notice to the Secretary of DHHS on behalf of the Department, the State, the group plan(s), and the Program.
(2) Contractor shall maintain a log of breaches described in 45 CFR §164.408(c) and that affect members and the group plan(s) administered by Contractor pursuant to the Underlying Agreement.

7. In fulfilling its obligations pursuant under this Contract in connection with 45 CFR §164.530, Contractor shall address the provisions of 45 CFR Part 164, subpart D in the manner provided in 45 CFR §164.414, as if Contractor were a covered entity in connection with the benefits plan administered by Contractor pursuant to this Contract and MS-IFB.

8. Contractor shall review any guidance from DHHS specifying the technologies and methodologies that render PHI unusable, unreadable, or indecipherable to unauthorized individuals. Contractor further agrees, to the extent practical, appropriate and reasonable, to incorporate such guidance into its administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of PHI.

9. Contractor shall ensure any agent, including a subcontractor, to whom it provides PHI received from, or created or received by the Contractor, agrees to provide notice of a breach and the information necessary for Contractor to comply with its notice requirements in sections (a) through (h) above.

4.2.6 Electronic Health Records

1. Contractor shall notify the Department if and when Contractor uses or maintains electronic health record(s) with respect to PHI.

2. As of the applicable effective date identified in §13405(c)(4) of the HITECH Act, when complying with the obligations to respond to requests for accounting under 45 CFR §164.528, Contractor shall respond to requests for an accounting of disclosure of PHI in compliance with the requirements of §13405(c)(1) and (3) of the HITECH Act and any regulations promulgated by the Secretary of DHHS pursuant to §13405(c)(2) of the HITECH Act. The requirements of this section shall apply if Contractor uses or maintains an electronic health record with respect to PHI.

3. When complying with the obligation to provide access to PHI under 45 CFR §164.528, Contractor shall respond to requests for access to PHI in compliance with the requirements of §13405(e) of the HITECH Act. The requirements of this section shall apply if Contractor uses or maintains an electronic health record with respect to PHI.

4. Contractor shall provide HIPAA certificates of creditable coverage, at no extra cost, within the timeframe required by the regulations (see 45 CFR §146.155).

5. Bidder confirms its bid, and plan design submitted, is in compliance with all federal and state laws and regulations pertaining to employee benefit plans.

6. Bidder understands that it has the necessary systems capability and complies with HIPAA's administrative simplification standards related to electronic data interchange (EDI), including the code set/transactions requests of 45 CFR Part 162.

7. Bidder requires any agents/subcontractors it brings onto the project(s) covered by this MS-IFB to comply with HIPAA standards for EDI.

8. Contractor shall ensure that the State data will not be sold or shared with another organization without the prior written authorization of the State and unless compliant with HIPAA as an action by the Plan. Fees from pharmaceutical manufacturers that are to offset the costs associated with FDA-required programs for utilization of certain Specialty Pharmacy medications, are exempt from this requirement.

9. Contractor shall load all current Prior Authorizations, open mail order refills, open specialty refills, and accumulator files that exist for current members from the existing PBM at NO charge to the State no later than the date of implementation of management by the selected PBM.

10. Contractor shall provide at least six (6) months' notice of any significant planned systems upgrades or changes, including but not limited to claims, customer service, eligibility and corporate operating systems.

11. Contractor shall accept electronic transfer of eligibility data in a format indicated by the State or Participating Pool Participant including cloud-based transfers.

12. Contractor shall accurately convert State data files, including the State master enrollment file and any other relevant files to the Contractor's data system.
a. File transfers between the Contractor and the State shall be exchanged using a secure protocol like SCP/SFTP or another method approved by the State of Maryland, Department of Information Technology.
b. File transfers with other entities shall be exchanged in a secure, encrypted, and mutually agreed-upon format.

13. Contractor shall maintain eligibility records for all participants.

14. Contractor shall conduct and maintain eligibility reconciliations between Contractor files and the State's eligibility files.

15. Contractor shall process and/or update eligibility immediately for a Member if requested. In addition, the Contractor shall also provide the State or its designee with both the ability to make real time updates to the Contractor's eligibility database and the ability to verify eligibility.

16. For Purchasing Pool Participants, Contractor shall maintain flexibility to deal with Pool Participant-specific eligibility data requirements and variations such as: member ID numbers varying in length; alpha-numeric ID numbers; incorporating client-specific departments, classes, or product coding.

17. Contractor shall retain records for a minimum of seven years or in excess of the period required by the Contract if required by state and/or federal regulations.

18. If requested, Contractor shall accept from the incumbent mail and specialty pharmacies a claims file which will be used to transfer member's current mail and specialty pharmacy prescriptions at no additional charge.

19. If requested, upon termination Contractor shall provide the new Contractor with applicable State Prescription Drug Data which will be used by the new Contractor to transfer member's current mail and specialty pharmacy prescriptions. (i.e.; open refill, prior authorization, accumulator files) at no additional charge.

20. Contractor shall transfer to the State, within thirty (30) calendar days of notice of termination, all required data and records necessary to administer the prescription drug plans subject to state and federal confidentiality considerations. The transfer may be made electronically, in a file format to be determined based on the mutual agreement between the State and the provider of services at no additional charge.

4.2.7 Claims Processing

1. Contractor shall provide an integrated system for processing retail, mail order and specialty pharmacy claims.

2. Contractor shall promptly process and fill all prescriptions submitted by the State's plan members. The Contractor must provide all prescription fulfillment and processing services for all covered members and must include in its bid a complete description of its claims handling capabilities.

3. Contractor shall assume claim fiduciary responsibilities, including appeals, for claim adjudication and defense of any drug utilization review (DUR) program decisions.

4. Contractor shall obtain the advice and consultation of qualified experts to review unusual charges or claims at no additional cost to the State.

5. Contractor shall have procedures in place for recovery of claims processing errors identified in, but not limited to, vendor audits, State Contractor audits, eligibility audits, or pharmacy audits. The Contractor also agrees to recover these payments and refund to the State of Maryland, if applicable. Such payments shall not be reduced by contingency fees, other fees charged by an auditor or other recovery service, or offset by performance overages or rebates.

6. Contractor shall provide claims eligibility audit response files to the Department's Audit Unit within fourteen (14) calendar days of receipt of error report from the Department.

7. Drug Substitutions and Therapeutic Interchanges
a. Contractor shall comply with Md. Ann. Code, Insurance Art. § 15-1634 in conducting therapeutic interchanges. (Please see reporting requirements related to drug substitutions generally, including therapeutic interchanges.)
b. Contractor shall conduct a therapeutic interchange for (as defined in Md. Ann. Code, Insurance Art. § 15-1601) the drug prescribed with another drug only if interchange complies with all applicable state and federal laws (such as, in Maryland, Md. Ann. Code, Insurance Art. §§ 15-1633 through 15-1639). (For the purposes of Md. Ann. Code, Insurance Art. § 15-1633, in the case of an individual enrolled in a plan sponsored by another Purchasing Pool Participant, savings must accrue to the Purchasing Pool Participant or individual member in that Purchasing Pool Participant's plan.)

