AMENDMENT NO. 1 TO CONTRACT NO. DMS-22/23-047
BETWEEN
DEPARTMENT OF MANAGEMENT SERVICES
AND
OPTUMRX, INC.

This Amendment No. 1 (Amendment) to Contract No. DMS-22/23-047 (Contract), effective as of the date last signed below, is entered into by and between the Department of Management Services (Department), and OptumRx, Inc. (Contractor), collectively referred to herein as the "Parties."

WHEREAS, the Department, pursuant to Invitation to Negotiate (ITN) No. DMS-22/23-047, entered into the Contract with the Contractor for Pharmacy Benefit Management services (Services), effective **September 28, 2023**;

WHEREAS, in accordance with section 204 of Title II of Division BB of the Consolidated Appropriations Act, 2021, insurance companies and employer-based health plans are required to submit information about prescription drug and health care spending (RxDC Report) to the Centers for Medicare and Medicaid Services (CMS). The RxDC Report is a recurring report due to CMS annually on June 1st for the prior calendar year's data;

WHEREAS, the Parties have agreed to amend the terms of the Contract to specify that the Contractor will prepare specified portions (Data Files D3-D8) of the RxDC Report and submit the complete report to CMS on behalf of the Department for the 2024 calendar year, and each year thereafter on a recurring basis, during the term of the Contract including any renewals or extensions thereto, in exchange for a flat rate payment by the Department to the Contractor [redacted] per year; and,

WHEREAS, the Parties wish to amend the Contract as described above and set forth herein below in accordance with section 3.4, Modifications and Changes, of the Contract.

NOW THEREFORE, in consideration of the mutual promises contained herein and other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the Parties agree as follows:

1. The terms and conditions of the Contract are incorporated by reference as if fully re-written herein. Except as expressly amended and supplemented by this Amendment, the terms and conditions of the Contract will remain in effect unchanged. If and to the extent that any inconsistency may appear between the Contract and this Amendment, the provisions of this Amendment shall control.

2. The definition of Contract, as set forth in Section 1, Definitions, of the Contract is hereby deleted in its entirety and replaced with the following:

   "Contract" means this agreement between the Department and Contractor consisting of, in order of precedence, the following documents:

   1. This agreement and its attachments, in the following order of precedence:

   a. Attachment 8: Privacy, Security, and Confidentiality Business Associate Agreement;
   b. Attachment 1: Administrative Requirements;
   c. Attachment 2: Performance Guarantees;

d. Attachment 3: Cost Reply / Price Sheet
e. Attachment 3a – Supplemental Cost Reply
f. Attachment 4: Department Selected Portions of Attachment B – Technical
g. Attachment 5: Department Selected Portions of Attachment C – Network
h. Attachment 6: List of Department approved Subcontractors
i. Attachment 7: Department selected portions of the Vendor's BAFO

In the event of conflict between this document and the Attachments, this document will control.

3. The following definitions shall be added to Section 1, Definitions, of the Contract as follows:

(s) "RxDC Report" means the annual data report required under Section 204 of Division BB, Title II (Section 204) of the Consolidated Appropriations Act of 2021 (CAA). Section 204 of the CAA, as implemented through federal rules promulgated by the Department of Health & Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS) at 5 C.F.R. part 890, 26 C.F.R. part 54, 29 C.F.R. part 2590, and 45 C.F.R. part 149, requires group health plans (plans) and health insurance issuers (issuers) offering group or individual health insurance coverage to submit information about prescription drugs and health care spending to CMS. CMS, in turn, aggregates and submits the RxDC Report information to the Department of Health and Human Services (HHS), the Department of Labor (DOL), and the Department of the Treasury. The RxDC Report is an annual report submitted for each calendar year on a recurring basis and is due to CMS by June 1st of each year.

(t) "RxDC Report Instructions" means the RxDC Report requirements and instructions published by CMS on its website on an annual basis and may be found at:https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/prescription-drug-data-collection-rxdc.

4. Section 6, of the Contract, is hereby deleted in its entirety and replaced with the following:

Section 6, Supplier Development

Office of Supplier Development. The State of Florida supports its business community by creating opportunities for business enterprises to participate in procurements and contracts. The Department encourages supplier development through certain certifications and provides advocacy, outreach, and networking through regional business events. For additional information, please contact the Office of Supplier Development (OSD) at OSDHelp@dms.fl.gov.

Reporting Certified Business Enterprises. Upon request, the Contractor will report to the Department its spend with business enterprises certified by the OSD. These reports must include the time period covered, the name and vendor identification information of each business enterprise utilized during the period, commodities and contractual services provided by the business enterprise, and the amount paid to the business enterprise on behalf of each agency purchasing under the Term Contract.

5. Attachment 1 - Administrative Requirements, is hereby deleted and replaced with ATTACHMENT 1 – REVISED ADMINISTRATIVE REQUIREMENTS, AMENDMENT 1.

6. Attachment 2 - Performance Guarantees, is hereby deleted and replaced with ATTACHMENT 2 – REVISED PERFORMACE GUARANTEES, AMENDMENT 1.

7. Attachment 3a – Supplemental Cost Reply, is hereby added.

8. This Amendment is effective on the last date of execution.

IN WITNESS WHEREOF, the Parties agree to the terms and conditions of this Amendment and have duly authorized their respective representatives to sign it on the dates indicated below.

FLORIDA DEPARTMENT OF MANAGEMENT SERVICES	**OPTUMRX, INC.**
DocuSigned by: 29FBC1724E334F8...	Signed by: Kathryn Carey 1BB0BBDC82EB477...
Signature	Signature
Pedro Allende Edric Sanchez	Kathryn Carey
Print Name	Print Name
Secretary Deputy Secretary	CFO
Title	Title
4/7/2025 | 12:06 PM EDT	4/2/2025 | 10:54 AM EDT
Date	Date

Invitation to Negotiate (ITN) for the State of Florida, Florida Department of Management Services (the Department)

Pharmacy Benefit Management Services

ATTACHMENT 1 - REVISED ADMINISTRATIVE REQUIREMENTS AMENDMENT 1

Respondent Name:

OptumRx, Inc.

Instructions: The following are Administrative Requirements (AR) that the Department expects the awarded Respondent to provide. Enter the answer to each question in the space provided.

I.	Implementation
1	Awarded Respondent shall submit the final Implementation Plan to the Department for approval not later than ten (10) business days following execution of the Contract. If the Implementation Plan is not determined by the Department to be sufficient, Awarded Respondent will diligently work to deliver a final Implementation Plan satisfactory to the Department and recognizes that time is of the essence in completing an Implementation Plan. The Implementation Plan shall contain a detailed description and manner in which all work is to be performed and detail all steps necessary to begin full performance of the Contract on January 1, 2024 at 12:00 A.M., Eastern Time, specify expected dates of completion of all such steps, and identify the persons responsible for each step. The Implementation Plan shall include, but is not limited to, the following Implementation Milestones:
	a. The Awarded Respondent shall establish an interactive website exclusive for State of Florida Participants
	b. The Awarded Respondent shall establish exclusive toll-free phone line(s);
	c. The Awarded Respondent shall develop and obtain Department approval for all communications in advance of the fall 2023 Open Enrollment period;
	d. The Awarded Respondent shall participate in the fall 2023 Open Enrollment benefit fairs coordinated by the Department;
	e. The Awarded Respondent shall participate in regular Implementation status meetings with the Department's Contract Manager. The Awarded Respondent shall be responsible for recording detailed meeting minutes and follow up action items on behalf of all team members during implementation meetings;
	f. The Awarded Respondent shall conduct background checks in accordance with section 4.2.4 of the Contract
	g. The Awarded Respondent shall apply the Plan provisions of the Benefits Document and/or certificates of coverage for all covered drugs and supplies, exclusions, limitations, etc.; establishing and successfully implementing any necessary edits, controls or other functions to ensure accurate Plan coverage;
	h. The Awarded Respondent shall test eligibility files, reviewing key procedures and program process controls (i.e. approval, design, testing, acceptance, user involvement, segregation of duties, and documentation). Functional acceptance approval by the Department is required;
	i. The Awarded Respondent shall conduct a pre-implementation audit of approximately two hundred (200) to three hundred (300) manually created claims;
	j. The Awarded Respondent shall finalize and validate billing procedures, invoice design, manufacturer revenue payments and reports, and all other financial processes that must be approved by the Department;
	k. The Awarded Respondent shall design and present to the Department for approval all communication materials to be used for Plan Participants. Communication materials include but are not limited to ID Cards, brochures, explanation of benefit statement forms, paper claim (reimbursement) forms, standard letters, system generated letters, templates, envelopes, clinical program notices and letters, and posters;
	l. The Awarded Respondent shall provide complete details of the Awarded Respondent's plan to educate and enforce Plan benefits, utilization management, and other Plan specifics to network pharmacies;
	m. The Awarded Respondent shall participate in all activities related to a readiness assessment prior to the Effective Date.

	i. The development and execution of the Implementation Plan is subject to PG 1 and the liquidated damages of Section 7 of the Contract for failure to meet the milestones identified therein.
	ii. The Awarded Respondent shall establish an Implementation Team, which shall be detailed as part of the final Implementation Plan, including names, roles and responsibilities of team members. The Account Manager shall participate full-time on the Implementation Team.
	iii. The Awarded Respondent agrees that the Department may, upon request, require the immediate addition or removal of staff from the Implementation Team.
	iv. The Awarded Respondent shall be one hundred percent (100%) operational prior to the Implementation Date of January 1, 2024 at 12:00 A.M., Eastern Time. Awarded Respondent is subject to the liquidated damages of Section 7 of the Draft Contract for failure to meet this milestone.
	v. The Awarded Respondent shall mail ID Cards (without Social Security Numbers) to all Participants the earlier of December 20, 2023 or ten (10) Business Days after the receipt of a clean and accurate Open Enrollment eligibility file subject to PG 2c.
	vi. The Awarded Respondent shall facilitate the transition of open mail order and specialty prescriptions/refills from the previous PBM vendor, as applicable, using electronic transfer of refills, with the exception of controlled substances, compounds and expired prescriptions.
	vii. The Awarded Respondent shall facilitate the transition of open prior authorizations from the previous PBM vendor, as applicable, using appropriate electronic transfer of information.
	viii. The Awarded Respondent shall facilitate the transition of the required paid claims history from the previous PBM vendor, as applicable, using appropriate electronic data transfer.
II.	**Account Management**
	Account Manager
	a.) The Awarded Respondent shall assign a dedicated Account Manager as a primary contact(s) for the Department.
	b.) The Account Manager shall participate full-time on the Implementation Team.
2	c.) If requested by the Department, the Account Manager shall be replaced with one that the Department is allowed to interview and approve.
	d.) The Awarded Respondent shall inform the Department Contract Manager in advance of any planned periods of unavailability of the Account Manager.
	e.) The Account Manager shall have the responsibility and authority for the vendor to manage the entire range of services discussed in the resultant Contract and must be able to respond immediately to changes in plan design, changes in claims processing procedures, or general administrative problems identified by the Department or the Department' third party consultant.
	Account Director/Executive
	a.) The Awarded Respondent shall assign a dedicated Account Director/Executive as a primary contact(s) for the Department.
	b.) If requested by the Department, the Account Director/Executive shall be replaced with one that the Department is allowed to interview and approve.
3	c.) The Awarded Respondent shall inform the Department Contract Manager in advance of any planned periods of unavailability of the Account Director/Executive.
	d.) The Account Director/Executive shall have the responsibility and authority for the vendor to manage the entire range of services discussed in the Contract and must be able to respond immediately to changes in plan design, changes in claims processing procedures, or general administrative problems identified by the Department or the Department' third party consultant.
	Account Management Team
	a. Awarded Respondent shall assign a dedicated, but not necessarily Account Management Team, which shall include an executive sponsor, an account director/executive, an Account Manager, a customer service manager, a data/fiscal analyst, and a registered pharmacist or PharmD.
4	b. The Awarded Respondent shall provide the Department reasonable advance notice of any changes to Awarded Respondent's Account Management Team; post change notice shall be provided within fifteen (15) Calendar Days of such change.
	c. The Awarded Respondent agrees that the Department may, upon request, require the immediate addition or removal of staff from the Account Management Team.
	d. The Awarded Respondent shall inform the Department in advance of any planned periods of unavailability by the Account Management Team.
	e. The Account Management Team shall devote the time and resources necessary to successfully manage the State of Florida account, including being available for frequent telephonic, email, and on-site consultations.
	Quarterly Meetings