8. Generic Drugs
a. Contractor shall apply and maintain a broad and comprehensive MAC list used consistently at retail and mail order.
b. Contractor shall agree that the Dispensing Fees used to calculate cost will be the same as the Dispensing Fees used to determine contractor adherence with all performance guarantees.

4.2.8 Payment Specifications

1. Contractor shall accept premium payments in accordance with the payment procedures described in MS-IFB Section 3.3, Invoicing.

2. Contractor shall conform to the State's payment procedures for payment of administrative fees as outlined below.
a. Contractor agrees to accept monthly payments of PPPM administration fees for EGWP members based on the State's deduction report data (calculated by the State).
b. Contractor agrees to accept monthly payments of PMPM administration fees for non-EGWP members based on the State's deduction report data (calculated by the State).
c. Contractor agrees to accept payment processed through normal State transmittal process (i.e., transmittal sent to Annapolis, electronic funds transfer to Contractor). Payment is usually made by the 15th of each month for the preceding month.
d. For any recoveries as a result of fraud investigations and audits, the Contractor shall pay the State using one of the following methods:
i.) A separate check payment and provide documented substantiation; or
ii.) Claim reversals/credits for which recoveries flow through to the State in the invoice, and for which the Contractor shall provide detailed reports that specifically document such reversals/credits in order to fulfill the State's accounting requirements.
e. The Contractor agrees that the only compensation to be received by or on behalf of its organization in connection with this Plan shall be that which is paid directly by the State.
f. The Contractor agrees that, upon contract termination or expiration, the cost of any work required by a new administrator to bring records in unsatisfactory condition up to date shall be the obligation of the new administrator and such expenses shall be reimbursed by the Contractor within three (3) months of the end of the contract term.

3. Contractor shall confirm bank transfers as they occur.

4.2.9 Special Provisions

1. Contractor is responsible for the cost of all programming required to support the implementation of any benefit design changes.

2. Contractor shall provide necessary legal defense in the event of litigation resulting from Contractor errors or omissions.

3. Contractor shall cover all costs associated with legal defense in the event of litigation against the Contractor and the State for Contractor errors or omissions.

4. All claim records and eligibility data used by the Contractor shall remain the property of the State as plan sponsor and plan administrator.

5. Contractor agrees to prepare and file all legal documents necessary to implement and maintain the plan, including policies, amendments, contracts, required state filings, and development of booklet/certificate formats.

6. Contractor agrees to retain records in excess of the period required by the contract if required by state or federal regulations.

7. Contractor shall provide a general allowance of $1,000,000 per contract year (including optional years), to reimburse the actual, fair market value of: (i) expense items and services related to monitoring, transitioning, administering, and/or implementing the pharmacy benefit initially and throughout the term, such as, custom ID Cards, IT programming, custom formulary letters, Member communications, plan design adjustments, and benefit set-up quality assurance; and/or (ii) mutually agreed upon expense items and services related to implementation of additional clinical or other similar programs provided by Contractor throughout the contract term. The State shall determine the application and timing of the allowance from the Contractor. The application and timing of the general allowance reimbursements shall be determined by the State.

4.2.10 EGWP

1. Contractor shall provide a self-insured EGWP program to the State's Medicare retirees.

2. Contractor shall maintain information as required for the State and/or Purchasing Pool Participant including but not limited to the following:
a. Drug lists and prior authorizations necessary to categorize Part B covered drugs for exclusion from claim submission;
b. Storage of data for CMS audit, and support for, and participation in CMS audits, as needed;
c. Exchange eligibility and enrollment data as necessary with the CMS COB Coordinator for accurate administration and processing of COB;
d. Certificates of coverage at termination of Creditable Coverage, including postage and mailing;
e. Record retention (claims, utilization management and eligibility data) for the period required by CMS; and
f. Provide claims data necessary to support audit processes.

3. Contractor shall appropriately process electronic (in real time) and paper claim submissions for COB as secondary payor for Medicare Part D enrollees.

4. Contractor's Pharmacy & Therapeutics Committee meets CMS' requirements for objectivity and validity.

5. Contractor shall provide all CMS required filings related to formulary, medication therapy management, and other clinical programs on a timely basis.

6. Contractor shall provide all CMS required filings related to certification of compliance to all waste, fraud, and abuse requirements.

7. Contractor member appeals process meets all CMS Medicare Part D requirements.

8. Contractor shall provide all CMS required member communications.

9. Contractor shall mirror the current retiree plan design and clinical programs.

10. Contractor shall process low-income premium subsidy refunds to members and the Plan as well as low-income cost sharing refund requests to the members.

11. Contractor shall match, or closely mirror the EGWP pharmacy network to the commercial pharmacy network to minimize member disruption.

4.3 Ongoing Claims Review

1. Contractor shall allow third-party Ongoing Claims Review for the life of the contract. For clarification, Ongoing Claims Review is not an audit but a proactive review and re-adjudication of all claims underlying each PBM invoice.

The State recognizes that some aspects of State Prescription Drug Data may be competitively sensitive when identifiable by name and likeness identifiers as relating to Contractor (Trade Secrets), and should not be released to third parties that are not performing an ordinary course function for the State, and that Contractor has a legitimate interest in protecting Trade Secrets that might reasonably be revealed in State Prescription Drug Data.

2. Contractor shall agree to set up and send full State Prescription Drug Data for reconciliation to the State's elected consultants. The State Prescription Drug Data will be used for Ongoing Claims Review and provided no less than daily at no charge to State.

3. In addition to claims files, Contractor shall agree to provide all final contracts, exhibits, addendums, and lists, such as Specialty lists, census information, plan design documents, and any other pertinent information requested by the State and/or consultant.

4. Contractor shall agree that all quarterly lists and reports for Ongoing Claims Review shall be provided to consultants within five (5) Business Days from quarter end.

5. Contractor shall provide all required formulary information, including, current formulary and preferred drug list with Member Copayment Tiers and excluded drugs (when applicable) in Microsoft Excel or text format no less than quarterly at no charge.

6. Contractor shall respond to all questions and inquiries from State and/or consultant within three (3) Business Days.

7. Contractor shall respond to all Ongoing Claims Review findings from State and/or consultant within thirty (30) Business Days.

8. Contractor shall provide Brand/Generic alternatives for non-formulary and excluded products upon request.

9. Contractor shall provide an NDC-11 level Formulary exclusion file no less than quarterly in Microsoft Excel or text format at no charge.

10. Contractor shall provide quarterly Rebate reports of earned, expected, and paid Rebates.

11. Contractor shall provide a full Specialty list at the NDC-11 level including pricing, no less than quarterly in Microsoft Excel or text format at no charge.

12. Contractor shall provide an NDC-11 listing of New to Market, Biosimilar, and Limited Distribution Drugs, no less than quarterly in Microsoft Excel or text format at no charge.

13. Contractor shall provide an NCPDP/NPI listing of all Specialty and Mail Order Pharmacies in the current network within fifteen (15) calendar days after any changes occur.

14. Contractor shall provide other listings or exhibits specific to their contractual language (Inclusions and Exclusion).

15. Contractor shall agree that data received for Ongoing Claims Review shall be used in execution of an audit, as needed and requested by the State. This does not preclude the State from requesting additional details as needed for an audit.

4.4 Quality Assurance and Audits

1. Contractor shall allow the State or its designee the right to audit, with an auditor of the State's choice, with full cooperation of the selected PBM, on an annual basis, the services and pricing (including Rebates) provided in order to verify compliance with all program requirements and contractual guarantees. The State's right to audit shall survive the termination of the agreement between the parties for a period of five (5) years.

2. Contractor shall provide the State (at minimum) and the State's auditor the following audit access, in addition to any other rights specified in the MS-IFB, and any audit right specified in the MS-IFB and Reverse Auction:

a. To audit any data necessary to ensure the Contractor is complying with all contract terms, such audit rights to include but not be limited to: 100% of pharmacy claims data, which includes at least all NCPDP fields from the most current version and release; retail pharmacy contracts; data management and pharmaceutical manufacture agreements; approved and denied utilization management reviews; clinical program outcomes; appeals; and information related to the reporting and measurement of performance guarantees;

b. To audit post termination;

c. To audit more than once a year if the audits are different in scope or for different services;

d. To perform additional audits during the year of similar scope if requested as a follow-up to ensure significant or material errors found in an audit have been corrected and are not recurring, or if additional information becomes available to warrant further investigation; and

e. To submit to an annual audit of contractual compliance;

f. The Contractor shall pay to the State 100% of any overpayment(s) made, along with any liquidated damages assessed, as determined from an audit no later than thirty (30) calendar days after the Contractor has been made aware of the overpayment.

g. The Contractor shall cooperate with requests for information, which includes but is not limited to the timing of the audit, deliverables, data/information requests and your response time to questions during and after the process. The Contractor shall also provide an initial response to all findings that the Contractor receives within thirty (30) calendar days and any subsequent responses within two (2) weeks, or at a later date if mutually determined to be more reasonable based on the number and type of findings.

3. Contractor shall agree it will provide Claim detail, as needed, to a designated third party for independent reconciliation of all component level Discount and Dispensing Fee guarantees. Claim detail will include categorization of both included and excluded Claims for measurement purposes.

4. Contractor shall agree that Pharmacy audit results must be reported to the State.

5. Contractor shall agree that the State may audit multiple years at any time during the contract period.

6. Contractor shall not limit the time period of data being audited.

7. Contractor shall agree that as part of any claims audit, State or its auditor shall have access to the prescription records associated with the claims being audited.

8. Contractor shall agree that as part of a pricing or financial audit, State or its auditor shall have access to detailed participating pharmacy remittance and other data as necessary for State or its auditor to determine the network arrangement under which Bidder/PBM adjudicated the paid claim.

9. Contractor shall support pre- and post-implementation review by the State or their designated consultant.

10. Contractor shall agree to payback all spend associated with Claims resulting from an inappropriate prior authorization (PA) setup, processing or a discrepancy.

11. Contractor shall agree that when an audit identifies contract compliance or performance issues, the State's designated third party auditor may re-audit at no additional cost to State, and/or State may require the Contractor to implement a corrective action plan to remediate and prevent recurrence of the identified issues.

12. Contractor shall agree that the State's full auditing rights include State (or its designated third party) having the right to annually audit Rebates to ensure that one hundred percent (100.00%) of Rebates are passed through to State. The State (or its designated third party) will be allowed to audit one hundred percent (100.00%) of Claims and one hundred percent (100.00%) of manufacturer contracts, attributable to up to five (5) manufacturers. The Bidder will provide a summary of Rebates received by each manufacturer, and the State will be allowed to select up to five (5) manufacturers to audit annually.

13. Contractor shall allow State, or an independent firm chosen by them, to audit claims and drug company utilization incentives (e.g., Pricing Guarantees and Rebates) on an annual basis with thirty (30) calendar days advanced notice.

14. Contractor shall have each billed invoice reviewed and claims reconciled by an independent firm and shall cooperate on a timely basis to all requests for information and respond to any resulting findings from the Ongoing Claims Review process.

15. In the event that the Contractor discovers or receives recoveries (e.g., overpayments, mispayments, etc.) from third parties (e.g., pharmacies) as part of audits or other activities, the Contractor shall remit such recoveries to the State to the extent such recoveries are attributable to the State Plan within thirty (30) calendar days of receipt by PBM. Such payments shall not be reduced by contingency fees or other fees charged by an auditor or other recovery service.

4.5 Benefit Management

4.5.1 Formulary, Plan Design, and Utilization Management

1. The State reserves the right to exclude medications on the Contractor's formulary that are considered low-value medications (e.g., Duexis) and/or prefer medications with a lower net cost.

2. Contractor's financial bid shall include all clinical and utilization management programs such as step therapy, prior authorization, quantity limits, etc., as provided in the Solicitation.

3. Contractor shall manage prior authorization requests using State-approved criteria.

4. Contractor shall respond to prior authorization requests within forty-eight (48) hours, seven (7) days a week.

5. Contractor shall only initiate therapeutic interchanges when switching to drugs with a lower net cost (including rebates).

6. Contractor shall only initiate therapeutic interchanges on drug pairs authorized by the State.

7. Contractor shall provide the opportunity for the State to participate in patient assistance management or coordination programs.

8. Contractor shall provide a means of tracking claims using manufacturers' or other entities' patient assistance programs or coupons.

9. Contractor shall provide a system that adjusts Member accumulators when Members use patient assistance, coupons, or other similar manufacturer Member financial assistance programs.

10. Contractor shall not charge the State for any patient assistance, coupon, or other similar manufacturer co-pay assistance programs.

11. Contractor shall hold all negative formulary tier changes until 1/1 of the next Calendar year, unless directed otherwise by the State.

12. Contractor shall notify the State at least 90 calendar days prior to any formulary change.

13. Prior to making any modification to the formulary, Contractor shall advise the State regarding the impact on Members and whether it will impact any Rebate guarantees.

14. Contractor shall grandfather any formulary excluded drugs for up to three (3) months without any impact on financial guarantees during the initial plan year (i.e., discount and Rebate guarantees will be in effect as of the go-live date).

4.5.2 Specialty, LDD, New-to-Market

1. Contractor agrees that if a Specialty Drug package is lost, stolen, or not delivered, Contractor will not charge the Member or Plan Sponsor for such Specialty Drug.

2. Contractor agrees that Non-Specialty Drugs filled through a Specialty Pharmacy will be adjudicated and billed at Mail Order rates, and further, included with the Mail Order Network Discount guarantees and the Mail Order Rebate guarantees.

3. Contractor agrees that consistent pharmacist-led clinical support, including without limitation, side effect and adherence management, physician interactions as necessary, and Member questions regarding product administration, will be provided for Members who are prescribed Specialty drugs, regardless of the channel that their Specialty drugs are filled.