	a. The Account Management Team (excluding the executive sponsor) shall attend all quarterly meetings at the Department's offices in Tallahassee, Florida, or via conference call, as determined by the Department. The Awarded Respondent shall not be entitled to additional compensation for meeting preparation or attendance. The meetings shall be scheduled no later than fifty (50) Calendar Days following the end of each reporting quarter. The meeting to review the fourth quarter of a calendar year is considered both a quarterly and year-end meeting.
5	b. The Awarded Respondent shall provide, for Department approval, a draft agenda five (5) Business Days in advance of a meeting, allowing changes to the agenda and a reasonable opportunity to prepare for the meeting. At a minimum, during the meeting the Awarded Respondent and Department will discuss goals, expectations and priorities; review the Awarded Respondent's quarterly reports and other issues such as performance guarantees, quality assurance, operations, benefit and program changes or enhancements, legislative issues, audits, trends, utilization, program outcomes, customer service issues, future goals and planning; and consider any other issues reasonably related to the Contract and the prescription drug industry in general. The Awarded Respondent shall address past performance and anticipated future performance and compare the Plan's experience to national trends and the Awarded Respondent's total book of business, and other similar governmental clients.
	c. Within five (5) Business Days after any meeting, the Awarded Respondent shall provide the Department detailed and well-documented draft meeting minutes. the Department will review and revise the draft minutes as appropriate and return to the Awarded Respondent. The Awarded Respondent shall provide the Department with final minutes within five (5) Business Days after receipt of the revised minutes. Minutes shall include a clear and detailed account of the meeting, a list and description of all deliverables, identify the responsible party(ies) and provide projected delivery dates.
	d. Progress meetings, issue meetings, and emergency meetings shall be held as needed. Either Party may call such a meeting, subject to reasonable notice.
	e. Any meeting held in person shall be at the Department's offices in Tallahassee, Florida. The Awarded Respondent shall not be entitled to additional compensation for meeting preparation or attendance.
III.	**Support Services**
	Benefit Fairs
6	a. Awarded Respondent shall participate in all locations of the annual Open Enrollment Benefit Fairs that are sponsored by the Department or its designee. (Number and locations may vary each year, and Open Enrollment Benefit Fairs may be virtual.) Awarded Respondent representatives attending the Benefit Fairs shall be employees of Awarded Respondent (not subcontractors or temporary personnel) and adequately trained and knowledgeable about the Plan. Open Enrollment is held annually in the Fall for enrollment coverage effective the following January 1. Participation in the Open Enrollment Benefit Fairs is subject to PG 5.
	b. The Awarded Respondent shall be responsible for all costs associated with participating in Benefit Fairs including travel, a proportionate share of facility fees.
	c. The Awarded Respondent shall share in any expenses for the printing and distribution of the Benefits Document or other Benefit Fair documentation distributed by the Department, the cost for which shall be shared equally among all benefit plan providers including prescription drug and medical plans offered by the Department.
7	**Plan Materials**
	a. No promotional, educational, or any other materials or written communication related to the Plan may be distributed or otherwise communicated without the prior review and written approval of the Department. The Department shall be provided the opportunity to customize, including editing, revising, and co-branding, all such communications. The final materials used by the Awarded Respondent must not differ in form or utility from those approved by the Department. This requirement will not apply in situations of a drug recall and other instances in which the immediate health and safety of a patient may be in question. Recall notices must be provided to the Department before or no later than the time they are disseminated to Participants and are subject to post-review by the Department.
	b. Subject to the Department's customization and prior written approval, Awarded Respondent shall be responsible, at no additional cost, for the development (including, but not limited to, the writing, printing, distributing and mailing thereof) of all Plan-related printed materials, including, but not limited to:
	i. Mail order forms;
	ii. Participant educational materials;
	iii. Member ID cards and replacement ID cards;
	iv. Benefit brochures (including, but not limited to, open enrollment materials);
	v. Claim forms;
	vi. Retail pharmacy directory/list (upon request);

	vii. Two (2) benefit statements (one (1) year-to-date in conjunction with Open Enrollment, to be received no later than the first day of Open Enrollment and one (1) distributed no later than February 15th of each year reflecting the full prior calendar year) for all members. Benefit statements must show complete claim details, including plan and member cost share, date of service, drug name, delivery method, deductible, out-of-pocket maximum, etc. Each adult Participant (age eighteen (18) years and older) shall receive their own Benefit Statements and claims for minor Dependents (less than eighteen (18) years) shall be included on the Benefit Statements for the Subscriber. Awarded Respondent shall have a mechanism in place so that Members may opt out of receiving a hard copy of the benefit statement and instead receive the benefit statement electronically or print from the Awarded Respondent's website;
	viii. Explanation of Benefits (EOBs);
	ix. Letters and correspondence related to all aspects of appeals and external reviews; and
	x. Any other materials such as notices, preformatted letters, clinical program notices, templates, system generated letters and notifications, other correspondence including those delivered electronically, global email blasts, and similar material.
	c. The Awarded Respondent shall assist the Department (i.e., review, clarify, edit as necessary and confirm accuracy) as requested in the development of Department communications regarding the Plan, including, but not limited to, the annual Benefits Guide and the Department's benefit website (www.mybenefits.myflorida.com).
	d. When the Awarded Respondent mails membership materials, the Awarded Respondent may include a customized greeting and form letter to new Participants. The greeting and letter are subject to Department customization and approval.
	e. Upon request of the Participant, the Awarded Respondent shall provide printed materials in a medium widely accepted for the visually impaired.
	f. Upon request of the Participant, the Awarded Respondent shall provide Plan materials in a culturally and linguistically appropriate manner, as defined by section 2719 of the Public Health Service Act (PHSA).
	g. Awarded Respondent shall provide a list each October 1st to the Department of any Participants residing in a county outside the state of Florida and impacted by Section 2719 of the PHSA along with the language requirement for each Participant.
	h. All printed materials provided by the Awarded Respondent shall be provided in electronic format with final versions submitted to the Department in PDF file format.
8	**ID Cards**
	The Awarded Respondent shall provide Subscribers with ID cards either as a new Subscriber, when there are changes in the card's elements, or when reported as lost at no additional cost to the Subscribers or the Department. The design of the ID card is subject to the approval and customization of the Department.
	a. The Awarded Respondent shall mail one (1) ID card for each individual contract and at least one (1) additional ID card for each family contract.
	b. The Awarded Respondent will provide additional ID cards as requested by the Subscriber.
	c. A unique Subscriber-identifying number that is not a Social Security Number (SSN) shall be displayed on the ID Cards. Although never displayed, the SSN shall be the number-of-record maintained in the Awarded Respondent's information system. ID cards shall be compliant with State of Florida and NCPDP standards.
	d. ID cards, including those mailed in the fall of 2023 for the 2024 coverage year, annual Open Enrollment periods, and otherwise as required due to Plan or law changes, shall be mailed in accordance to the provisions of PG 2.
9	**Special Post Office Boxes**
	The Awarded Respondent shall maintain dedicated and exclusive United States Post Office boxes which shall be used as a single point of contact for the Plan and Plan Participants for mailed materials from all Plan Participants, including, but not limited to, letters and correspondence, inquiries, appeals, paper prescriptions and paper claim forms.
10	**Responding to Requests, Department Inquiries, and Dispute Support**
	The Awarded Respondent shall, upon request of the Department or its attorneys and at no additional cost, make available all necessary resources (including, but not limited to, the Account Management Team, analytics and outcomes, research and development, actuarial support, and government relations departments/units) to assist the Department in responding to any aspect of services delivered under the Contract, including but not limited to, Departmental inquiries or those received by the Department from Participants, pharmacy providers, or any other persons or entities.
	Such requests shall:
	1) be given a priority status,
	2) be subject to a method of tracking,
	3) result in the delivery of all requested information, documentation, etc., and

	4) be overseen by a lead staff person specific to the subject matter area. When the Department is required to provide immediate responses to inquiries, the Awarded Respondent shall immediately assist the Department in preparing its reply which includes providing data and documentation within the timeframes prescribed by the Department at that time.
	Responding to Requests for Legislative Initiatives
11	The Awarded Respondent shall make available all necessary resources (including, but not limited to, the Account Management Team, analytics and outcomes, research and development, actuarial support, and government relations departments) to assist the Department in responding to bill analysis, legislative inquiries and requests related to any aspect of services delivered under the Contract. The Awarded Respondent shall respond within the timeframe set by the Department, which shall be determined at the time of the inquiry depending upon the scope and complexity of the request. All costing estimates and/or fiscal impact determinations shall be made on a PEPM (PEPM to include all Subscribers) basis unless otherwise requested by the Department. Support for such legislative initiatives shall be at no additional cost to the Department.
12	**Public Records Requests and Subpoenas**
	a. Awarded Respondent shall, upon request and at no additional cost, provide the Department with any necessary data, documents, etc. to enable the Department to timely (as defined by the Department) respond to Public Record Requests and subpoenas related to any aspect of services delivered under the Contract, as required by law.
	b. Awarded Respondent may receive record requests, subpoenas or other inquiries relating to the Plan. The Awarded Respondent shall notify the Department immediately in writing of such inquiries, and shall refer the requester to the Department to make the request directly, as provided in section 119.0701(3)(a), Florida Statutes. Any response or material responding to such an inquiry shall be submitted to the Department for approval prior to the Department disseminating it.
13	**Underwriting and Actuarial Services**
	Awarded Respondent shall provide the Department with underwriting and/or actuarial services as needed at no additional cost to the Department.
14	**Returned Mail**
	Mail returned to the Awarded Respondent shall be held for thirty (30) days during which time the Awarded Respondent shall search for an updated address with each subsequent enrollment file received from People First. After thirty (30) days, the Awarded Respondent shall store copies on its document imaging system in such a manner as can be easily retrieved based on the Participant's name and destroy the returned mail. Any returned mail containing personal health information shall be shredded.
15	Online Reporting and Management Tools: Computer Access to Plan Data
	At no additional cost to the Department, Awarded Respondent shall provide for online access, for unlimited users from the Department, to its reporting and management services, systems, programs, customer service call notes and logs, and any Participant-specific correspondence.
	a. The Awarded Respondent shall provide corresponding manuals and any other printed or digital material used in connection with the systems (related documents). This online tool shall have data accumulation, claims specific, and ad-hoc reporting capabilities.
	b. Online access shall include access to the same information visible to the Awarded Respondent's customer service representatives including, but not limited to, complete unique Participant claim (retail, mail order, specialty, Medicare secondary drugs, paper claims, and supplies) details and call notes for any nonclinical staff assisting Participants.
	c. Awarded Respondent shall, as necessary and upon request of the Department, provide designated Department staff with training at the Department's facilities for the online reporting and management tools. Additional training beyond the initial training following Contract implementation may be requested from time to time as system updates occur, new Department staff is hired and in need of training, or other factors with all expenses to be paid by the Awarded Respondent.
	d. All call notes and logs shall be provided in plain language with sufficient detail that the exact purpose of the call, the dialog exchange between the Participant and the Awarded Respondent, and the detailed resolution are documented and easily ascertained;
	e. the Department shall have access to add, delete and update eligibility in real time and review claim history;
	f. the Department shall have the ability to print and order ID Cards; and,
	g. vaccinations
	Plan Website and Mobile App

	The Awarded Respondent shall provide and maintain a Plan specific website, with access twenty-four (24) hours a day, seven (7) days a week, for prescription drug and general health information, subject to the Department's customization and approval. The website shall be accessible to non-members of the Plan as well as Participants. Without logging in to the website as a Participant, the website shall provide at a minimum: Plan benefit information, the current preferred drug list, current maintenance drug list, current specialty drug list, and, if applicable, current list of drugs requiring prior authorization to be covered by the Plan. The website shall also include links to the Department website, health plan websites, and other state, federal, disease state and/or condition specific websites, and general health websites as appropriate to make available a multitude of information to Participants. For Participants, such web-based access shall include the ability to, at a minimum:
	a. track Plan accumulators (medical and pharmacy) including separate tracking for both individual and family coverage (annual coinsurance maximum, annual deductible, and annual in-network out-of-pocket maximum);
16	b. track other required or mandated medical and prescription drug accumulator information;
	c. access online refills, check order status and track mail and specialty drug order shipments, in real time;
	d. view and print prescription (retail, mail order, specialty, Medicare secondary) history (three (3) years minimum);
	e. find prescription drug price/costs (retail, mail order, specialty, Medicare secondary);
	f. find lower cost prescription alternatives (retail, mail order, specialty, Medicare secondary);
	g. locate participating retail pharmacies, including location, phone number, and an indicator for twenty-four (24) hour pharmacy and drive-through services;
	h. order replacement ID cards;
	i. download and print temporary ID cards;
	j. communicate with a pharmacist or a customer service representative;
	k. view the current preferred drug list;
	l. view the current maintenance drug list;
	m. view the current specialty drug list;
	n. view the current list of drugs requiring prior authorization to be covered by the Plan;
	o. view Plan benefit information;
	p. view and/or download and print forms and brochures;
	q. download and print mail order form(s) in PDF format;
	r. download and print paper claim form(s) in PDF format;
	s. access preventive educational information;
	t. access Shared Savings Program/transparency information;
	u. access general health, prescription compliance, and chronic disease information;
	v. add credit card information for member cost share for mail order and specialty pharmacy prescriptions
	Fraud, Waste, Abuse, Misuse, and Suspicious Activity Investigative Services
17	The Awarded Respondent shall develop and/or maintain protocols, procedures, and/or system edits to aggressively monitor fraud, abuse, waste, and suspicious activities, and shall provide the Department with a monthly report of all activities and discoveries relating to this Contract subject to the timeliness and accuracy provisions of PGs 22-23. The protocols, procedures and/or system edits shall be provided to the Department upon request and are subject to the Department's customization and approval. The Awarded Respondent shall investigate any fraudulent, suspected fraud, or suspicious activity, which it believes to be fraudulent or abusive whenever detected by the Awarded Respondent or brought to the attention of the Awarded Respondent by the Department or other persons relating to the Plan. The Awarded Respondent shall notify the Department within thirty (30) days of detection of any fraudulent or abusive Claims or other activities relating to the Plan which it uncovers and shall fully cooperate with and assist the Department, law enforcement, and State in their investigations or inquiries regarding any such matters and in any related recovery efforts. Along with any findings, the Awarded Respondent shall submit a corrective action plan to the Department to mitigate the reoccurrence of the finding. the Department shall be notified immediately if law enforcement is involved in any action or potential action taken against or related to a Plan Participant.
IV.	**Customer Service**
	The Awarded Respondent shall maintain a dedicated and exclusive Customer Service Unit comprised of dedicated and exclusive employees of the Awarded Respondent (not contracted or temporary labor) that shall perform all aspects of customer service for Participants and prospective Participants regarding any and all aspects of the Plan, including, but not limited to, retail, mail, specialty pharmacy, and Medicare secondary drugs and supplies. The Awarded Respondent shall staff this dedicated and exclusive Customer Service Unit with sufficient numbers of personnel to meet or exceed related performance guarantees. the Department expects that in the event of overflow calls, a secondary call center(s) (not dedicated and exclusive) may assist Participants. The dedicated and exclusive Customer Service Unit shall include a state-of-the-art call center.