4. Contractor agrees once a drug is added to Specialty list, it cannot be removed without State's approval.

5. Contractor agrees that non-Specialty drugs available for more than six (6) months may not be added to the Specialty List, without State approval. This applies to new GPI-14s, not new NDCs for GPI-14s already on the Specialty list.

4.6 Pricing Guarantee Requirement

4.6.1 Network

1. Bidder agrees that there shall be no minimum day supply required for Specialty guarantees, including network and Rebate guarantees.

2. There shall be no minimum day supply required for Mail Order Pharmacy guarantees, including network and Rebate guarantees.

3. Bidder agrees Specialty pricing is based on the actual NDC-11 and package size from which the prescription is dispensed.

4. Bidder agrees Mail-service pricing is based on the actual NDC-11 and package size from which the prescription is dispensed.

5. Bidder agrees to exclude funding, discounts, or compensation from co-pay cards, manufacturer coupons, discount programs, or other Member financial assistance programs from drug discount guarantees.

6. Bidder agrees dollars collected for foundational support, patient assistance, coupons, or other similar copay assistance programs may not be applied to network discount guarantees.

7. Bidder shall apply Lower of Pricing Logic to all drugs at all channels.

8. Bidder agrees members will pay the Lower of Member Cost Logic for all drugs at all channels.

9. Bidder agrees that pricing terms and guarantees will not be reduced during the contract term.

10. Bidder agrees that Claims paid at U&C, Ingredient Cost will be calculated as U&C minus the Dispensing Fee.

11. Bidder agrees that all Generics (including non-MAC, MAC, single-source, and multi-source generic products) are to be included in the Generic discount guarantee measurement.

12. Bidder agrees to not cap exposure to Network or Specialty Pricing Guarantees.

13. Contractor shall provide initial and on-going contracting with a sufficient number of national chains and regional or local pharmacies to ensure appropriate access for State participants.

14. Contractor shall notify the State prior to anticipated major changes to the network. The State reserves the right to accept or decline proposed changes to the network and set the effective date of such changes.

15. Contractor agrees that it will NOT implement or administer or allow any program that results in the conversion from lower discounted ingredient cost drug products to higher ingredient cost drug products without the prior written consent of the State or its designee.

16. Contractor shall provide up-to-date listings and participant support services live and on-line for selecting and/or locating network pharmacies.

17. Contractor shall notify plan participants, in writing, with at least forty-five (45) calendar days advance notice (or as much time as is feasible if the terminating Pharmacy gives the Contractor less than forty-five (45) calendar days' notice), in the event that the contract for a participant's network pharmacy (or pharmacy chain) terminates for any reason. For the purposes of this requirement, plan participant shall mean a member who has had a prescription filled within the last thirty (30) calendar days or a member has an active refill on file with the affected pharmacy.

18. Contractor shall be responsive to requests by the State to recruit additional pharmacies for the network, on a general, regional, or specific basis.

19. Contractor has a network of retail pharmacies that have agreed to discount their charges for 90-day supply of maintenance medications. The Contractor must provide this network through the entire term of the contract, including term extensions.

20. Contractor agrees to apply MAC pricing to Retail Pharmacy 90-Day Network. The MAC price must be the same MAC as the Retail Network or better on an individual drug basis.

21. Contractor shall provide mail order and specialty pharmacy services, and all mail order and specialty pharmacies must be registered with the State of Maryland, as required by Md. Ann. Code, Insurance Art.§15-1610 and Md. Ann. Code, Health Occupations Art. §12-403 even if such operations are not located within the State of Maryland.

22. Contractor shall accept electronically submitted Mail Order prescriptions.

23. Contractor agrees that it will not repackage prescriptions or otherwise change the NDC for any prescription or OTC products dispensed at mail order.

24. Contractor shall communicate any delays beyond three (3) calendar days in delivery of mail order and/or specialty prescriptions to the member.

25. Contractor shall send prescription orders to members that do not provide appropriate payments with their prescription order, up to three times the plans highest copayment for each enrollee. After the ceiling is reached, the Contractor may implement standard accounts receivable policies and procedures.

26. If requested, Contractor shall provide participants with notification of any credits or overpayments on their accounts.

27. Contractor shall not require the State to pay outstanding balances owed by the member.

28. Contractor shall not require the State to implement programs that encourage use of the mail or specialty pharmacy. Further, unless requested and implemented within the State's plan design, there shall be no limits placed on mail order or specialty pharmacy use.

29. If requested, Contractor shall provide participants who are currently using another mail order facility with a toll-free 800 number that may be called to provide the Contractor with the necessary information to transfer the member's current mail order prescriptions to the Contractor's mail order facility.

30. Bidder shall agree to respond to questions 31-46 with the understanding that these sections will be applicable should Bidder qualify for the Reverse Auction phase.

31. Bidder shall agree that their Bid and Reverse Auction will be Pass-Through.

32. Bidder shall agree that their Functional Area 1 - Commercial Bid and Reverse Auction will be for a Broad Retail 30 network, Broad Retail 90 network, PBM Exclusive Mail network (with 90 day allowed at Broad 90 network), and an Open Specialty Network.

33. Bidder shall agree that their Functional Area 2 - EGWP Bid and Reverse Auction will be for a Broad Retail 30 network, Broad Retail 90 network, Open Mail network (with 90 day allowed at Broad 90 network), and an Open Specialty Network.

34. Bidder shall agree that only the following shall be excluded in their Bid and Reverse Auction for network guarantees: COB, Compounds, Vaccines, Direct Member Reimbursement Claims ('DMRs'), 340B Claim, subrogation claims, claims through on-site, in-house, or State-owned pharmacies.

35. Contractor shall reconcile all Discount guarantees and Dispensing Fee guarantees on a bi-annual basis per the performance guarantee. Bidder will conduct reconciliation without the requirement of a request from the State and provide the State with a detailed Claims reconciliation file, which identifies all Claim IDs included and excluded from each financial guarantee and reason code.

36. Contractor shall agree that ALL State guarantees will be measured and reconciled on a dollar-for-dollar basis with 100% of any shortfalls recouped by State.

37. Contractor shall agree that each distinct Discount and Dispensing Fee Pricing Guarantee will be measured and reconciled individually with no offsets allowed.

38. Bidder shall agree that their network bid includes all clinical and utilization management programs such as step therapy, prior authorization, quantity limits, etc., excluding enhanced utilization management programs and appeals.

39. Bidder shall agree that all values presented in the Bid during the Reverse Auction will be minimum guarantees, with the value of any over performance accruing to the State.

40. Contractor shall agree it will not increase the mail order dispensing fees for the term of the agreement and it will not charge any increases in postage rates to State.

41. Contractor shall agree that there shall be no limitations on guarantees.

42. Bidder shall follow current Specialty Plan design and that there shall be no days supply average required for Specialty guarantees.

43. Bidder shall agree that Specialty network guarantees will include a separate overall discount guarantee for Specialty Brands and Specialty Generics.

44. Contractor shall reach out to any non-contracted independent pharmacies within the State, at least quarterly, in an attempt to include all independent pharmacies in the proposed network.