18	a. The Customer Service Unit shall have the capability to adequately provide service and issue resolution, as well as sufficient numbers of qualified personnel trained in the administration of the Plan to meet or exceed related Performance Guarantees. In the case of infrequent and unexpected overflow calls, Participants shall have access to secondary call centers and customer service units.
	b. The Customer Service Unit shall have adequately trained customer service representatives to handle calls from Participants and shall be knowledgeable of the State Plan, including but not limited to, network pharmacies, formulary, medical plans, and plan designs. Any customer service deficiencies noted by the Department shall be immediately rectified by the Awarded Respondent to the Department's satisfaction.
	c. The Customer Service Unit shall include multi-lingual staff or service to assist Participants in Spanish and any other language pursuant to the most recent Culturally and Linguistically Appropriate Services county data as defined by Section 2719 of the Public Health Service Act (PHSA). For languages other than English and Spanish, the multi-linguistic customer service function supporting the Department may be provided by personnel outside of the dedicated and exclusive Customer Service Unit (including by an approved Subcontractor).
	d. The Customer Service Unit shall have staff with skills, services, and equipment to assist hearing and vision impaired Participants.
	e. The Customer Service Unit shall have the ability to assist Participants who contact the unit with only their name and/or SSN.
	f. The Customer Service Unit shall have a process or procedure for handling emergency Participant requests (i.e., vacation requests, early fills, etc.) in accordance with the Plan.
	g. The Customer Service Unit shall maintain an exclusive toll-free telephone number, for use by Participants and prospective participants, accessible from anywhere in the United States.
	h. The Awarded Respondent shall maintain an adequate number of incoming telephone lines dedicated to servicing Participants and pharmacy/provider inquiries.
	i. The toll-free telephone line shall be supported by live dedicated and exclusive customer service representatives twenty-four (24) hours a day, seven (7) days a week.
	j. Any automated voice-response telephone system shall provide an option for the caller to opt-out to a live representative at any time during the call.
	k. One hundred percent of all calls to Awarded Respondent's Customer Service Unit or the Customer Service Centers staffed by the specialty drug provider shall be recorded throughout the term of the Contract and the Awarded Respondent shall have the ability to retrieve and deliver an audio recording to the Department of any calls requested within three (3) Business Days.
	l. All complaint types received by the Customer Service Unit related to the Plan shall be documented and reported to the Department on a monthly basis which shall include Awarded Respondent's corrective action plan to address recurring complaint types.
	m. The Awarded Respondent shall make available to Department staff the ability to listen to and monitor calls to and from the dedicated and exclusive Customer Service Unit.
	n. The Customer Service Unit shall document Participant calls (all issues, concerns of the Participant, all responses, and feedback of the Awarded Respondent) in complete detail such that Department staff with online access to Plan data can fully understand the contents of the call.
19	**Service Disruption Plan** The Awarded Respondent shall maintain a service disruption plan or procedure to continue customer servicing activities (i.e. continue to fill all prescription requests and handle Participant inquiries) using alternative sites or locations as reasonably necessary and appropriate when existing service is temporarily unavailable due to either scheduled or unforeseen events (e.g., relocating offices, repairing/restoring utility or power supply, upgrading telephone systems, and other events.) The Awarded Respondent shall notify the Department within five (5) Business Days in advance for scheduled disruptions and as soon as possible for other events. In accordance with section 626.8825(2)(h), F.S., if the State revises its formulary of covered prescription drugs during a plan year, the Awarded Respondent shall process claims to continue to provide a 60-day continuity-of-care period in which the covered prescription drug that is being revised from the formulary continues to be provided at the same cost for the Participant for a period of 60 days. The 60-day continuity-of-care period commences upon notification to the Participant. This requirement does not apply if the covered prescription drug: 1) has been approved and made available over the counter by the USFDA and has entered the commercial market as such; 2) has been removed or withdrawn from the commercial market by the manufacturer; or 3) is subject to an involuntary recall by state or federal authorities and is no longer available on the commercial market. Beginning January 1, 2024, and annually thereafter, the Awarded Respondent shall submit to the Department a statement attesting to its compliance with the requirements of this subsection.
	a. The Awarded Respondent shall respond to and resolve all Participant inquiries within the timeframe specified in PG11.
V.	**Retail Network Requirements**

20	The Awarded Respondent shall provide a statewide and a nationwide retail pharmacy network in accordance with the provisions of the Draft Contract (Attachment A) and subject to the standards described in PGs 28a-c and 29a-b. In accordance with section 626.8825(2)(e)4., F.S., for the in-person administration of covered prescription drugs, the Awarded Respondent shall not require a Participant to receive pharmacist services from an affiliated pharmacy or an affiliated health care provider. Further, in accordance with section 626.8825(2)(e)5., F.S., the Awarded Respondent shall not offer or implement pharmacy networks that require or provide a promotional item or an incentive, defined as anything other than a reduced cost-sharing amount or enhanced quantity limit allowed under the benefit design for a covered drug, to a Participant to use an affiliated pharmacy or an affiliated health care provider for the in-person administration of covered prescription drugs; nor shall the Awarded Respondent advertise, market, or promote an affiliated pharmacy to Participants. Subject to the foregoing, the Awarded Respondent may include an affiliated pharmacy in communications to Participants regarding network pharmacies and prices, provided that the Awarded Respondent includes information, such as links to all nonaffiliated network pharmacies, in such communications and that the information provided is accurate and of equal prominence. This is not be construed to prohibit the Awarded Respondent from entering into an agreement with an affiliated pharmacy to provide pharmacist services to Participants.
21	**Retail Pharmacy Reimbursement**
	a. The Awarded Respondent shall reimburse network retail pharmacies based on an amount determined as the lowest of: (a) the contracted discount price with the retail pharmacy plus dispensing fee; (b) MAC plus dispensing fee; or (c) the usual and customary (U&C) (cash) price or sale price, if any. U&C claims shall not be subject to a dispensing fee. The payment to the pharmacy shall be equal to the amount determined above less (a) retail copayment or coinsurance, less (b) retail convenience fee, if applicable, and/or less (c) the deductible, if applicable. All information and claims data pertaining to U&C claims shall accurately reflect the specific data elements and amounts applicable to the calculation of the U&C pricing.
	b. The Awarded Respondent shall adjudicate all retail claims according to the "lowest of" logic such that Participants always pay the lowest of the applicable copayment or coinsurance, the contracted price, or the retail pharmacy's U&C amount (including the pharmacy's sale price, if any). The Awarded Respondent shall not be allowed to adjudicate based on "zero balance logic" or on a minimum copayment or coinsurance amount and retail pharmacies shall not be allowed to collect a minimum payment.
22	**Coordination of Benefits at Retail**
	a. The Plan shall be the secondary payer for all drugs and supplies covered by Medicare Part B for any Participants in a retiree subscriber class (coverage code) and enrolled in Medicare Part B. The Awarded Respondent shall provide complete details and documentation of such process and the parties shall finalize the process during the Implementation Period.
	b. As a secondary payer, the Awarded Respondent shall reimburse as specified in the Coordination of Benefits section of the appropriate Benefits Document or Certificate of Coverage.
	c. As a secondary payer, the Awarded Respondent shall coordinate with Medicare and benefits shall be paid up to the lesser of 1) the covered expenses Medicare does not pay, up to the Medicare allowance; or 2) the amount this Plan would have paid if the Participant had no other coverage.
23	Awarded Respondent shall assist the Department in retrieving prescription details/information from the Awarded Respondent's network retail pharmacies upon request and at no additional charge.
24	The Awarded Respondent shall provide written notice to the Department of anticipated material changes to the retail pharmacy network which may impact Plan Participants. Such written notice shall be provided at least ninety (90) Calendar Days in advance or as soon as possible if the terminating pharmacy or pharmacy chain gives the Awarded Respondent less than ninety (90) Calendar Days' notice.
25	The Awarded Respondent shall provide impacted Participants ninety (90) days written notice or as soon as possible if the terminating pharmacy (or pharmacy chain) gives the Awarded Respondent less than ninety (90) days' notice. For the purposes of this requirement, Participant shall mean a Participant who has had a prescription filled within the last one hundred and eighty (180) Calendar Days or a Participant that has an active refill on file with the terminating pharmacy or pharmacy chain.
26	The Awarded Respondent shall, upon request of the Department, add additional pharmacies to the retail network on a general, regional, or other specific basis. Awarded Respondent shall not charge the Department an administrative fee to recruit and contract with targeted retail providers. Additionally, the Awarded Respondent shall remove pharmacies from the retail network upon the request of the Department.
27	The Awarded Respondent shall accept nominations from Participants of pharmacies to be included in the retail network.
28	The Awarded Respondent shall not contact, solicit from, or issue point of service messaging to the Department's Participants regarding Awarded Respondent's contract or rate negotiations with a retail pharmacy. In situations where a retail contract has been terminated, and/or a patient safety issue is noted, then the Awarded Respondent will work directly with the Department to determine the communication strategy and outreach to the affected Participants.