45. Contractor shall not deny any pharmacy the right to participate so long as the pharmacy agrees to meet the Contractor's terms and conditions.

46. Contractor shall follow all Maryland rules and regulations applicable to pharmacies within the State, as amended from time to time.

4.6.2 Rebate

1. Bidder shall agree that minimum Rebate guarantees will be quoted on a per all Brands basis (including multi-source brands and non-preferred brands).

2. Bidder shall agree that minimum Rebate guarantees will be quoted by Retail 0 -45 day supply, Retail 46+ day supply, Mail Order and Specialty.

3. Bidder shall agree that minimum Rebate guarantees for Mail Order and Specialty may not include qualifications for days supply, average of days supply, or be pro-rated by day supply.

4. Bidder shall agree that the Minimum Rebate guarantee for Specialty shall apply to all Specialty claims regardless of dispensed distribution channel.

5. Bidder shall agree to provide all Rebate administration at no additional cost.

6. Contractor shall agree that on a quarterly basis, the State will receive the minimum Rebate guarantees.

7. Contractor shall agree that Rebate payment shall be made within ninety (90) Calendar Days of the end of the corresponding calendar quarter. For example, the following indicates quarterly payment due dates:
Q1 – July 1
Q2 – Oct 1
Q3 – Jan 1
Q4 – Apr 1

8. Contractor shall agree that on an annual basis, within one hundred twenty (120) calendar days from Calendar year end, the State will receive Earned Rebates defined as the greater of the minimum Rebate guarantee or 100% of Rebates and Manufacturer Payments collected.

9. Contractor shall agree that Rebate guarantee exposure shall not be capped.

10. Contractor shall exclude alternative funding, discounts, or compensation from co-pay cards, manufacturer coupons, discount programs, foundational support, patient assistance, or any other Member financial assistance programs from applying towards achieving Rebate guarantees.

11. Contractor shall agree that all Pharmaceutical Manufacturer Payments, including Rebates, fees, discounts, grants or payments of any kind that are associated with the utilization of State's pharmacy benefit program are to be considered a Rebate and are to be passed through to the State.

12. Contractor shall agree that all phases of the Rebate process, including the agreements with the Pharmaceutical Manufacturer, third-party rebate aggregator or group purchasing organization, can be audited by the State or the State's designated representative to the extent permitted in Contractor's agreement with the group purchasing organization.

13. Bidder shall agree that the Formulary for Commercial Rebates applicable to this bid shall be a Standard Broad Formulary as defined in PBA section 4.1. Any additional exclusions shall be mandated by the State's Plan Design. In the comments, provide only the name of the formulary you intend to respond with during the Reverse Auction phase and the total number of excluded NDCs.

14. Bidder shall agree that the Formulary for EGWP Rebates applicable to this bid shall be a Standard Broad Formulary as defined in PBA section 4.1. Any additional exclusions shall be mandated by the State's Plan Design. In the comments, provide only the name of the formulary Bidder intends to respond with during the Reverse Auction phase and the total number of excluded NDCs.

15. Bidder shall agree to mirror the State's current Copay/Coinsurance pursuant to the Plan Design provided in solicitation. Bidder shall not impose a different Copay/Coinsurance differential for minimum Rebate guarantees to be applicable.

16. Bidder shall agree the Rebate bid shall apply to the current plan benefit design and formulary type as noted in the scope of work.

17. Bidder shall agree that only the following claims will be excluded from your minimum Rebate guarantees: COB, Compounds, Vaccines, DMRs, 340B Claim, subrogation claims, claim through on-site, in-house, State-owned pharmacy, home infusion pharmacy or military/ veteran's administration pharmacy. (Disagreement to this question may result in disqualification).

18. Contractor shall agree that Minimum Rebate guarantees will exclude Rebates generated by excluded claims in both the numerator and denominator of the calculation.

19. Contractor shall agree to pass-through 100% of Rebates.

20. Bidder shall provide minimum Rebate guarantees and not estimates only.

21. Bidder shall agree that EGWP wrap and supplemental coverage claims shall be included in the Commercial Minimum Rebate guarantees.

22. Bidder shall agree that all Brand Biosimilar and LDD products regardless of dispensed distribution channel shall be included in the applicable Rebate guarantee.

4.6.3 Maximum Aggregate Base Administrative Fees

Bidder agrees to provide a Maximum Aggregate Base Administrative Fee during the Reverse Auction.

1. Bidder shall agree that the Maximum Aggregate Base Administrative Fee shall include all items in the Maximum Aggregate Base Administrative Fees Table below.

2. Maximum Aggregate Base Administrative Fees Table

Administrative Fee Type
Transfer of State Prescription Drug Data to medical carrier, Data warehouse and Consultants.
Daily or weekly State Prescription Drug Data (sent to State and/or Consultants).
Quarterly or annual claims detail electronic file (sent to State and/or Consultants).
Fees associated with audits
Toll-free telephone access to customer service for the program for use by plan members, benefits personnel, and physicians.
Toll-free telephone access to voice response unit for location of network pharmacies in zip code area.
24-hour access to a Bidder pharmacist via toll-free telephone service.
Toll-free access to PBM pharmacists to obtain DUR assistance.
Formulary Management
Point of Sale Edits, Dose/Quantity Duration Edits, Step Therapy Edits, Dispensing Quantity Edits
Prior Authorization - Clinical and Administrative
First Level and Higher Level Appeals
Attendance at Annual Enrollment Meetings and Benefit Fairs
Standard management reports.

Administration of eligibility submitted in a Bidder/PBM-standard digital format.
Eligibility maintenance.
Hard copy eligibility submission.
State access to PBM's systems to support coverage, eligibility & authorization activities.
Connectivity to customer and provider support system.
Administration of PBM standard plan designs including tiered (3 and greater) copayments, coinsurance, maximum limits, out-of-pocket limits, and deductibles.
In-network claims adjudication via online claims adjudication system.
Direct reimbursement/out-of-network claims adjudication (including check and EOB)
Online claims history retention more than 12 months.
Compound Claim Adjudication
Vaccine Claim Adjudication
Establish, maintain, credential and contract an adequate panel of participating network pharmacies.
Monitor network pharmacy performance and compliance, including Generic substitution rates, formulary program conformance, and DUR intervention conformance through retail network management initiatives and reporting.
Standard pharmacy audit program (including member survey, and onsite pharmacy audits).
Web-based online, decision support tool allowing State access to reports and ad hoc query capabilities.
Additional ad hoc/custom report production, reprogramming and testing of non-standard requirements for State.
Up to 10 programming hours to support specialized reporting or benefit design.
Bidder enrollment package for new members, including announcement letter, descriptive brochure, and Mail-service envelope.
Distribution of customized materials, except as described elsewhere.
Required Explanation of Benefits (EOB) to describing the application of deductibles and coinsurance for Functional Area 2 (EGWP).
Customized, targeted member mailings for supporting formulary initiatives.
Standard Member website capabilities including online prescription ordering and status, coverage and benefit information, health information, and assessment resources.
Online drug cost comparison tool including formulary status and average cost per prescription.
State's clinical and plan consulting, analysis and cost projections.
Annual analysis of program utilization, impact of plan design and managed care interventions.
Processing of prescriptions received via internet, fax, phone or mail.
Refill orders received by phone or internet 24 hours a day, 7 days a week.
Handling and postage expense of home delivery prescriptions.

Communication/educational materials included in medication packages including benefit summary statement, drug information leaflet, Mail-service envelope, and refill forms (as needed).
General communications regarding utilization of home delivery including brochures, table tent cards, posters, content for general e-mail messaging to members and newsletter content.
Account Management
Abuse/Fraud program development and management
Rebate management / administration
Data Processing
Network Management
Controlled Substance Management
Controlled Substance Management- Provider Lock-In
Core Medication Management
Diabetes: Standard Meter Program
Formulary Management: Brand Over Generic Tier 1 & 2
Specialty Connect
Specialty Expedite
Unapproved Drugs (Management of Select Unapproved Drugs)
Concurrent DUR
Retrospective DUR
Retrospective Safety Review
Medication Therapy Management
Drug Saving Review
EGWP Administration

4.6.4 Clinical Program Fees

Bidder is requested to propose similar clinical programs that the State has in place today.

1. Bidder to complete the following table based on each clinical program. For any additional costs the State requests the PBM quote on a per program enrolled participant fee.
Some programs listed may be included in Bidder's base services- Maximum Aggregate Base Administrative Fee. If no additional cost to the State indicate "$0.00- Included in Maximum Aggregate Base Administrative Fee".

Clinical Program	Program Cost
Diabetes Care program - (per solicitation 2.3.8)	

4.7 Performance Guarantees

Bidder will report results on all performance measurements quarterly per the requirements of the Report Card. Performance results will also be audited annually by the State's contract auditor.

NOTE: It is critical to the success of the State's programs that services be maintained in accordance with the schedules agreed upon by the State. It is also critical to the success of the State's programs that the Contractor operates in an extremely reliable manner. It would be impracticable and extremely difficult to fix the actual damage sustained by the State in the event of delays or failures in claims administration, service, reporting, and attendance of Contractor personnel on scheduled work and provision of services to the citizens of the State. The State and the Contractor, therefore, presume in the event of certain delay(s) or failure(s), the amount of damage which will be sustained from the delay or failure will be the amount set forth below, and the Contractor agrees in the event of any such failure of performance, the Contractor shall pay such amount as liquidated damages and not as a penalty. The State, at its option for amount due the State as liquidated damages, may deduct such from any money payable to the Contractor or may bill the Contractor as a separate item.

1. Bidder agrees to the below Performance guarantees:

PG #	Performance Guarantee Indicator	Standard Goal	Reporting Measurement	Liquidated Damages	Agree or Disagree
PG-1	Implementation	All administrative functions completed within time requirements noted in Implementation Schedule list in the solicitation, as determined by the State.	One time measurement after the first quarter of the initial plan year by State of Maryland DBM staff	$300,000. Payment due within thirty (30) calendar days of invoice.	
PG-2	Implementation Project Schedule	a) Contractor shall submit draft project schedule within five (5) Business Days after the Kick-Off Meeting for review; b) Contractor shall submit final project schedule within ten	a) One time measurement; b) One time measurement; c) weekly status update reports to the project	a) $5,000 per day for each Business Day during which the Contractor fails to deliver draft project schedule; b) $5,000 per day for each Business Day	

		(10) Business Days after the Kick-Off Meeting; c) Contractor shall submit to the State weekly status update reports to the project schedule, including task-level detail and dates; and d) Contractor shall complete all implementation phases per the State-approved project schedule (changes to project schedule must be approved by the State)	schedule due by Noon EST Friday each week, through March 31, 2025 (or when all project schedule tasks are complete); and d) measured at time of completion of phases defined in the State-approved project schedule.	during which the Contractor fails to deliver final project schedule; c) $5,000 per day for each Business Day during which the Contractor fails to deliver a weekly status update report; and d) $5,000 for each Business Day when Contractor fails to successfully complete a phase within the project schedule	
PG-3	Accuracy of Processing the State's Enrollment Eligibility Information	Plan will process electronic interchange of the State's enrollment information within twenty-four (24) hours.	Report Card - Contractor to maintain log and system generated reports for review by the State's contract auditor. Frequency of measurement: Quarterly	$3,000 for each calendar day over twenty-four (24) hours, or portion thereof, of delay.	
PG-4	Delivery of Quarterly Plan Performance Measurement Report Card and Utilization Reports to the State and the State's Consultant	Delivery or report including actual performance and supporting documentation for each Performance Guarantee to the State and the State's consultant by 6:00 pm on the following dates**: First Quarter	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Date-stamp of receipt by the State. Frequency of	$3,000 for each week, or fraction thereof, the data report is not received or is incomplete.	

		(Jan -Mar) Due: May 1st Second Quarter (Apr - Jun) Due: August 1st Third Quarter (Jul - Sep) Due: November 1st Fourth Quarter (Oct - Dec) Due: February 1st	measurement: Quarterly		
PG-5	Claims Standards Financial Accuracy	Measures the gross dollars paid incorrectly (overpayments plus underpayments) subtracted from total paid claim dollars, divided by total paid claim dollars within the audit sample 99.00% of claim dollars processed accurately.	Measured by the State's independent auditor as part of the annual claims audit. Criteria as defined by the State's independent auditor. Measured to two (2) decimal places. Frequency of measurement: Quarterly.	$25,000 if below 99.00% but at least 97.00%. $50,000 if less than 97.00%.	
PG-6	Claims Standards Payment Accuracy	Measures the number of incorrect drafts of payments made on behalf of the State, subtracted from the total draft or payment transactions, divided by the total draft or payment transactions. 97.00% of claims with benefit payments are processed accurately.	Measured by the State's independent auditor as part of the annual claims audit. Criteria as defined by the State's independent auditor. Measured to two (2) decimal places. Frequency of measurement: Quarterly	25,000 if below 97.00% but at least 95.00%. $50,000 if less than 95.00%.	
PG-7	Claims Standards Processing Time	95.00% of all claims are adjudicated within 10 Business Days; and	Measured by the State's independent	$2,500 per period in which standard is not met.	

		98.00% of all claims are adjudicated within 20 Business Days.	auditor as part of the annual claims audit. Criteria as defined by the State's independent auditor. Measured to two (2) decimal places. Frequency of measurement: Quarterly		
PG-8	State Prescription Drug Data and eligibility data to third party Contractor(s)	Delivery of agreed-upon State Prescription Drug Data, claims and eligibility data to third party vendors in the format and frequency required by the applicable Contractor(s).	Date-stamp of receipt by the third-party vendor and verification of accuracy and completeness of required documentation. Frequency of measurement: Quarterly	$1,000 for each calendar day the data is not received or is incomplete.	
PG-9	Participating Employees Satisfaction	Satisfactory or better results from an annual State-conducted Participant satisfaction survey. 80% of participating employees indicate satisfied or very satisfied. Measured annually.	Survey results. Frequency of measurement: Annually	$50,000 if less than 80% of participating employees indicate satisfied or very satisfied.	
PG-10	Telephone Call Availability	Average speed of answer by a live service representative (with knowledge of State of Maryland account) is thirty (30) seconds or less during call center live hours.	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Frequency of	$1,500 for each second over 30.	