29	The Awarded Respondent shall provide a toll-free number for pharmacy/physician inquiries that is answered twenty-four (24) a day, seven (7) days a week, by a live representative of the Awarded Respondent. It shall be acceptable for pharmacy/physician inquiries to be routed through an interactive voice response (IVR) system.
30	a. All of the Awarded Respondent's contracts with participating pharmacies shall include requirements for compliance with all applicable local, state and federal laws and regulations. In the event a pharmacy is out of compliance with these contractual requirements (i.e. dispensing counterfeit drugs), the pharmacy will be subject to removal from the Awarded Respondent's retail networks.
	b. The Awarded Respondent shall utilize the List of Excluded Individuals/Entities (LEIE) from federal and/or state governments to ensure that prescription claims written by listed excluded prescribers will not be paid under this plan.
31	The Awarded Respondent shall, at no additional cost to the Department, defend the Department, the State and/or Participants against any litigation brought by participating network providers (pharmacies / pharmacists) seeking payment for Covered Services provided by such providers in excess of the applicable payment negotiated by the Awarded Respondent. The Awarded Respondent agrees to pay all resulting damages awarded or settlement amounts in any such litigation, provided that the Department, the State and/or the affected Participants provided timely written notification to the Awarded Respondent of such litigation and provided that the Awarded Respondent had sole control of the defense of such litigation and any related settlement negotiations.
VI.	**Mail Order and Specialty Pharmacy**
32	The Awarded Respondent's mail order and specialty pharmacy or pharmacies shall be licensed, permitted, or registered as required by law.
33	The Awarded Respondent shall have the ability to override mail order prescriptions and provide coverage for a drug from a participating retail pharmacy, if approved by the Department (e.g., due to out-of-stock and/or backordered drugs). Pursuant to section 626.8825(2)(e)3., F.S., the Awarded Respondent shall not require a Participant to receive a prescription drug by United States mail, common carrier, local courier, third-party company or delivery service, or pharmacy direct delivery unless the prescription drug cannot be acquired at any retail pharmacy in the Awarded Respondent's network for the Plan. This does not prohibit the Awarded Respondent from operating mail order or delivery programs on an opt-in basis at the sole discretion of a Participant, provided that the Participant is not penalized through the imposition of any additional retail cost-sharing obligations or a lower allowed-quantity limit for choosing not to select the mail order or delivery programs.
34	The Awarded Respondent shall, at any time during the Contract, assist Participants with the transfer of a prescription to the Awarded Respondent's mail order or specialty pharmacy.
35	The Awarded Respondent shall have the ability to arrange with another drug provider if you are unable to fill and deliver a Participant's prescription(s) to avoid any disruption of therapy; such arrangement shall not delay the prescription for more than three (3) Business Days.
36	**Mail Order Pharmacy Reimbursement**
	a. The Awarded Respondent shall adjudicate network mail order and specialty pharmacy claims at the lesser of: (a) the contracted discount plus dispensing fee or (b) MAC plus dispensing fee.
	b. The Awarded Respondent shall ensure that the mail order and specialty pharmacy adjudicate all mail order claims according to the "lower of" logic such that the Participants always pay [redacted] The Awarded Respondent shall not be allowed to adjudicate based on a minimum mail order or specialty pharmacy copayment.
	c. Awarded Respondent agrees that in the event a Participant pays [redacted] of the cost of a prescription, the Department will not be billed for any portion of the claim. The mail order and specialty pharmacy will not be allowed to collect a minimum fee or charge from a Participant or the Department.
	d. The Plan will not be responsible for any Participant contributions (e.g., deductible, coinsurance, copayments) owed to the Awarded Respondent. Collecting such fees will be the sole responsibility of the Awarded Respondent.
	e. The Awarded Respondent shall offer consistent pricing (i.e. discounts, dispensing fees, and Rebates/ Manufacturer Payments) for all standard mail order prescriptions regardless of the days' supply (i.e., Awarded Respondent will not apply retail pricing to any mail order claims).
	f. The Awarded Respondent shall not charge the Department a higher AWP price for any repackaged products assigned a new NDC number by a re-packager, a manufacturer, or at mail order, than the original manufacturer/labeler AWP price for the same product (drug name, form, and strength).
	Coordination of Benefits at Mail Order and Specialty
	a. The Plan shall be the secondary payer for all drugs and supplies covered by Medicare Part B for any participants in a retiree subscriber class (coverage code) and enrolled in Medicare Part B. The Awarded Respondent shall provide complete details and documentation of such process and the parties shall finalize the process during the Implementation Period.

37	b. As a secondary payer, the Awarded Respondent shall reimburse as specified in the Coordination of Benefits section of the appropriate Benefits Document or Certificate of Coverage.
	c. As a secondary payer, the Awarded Respondent shall coordinate with Medicare and benefits shall be paid up to the lesser of 1) the covered expenses Medicare does not pay, up to the Medicare allowance; or 2) the amount this Plan would have paid if the Participant had no other coverage.
38	**Automatic Refills**
	a. The Awarded Respondent shall have the ability for Participants to elect automatic refill and automatic renewal for mail-order prescriptions.
	b. The Awarded Respondent shall not automatically refill or renew any prescription without the Participant so electing (e.g., opting in).
	c. Participants shall be required to have a valid credit card on file with the Awarded Respondent in order to elect automatic refill service.
39	The Awarded Respondent shall not require the State to pay outstanding balances owed by the Subscriber/ Participant.
40	The Awarded Respondent shall dispense and ship mail order and specialty prescriptions in accordance with PG 20a.
41	The Awarded Respondent shall provide a current and complete Specialty Drug Price list effective as of January 1, 2024, no later than December 1, 2023; and each December 1st for the following year throughout the term of the Contract. Only newly FDA-approved and launched drugs, and drugs not on the market as of December 1, 2024, may be considered for addition to the Specialty Drug Price List after this date. The Awarded Respondent's list will identify limited distribution drugs. The Awarded Respondent shall not add any drugs to the Department's Specialty Drug Price List that were previously available to Participants through non-specialty mail order unless there is a change to the specialty distribution or labeling due to regulatory or manufacturer requirements.
42	The Awarded Respondent may modify the Specialty Drug Price List and corresponding pricing terms, if the resulting pricing terms are improved, on sixty (60) days advance written notice to the Department along with an explanation of the rationale for such modifications. The Awarded Respondent shall permit the State to override any additions that do not meet required criteria. All updates shall be reported quarterly.
43	Pricing for Specialty Drugs added to the Specialty Drug Price List on or after January 1, 2024 shall be competitive in the marketplace and considered on an individual drug and/or therapeutic category basis and shall not automatically default to a minimum discount.
44	Awarded Respondent discounts for Brand Specialty Drugs dispensed through the specialty pharmacy channel shall always be [redacted] Awarded Respondent discounts for Generic Specialty Drugs dispensed through the specialty pharmacy channel shall always be [redacted] fee). All drugs that are classified as specialty but are designated by the FDA as generic shall be priced as generics.
45	All non-specialty products dispensed out of the Awarded Respondent's specialty mail pharmacy shall be subject to Awarded Respondent's proposed standard mail-order pricing terms (discounts, dispensing fees, and rebates guarantees).
46	All products being dispensed or prepared for automatic dispensing shall be visually inspected by a pharmacist for correct color, shape, and other identifying markings. Additionally, Awarded Respondent shall verify that all drugs from primary or secondary vendors have either been purchased directly from the manufacturer or Awarded Respondent will provide sufficient documentation to the Department to ensure the Awarded Respondent is not buying from secondary markets. Secondary wholesalers will only be used to cover for shortages that have occurred with the primary vendor and/or for limited distribution products. Awarded Respondent shall notify the Department when a secondary wholesaler is being used for this purpose(s).
47	Awarded Respondent's mail order pharmacy shall ship multiple drugs to the same Participant separately if a new prescription or refill needs additional information or authorization independent of other new prescriptions or refills.
48	The Awarded Respondent shall not contact Participants via any method (i.e., mail, telephone, text, or email) except when absolutely necessary to process new prescriptions or refills, unless specifically requested or approved by the Department.
49	The Awarded Respondent shall use all commercially reasonable efforts to immediately contact and communicate any delays in fulfillment of any mail order prescriptions to the Participant.
50	The Awarded Respondent shall allow for each adult (eighteen years of age and older) Participant to maintain his or her own respective credit card or other payment information on file for use of filling prescriptions.
51	The Awarded Respondent shall allow for each adult Participant to maintain an alternate address for the mailing of a prescription. Such alternate address shall only be used for the mailing of a single fill of a prescription medication (unless provided as the alternate address for the next fill and/or prescription) and shall not supersede the official address of record provided to the Awarded Respondent by the Department.
52	The Awarded Respondent shall provide Subscriber/Participant with written notification of any credits/overpayments on their accounts.

53	Awarded Respondent shall subject all mail order prescriptions to a human quality assurance check prior to packaging and shipping.
54	The Awarded Respondent shall ship all prescriptions via US Postal Service or other appropriate carrier(s) to the address provided by the Department, its designee, or the Participant. The Awarded Respondent shall not increase its mailing/postage fees to the Department or its Participants during the Contract term.
55	**Temperature Sensitive Drugs**
	a. For all temperature sensitive drugs, the Awarded Respondent shall maintain information from drug manufacturers and/or the Federal Drug Administration (FDA) regarding storage and shipping requirements of specific medications.
	b. The Awarded Respondent shall provide the Department and Participant(s) written information from the manufacturer and/or FDA detailing acceptable temperatures and timeframes for shipping (not limited to storage).
	c. Drugs that require special handling with regard to temperature sensitivity shall be packaged with cold packs which maintain the temperature of the medication at or below the recommended threshold for two (2) days.
	d. Only climate-controlled equipment for which the Awarded Respondent has provided documentation to ensure its suitability for temperature and humidity requirements should be considered for use in packaging temperature sensitive medications.
	e. If the temperature at the shipping destination will exceed eighty (80) degrees within the next three (3) days, the package shall be delivered via overnight shipping.
	f. If the temperature at the shipping destination will be below eighty (80) degrees for the next three (3) days, the package shall be shipped using second day delivery.
	g. Drugs that do not require refrigeration may be shipped by priority mail (two (2) to three (3) day delivery).
	h. Cold pack and overnight delivery shipping shall be available for prescription drugs upon the request of the Participant and the Department.
56	The Awarded Respondent shall ensure that items requiring special handling dispensed via its mail order and/or specialty pharmacy will have those conditions clearly indicated in the labeling for the product and packaging.
57	The Awarded Respondent shall make available generic drugs produced by specific manufacturers when the prescribing physician states that such manufacturer's product is medically necessary. Making such specific product available to a participant shall not delay the prescription more than three (3) Business Days. Vendor reserves the right to facilitate participant receipt of medically necessary product through retail channel if unavailable through mail order.
VII.	**Data and Interface Requirements**
58	Awarded Respondent shall be fully capable of accepting and implementing all Plan related information via FTP on or before October 1, 2023.
59	The Awarded Respondent shall not use, or otherwise disseminate, sell, copy, or make available to any person or entity, data relating to any aspect of performance of the Services, for any purpose other than what is necessary in order to perform the Services. If Awarded Respondent licenses aggregate, de-identified claims data to various entities, Awarded Respondent shall not include or provide the Department's data to these entities. Therefore, Awarded Respondent shall receive no such fees for the Department's data, and no such fees are included as Manufacturer Payments passed to the Department. This requirement shall survive the termination of the Contract.
60	**System Upgrades, Enhancements and Problems**
	a. The Awarded Respondent shall provide at least six (6) months' notice of any significant planned platform and/or system upgrades or changes, including but not limited to claims, customer service, eligibility, mail order pharmacy, retail pharmacy contracting, operating systems and any other changes that may materially affect the administration of the Plan. Changes shall be discussed with and are subject to prior written approval by the Department.
	b. The Awarded Respondent shall immediately notify the Department upon the discovery of problems or issues with any systems, platforms, etc. that in any manner impact the Plan or Participants. Failure to timely notify the Department shall be considered a material breach of the Contract.
	c. The Awarded Respondent shall advise the Department of all corrective actions related to systemic problems or issues that in any manner impact the Plan.
	Eligibility File Transfers from the Department
	a. The Awarded Respondent shall maintain an information system capable of electronically receiving and updating Participant eligibility information (e.g., eligibility, name, address, coverage code). The Awarded Respondent shall accurately convert and load the Department' eligibility files.
	b. The Awarded Respondent shall maintain eligibility records for all Participants based on the Department' eligibility files submitted to the Awarded Respondent.
	c. The maintenance of eligibility records shall be compliant with the required HIPAA standards.
	d. the Department's eligibility file shall be the official system of record and the Awarded Respondent shall not overwrite, update or in any way change the eligibility information without express direction from the Department.