		The representative must be able to address the member's issue or question. Time over which standard is measured: Quarterly	measurement: Quarterly		
PG-11	Telephone Call Abandonment Rate Measurements must be specific to the State or for only the service center handling the State account.	Abandonment rate of less than 3.00%. Time over which standard is measured: Quarterly.	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Frequency of measurement: Quarterly	$500 for each percentage point, or fraction thereof, over 3.00%. Measured to two (2) decimal places.	
PG-12	Mail Order Dispensing Turnaround Time-For Prescriptions not requiring intervention	95.00% of prescriptions dispensed within two (2) Business Days and 100.00% within four (4) Business Days.	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Measured by the State's independent auditor as part of the annual claims audit. Criteria as defined by the State's independent auditor. Frequency of measurement: Quarterly	$25,000 if below 95.00% but at least 90.00%. $50,000 if less than 90.00%. Measured to two (2) decimal places.	
PG-13	Mail Order Dispensing Turnaround Time-For Prescriptions	95.00% of prescriptions dispensed within four (4) Business Days and	Quarterly Plan Performance Measurement Report Card	$25,000 if below 95.00% but at least 90.00%. $50,000 if less than 90.00%.	

	requiring intervention	100.00% within seven (7) Business Days.	(Report Card to be submitted by the Bidder). Measured by the State's independent auditor as part of the annual claims audit. Criteria as defined by the State's independent auditor. Frequency of measurement: Quarterly	Measured to two (2) decimal places.	
PG-14	Paper Claim Processing	95.00% of paper claims will be reimbursed within ten (10) Business Days and 100.00% within fifteen (15) Business Days.	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Measured by the State's independent auditor as part of the annual claims audit. Criteria as defined by the State's independent auditor. Frequency of measurement: Quarterly	$25,000 if below 95.00% but at least 90.00%. $50,000 if less than 90.00%. Measured to two (2) decimal places.	
PG-15	Account Management Responsiveness	Plan representatives will return all messages received from the State	Report Card - Contractor to maintain log for review by the	$150 for each delayed response.	

		(whether voice mail, e-mail or other communication method) within one (1) Business Day.	State's contract auditor. Frequency of measurement: Quarterly		
PG-16	Contractor attendance at State-sponsored open enrollment meetings	Attendance by plan representatives trained on the State Plan benefits at 100% of meetings scheduled by the State, for 100% of the meeting's duration. Representative must arrive early enough to have their table set-up prior to meeting start time. Display must be organized and include appropriate covering of table. Representative must have detailed plan knowledge, interact with members, and exhibit professional appearance and behavior.	Sign-in sheets at meetings or minutes of State meetings. Frequency of report: Annually	$500 for each scheduled meeting date Contractor fails to attend.	
PG-17	Complaint Resolution Time	Contractor will: a) acknowledge receipt of the written complaint to the State and Member within two (2) Business Days of receipt of the complaint letter; b) provide a written complaint response to the State and Member within twenty-one (21) Business Days	Self-reported and State correspondence logs	$250 for each late acknowledgment letter; $250 for each late written complaint response	

		following receipt of the initial complaint letter.			
PG-18	Provision of Draft Plan Documents Certificate/ Evidence of Coverage Document	Draft Plan Document including all required updates provided to the State at least two (2) months prior to the first day of the plan year.	Receipt date as documented by vendor and confirmed by State. Frequency of measurement: Annually	$500 per calendar day for the first three (3) days the document is not received. $1,000 per calendar day for each day the document is not received for the fourth day and beyond.	
PG-19	Provision of Final Plan Documents Certificate/ Evidence of Coverage Document	Final Plan Document including all required edits and in a format, ready for posting to State intranet is returned to the State within fifteen (15) calendar days of the carrier's receipt of the State's edits.	Receipt date as documented by vendor and confirmed by State. Frequency of measurement: Annually	$500 per calendar day for the first three (3) days the document is not received. $1,000 per calendar day for each day the document is not received for the fourth day and beyond.	
PG-20	Rebate Payments	Agrees to reimburse the State all Rebates received on a quarterly basis to be paid no later than ninety (90) calendar days following the end of the reporting period. Payment must include all Rebates received for the quarter up to ten (10) Business Days before the Rebate payment is due to the State. An annual reconciliation will occur no later than 120 calendar days	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Receipt date as documented by vendor and confirmed by State. Frequency of measurement: Quarterly	$1,000 for each calendar day the data is not received or is incomplete	

		following the end of the fiscal year.			
PG-21	Average cost discount guarantee and dispense fee guarantee Reconciliation Payments	Agrees to prepare bi-annual reconciliation of average cost discount and dispensing fees compared to guarantees and to reimburse the State for all average cost discount and dispensing fee shortfalls on a semi-annual basis to be paid no later than 90 calendar days following the end of the reporting period. An annual reconciliation will occur no later than 120 calendar days following the end of the fiscal year.	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Receipt date as documented by vendor and confirmed by State. Frequency of measurement: Bi-Annual	$1,000 for each calendar day the data is not received or is incomplete. $1,000 for each calendar day the shortfall payment is not received or is incomplete.	
PG-22	DBM Claims Eligibility Audits	Plan will provide response files to Department's Audit Unit within fourteen (14) Business Days of receipt of error report from Department.	Receipt data as documented by vendor and confirmed by State.	$500 per calendar day for the first three (3) days the document is not received. $1,000 per calendar day for each day the document is not received for the fourth day and beyond.	
PG-23	Ongoing Claims Review Submission and Response	Agree to respond within fourteen (14) Business Days to monthly invoice review report findings or questions.	Receipt data as documented by vendor and confirmed by State.	$500 per calendar day for the first three (3) days the document is not received. $1,000 per calendar day for each day the	

				document is not received for the fourth day and beyond.	
PG-24	Clean State Prescription Drug Data	All data files will be clean, accurate, complete and include all required fields as specified and mutually agreed upon by Consultant, State, and Bidder. Resending a data file or supplementing a previous data file will be considered a miss.	Date-stamp of receipt by the third-party vendor and verification of accuracy and completeness of required documentation. Frequency of measurement: Quarterly	$500 for each file that is resent.	
PG-25	New Member ID Cards	100% of ID cards will be mailed accurately to new Members within three (3) Business Days of receipt of eligibility file load (if applicable).	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Receipt date as documented by vendor and confirmed by State. Frequency of measurement: Annually	$5,000 if below 100.00%.	
PG-26	Member Communication Approval	100.00% of Member communications will be approved by the State.	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Receipt date as documented by vendor and confirmed by	$10,000 per occurrence.	

			State. Frequency of measurement: Annually		
PG-27	Member Communication Accuracy	100.00% of all Member communications will be accurate and complete for the intended recipient.	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Receipt date as documented by vendor and confirmed by State. Frequency of measurement: Annually	$20,000 per occurrence.	
PG-28	Ad hoc Turn-around time	Ad hoc (non-standard) reports will be delivered within five (5) Business Days of request.	Date-stamp of receipt by the third-party vendor and verification of accuracy and completeness of required documentation.	$500 for each calendar day the data is not received or is incomplete.	
PG-29	Retail Network Access	At least 95.00% of participants will have at least one in network retail pharmacy within five (5) miles of their home zip code.	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Receipt date as documented by vendor and confirmed by State. Frequency of measurement: Quarterly	$25,000 if below 95.00% but at least 90.00%. $50,000 if less than 90.00%. Measured to two (2) decimal places.	

PG-30	Retail Network Turnover	Less than 2.50% of utilized network retail pharmacies list will change in/out of network status at any point during the year (measured at the NABP level).	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Receipt date as documented by vendor and confirmed by State. Frequency of measurement: Annually	$20,000 if greater than 2.50%. Measured to two (2) decimal places.	
PG-31	Account Management Satisfaction	The State will be satisfied with the account management services.	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). On a quarterly basis, Contractor will work with the State to develop a mutually agreed upon set of account management criteria for success for the subsequent quarter. Criteria may change based on any performance issues that arise during the Contract.	$25,000 per quarter where criteria are not met.	

PG-32	Benefit Change Requests	100% of benefit changes, add, and deletes will be setup accurately based on information contained in signed benefit forms.	Quarterly Plan Performance Measurement Report Card (Report Card to be submitted by the Bidder). Receipt date as documented by vendor and confirmed by State. Frequency of annually: Annual	$20,000 if failed.	

4.8 Required Documents

Attached are documents for Bidders to review and complete as instructed.

[Attachment R - FA1: Formulary Disruption]

[Attachment R - FA2: Formulary Disruption]

[Attachment R- FA1: Network Disruption]

[Attachment R -FA2: Network Disruption]

The following Claims Detail and Bidder Assumption attachments are provided in Phase II for reference only. These attachments will be provided again in Phase III and submitted with Bidder's Reverse Auction Bid.

[Attachment R – FA1: Claims Detail – Made available via SFTP

[Attachment R – FA2: Claims Detail – Made available via SFTP

[Attachment R- FA1: Bidder Assumptions]

[Attachment R -FA2: Bidder Assumptions]

Additionally, Bidder shall attach all required submission documents per MS-IFB section 5.6 and Section 7, Table 1.

The following Attachment T-1_Sample Required Document Formats contains requested formats for items 31 and 33 below.

[Attachment T-1_Sample Required Document Formats]

1. Bidder shall complete the attached FA1: Formulary Disruption workbook and upload. The State reserves the right to review the disruption workbook for reasonability to determine acceptability.

2. Bidder shall complete the attached FA2: Formulary Disruption workbook and upload. The State reserves the right to review the disruption workbook for reasonability to determine acceptability.

3. Bidder shall complete the attached FA1: Network Disruption workbook and upload. The State reserves the right to review the disruption workbook for reasonability to determine acceptability.

4. Bidder shall complete the attached FA2: Network Disruption workbook and upload. The State reserves the right to review the disruption workbook for reasonability to determine acceptability.

5. FA1 Certificates of Insurance including Errors and Omissions and Commercial General Liability.

6. Service Area Map: Provide a map of the proposed geographical service area.

7. Management Reporting Package: Attach a copy of your standard report suite, including a plan experience report, and performance metrics that would be provided to the State at the end of each quarter and the end of each fiscal year at no additional cost.

8. Audited Financial Statements: Provide a copy of your organization's last two year ending audited financial statements, or best equivalent report.

9. Financial Ratings: Please provide the results of your most recent two years the audits were completed.

10. Field Audit Findings Report: Please provide the results of your most recent two years the audits were completed.

11. Utilization Management Program List: Please provide your detailed utilization management program list, including specific drugs names in each program.

12. Drug Utilization Review Report: Provide a sample DUR report you produce and make available to clients.

13. Clinical Management Performance Report: Provide a sample of your client clinical management performance report.

14. Physician Score Card / Client Reporting: Provide a sample of a physician score card or other reporting that is provided to clients.

15. Member Communications Materials: Provide sample Member communication materials, including request letters for clinical programs, switching programs and sample EOBs.

16. Proposed Formulary: Provide a copy of your current proposed formulary (inclusive of NDC, Drug Name, Formulary Status, Tier Status)

17. Implementation Schedule: Please provide a detailed implementation schedule for active employees, non-Medicare retirees, and EGWP participants assuming an Open Enrollment of October, 2024, and a January 1, 2025 effective date. The Open Enrollment period would require, but is not limited to, telephone customer service support and support at open enrollment meetings.

18. Implementation Team Organizational Chart: Include an organizational chart identifying the names and expertise of each member.

19. Account Management Team Organizational Chart and Resumes: Provide an organizational chart identifying the names, functions and reporting relationships of key people directly responsible for account support services to the State Plan. It should also document how many account executives and group service representatives will work full-time on the State account and how many will work part-time on the State account. Provide resumes for key personnel.

20. Account Management Plan: Describe account management support, including the mechanisms and processes in place to allow the State personnel to communicate with account service representatives, hours of operation, types of inquiries that can be handled by account service representatives, and a brief explanation of information available online. The State requires identification of an account services manager to respond to inquiries and problems, and a description of how the Offeror's customer service and other support staff will respond to subscriber or client inquiries and problems. The management plan should include the names, resumes and description of functions and responsibilities for all supervisors and managers who will provide services to the State Plan with respect to this contract.

21. Diabetes Care program - Bidder must provide a description of their Diabetes Care program that closely aligns with the current program as referenced in MS-IFB, Section 2.3.8.

22. Completed Bid/Bid Affidavit

23. Certified MBE Utilization and Fair Solicitation Affidavit

24. Veteran–Owned Small Business Enterprise Utilization Affidavit

25. Completed Living Wage Affidavit of Agreement

26. Location of the Performance of Services Disclosure

27. Current copy of the Bidder’s Certificate of Authority issued by the Maryland Insurance Administration or evidence of acknowledgement of receipt of application for Certificate of Authority by the Go–Live Date (January 1, 2025).

28. FA 2- Promotional Materials and Management Reporting Package: Attach a copy of your standard report suite specific to FA 2, including a plan experience report, and performance metrics that would be provided to the State at the end of each quarter and the end of each fiscal year at no additional cost.

29. FA 2- Certificates of Insurance including Errors and Omissions and Commercial General Liability

30. Letter of Authorization for Services, Hardware, and Software proposed as furnished by a Third Party Entity

31. References

32. List of Current or Prior State Contracts

33. Subcontractors

34. Legal Action Summary

35. Proposed Work Plan

36. Problem Escalation Procedure (PEP)

5 Phase III: Reverse Auction

To be completed in Phase III. See Attachment B: Reverse Auction Instructions & Sample Export.