	e. The Awarded Respondent shall accept the eligibility files in a format and frequency as required by the Department.
61	f. In addition to the file schedule agreed to in paragraph (e), the Awarded Respondent shall accept an Open Enrollment eligibility file (generally provided at the end of November following Open Enrollment) for the purpose of generating ID cards for distribution prior to the coverage effective date. The Open Enrollment eligibility file shall not be loaded into production by the Awarded Respondent.
	g. The eligibility files, excluding the Open Enrollment eligibility file, and eligibility updates (including manual reinstatements and terminations) from the Department or the Department' HR vendor shall be processed as required in PG 21a-b at no additional cost to the Department.
	h. Eligibility file transfers and subsequent discrepancy reports between the Awarded Respondent and the Department or the Department's HR Vendor shall be exchanged as determined by the Department.
	i. File transfers with other entities shall be exchanged in a secure method approved by the Department.
	j. The Awarded Respondent shall maintain eligibility reconciliation between Awarded Respondent files and the Department' eligibility files.
	k. The Awarded Respondent shall provide discrepancy reports following every eligibility file load to the Department and the Department's HR vendor.
62	Paid Claims File to the Department. The Awarded Respondent shall provide, to the Department and/or its authorized third party(ies), a complete and detailed paid claims file (inclusive of all claims activity related to the Plan) in the method, timeframe, and format specified by the Department. Failure to timely submit complete, properly formatted data shall be considered a material breach of the Contract and is subject to PG 18a.
63	Paid Claims File to the Department' Health Insurance Management Information System (HIMIS) Vendor. The Awarded Respondent shall provide to the Department's HIMIS vendor a complete and detailed paid claims file in the timeframe and format specified by the Department or HIMIS vendor. Failure to timely submit complete, properly formatted data shall be considered a material breach of the Contract and shall be subject to PG 18d.
64	Paid Claims File Exchange with the Department' Health Plan Vendors. The Awarded Respondent shall exchange paid claims files with the Department' health plan vendors at least monthly. Such paid claims files are not required to contain pricing and/or cost data. Such paid claims files shall be provided in a format specified by the Department. Failure to timely submit complete, properly formatted data shall be considered a material breach of the Contract and shall be subject to PG 18e.
65	Accumulator Exchange with Health Plan Vendors. On a daily basis (or more frequently, if necessary) the Awarded Respondent shall:
	a. Provide a file of all Participant accumulator information to each health plan vendor and/or other required third parties as determined by the Department. The file shall be in a format specified by the Department and/or the health plan vendor and is subject to PG 18e. The Awarded Respondent and the health plan vendor shall be responsible for the member medical drug spend accumulator information/data.
	b. Accept a file of all Participant accumulator information from each health plan vendor and/or other required third parties.
66	Paid Claims File, Accumulator File, Other Data Files. The Awarded Respondent shall provide to any of the Department's additional authorized third parties complete data files in a timeframe and format/layout specified by the Department. Failure to timely submit complete, properly formatted data shall be considered a material breach of the Contract and is subject to PG 18c.
67	Upon termination of the Contract between Awarded Respondent and the Department for any reason, the Awarded Respondent shall provide the Department and subsequent Awarded Respondent with a file in the timeframe and format specified by the Department and to transfer Participant's current mail and/or specialty pharmacy prescriptions at no additional cost. The file transfer shall be subject to PG 18e.
68	The Awarded Respondent shall provide the Department, within thirty (30) Calendar Days of notice of contract termination, either for convenience or for cause, all data and records required by the Department.
VIII.	**Reporting and Deliverables**
69	The Awarded Respondent shall provide the required data and forecasts in support of the State Employee Group Program's Revenue Estimating Conference Report. Such data shall be provided in the timeframes and layout specified by the Department.
70	The Awarded Respondent shall prepare and provide, at no additional cost, ad hoc reports in formats required by the Department. The Awarded Respondent shall provide the Department with priority positioning for delivery of ad hoc report requests made by the Department or its designee regarding Plan-specific financial and statistical files, prescription processing, Participant services, network adequacy, patient management, and drug utilization reports. The Awarded Respondent shall acknowledge report requests within one (1) business day and shall provide an expected timeline for completion and delivery. Ad hoc reports are subject to PG 24a-b
	The Department requires regular weekly, monthly, quarterly, Semi-annual, and annual reports and/or deliverables.

71	a. Reports shall be provided in a format subject to customization and approval of the Department that provide utilization, claims reporting, rebates, and administrative services data both by total Plan, total PPO, total HMOs, and by subgroup. The subgroups at a minimum are: Agency SAMAS code, Active, COBRA, Retirees Under 65, and Retirees 65 and over. Note: Department anticipates that the subgroups will ultimately include variable hour (hourly) employees. The Department shall have access to these reports to provide assistance in Program Integrity inquiries.
	b. Reports shall contain all such data/details as required by the Department.
	c. Reports shall be delivered electronically to the Department and/or its designee, and in hard copy by request. Reports that contain proprietary, trade secret and/or confidential information shall also be delivered in a redacted format at the same time as the non-redacted format; the redacted report is only required to be delivered electronically.
72	Complete and detailed backup/supporting documentation must be provided **with submission** of each report. Backup/supporting documentation must identify the source of the material. Each weekly, monthly, quarterly, Semi-annual and annual report and/or deliverable shall be subject to the timeliness and accuracy provisions of PGs 22-23
73	**Weekly Reports and Deliverables:**
	a. Enrollment File Reject Records Report, this report is to notify the Department of enrollment file discrepancies identified by the Service Provider that result in a record being rejected in the Service Provider's enrollment system; format and detail as prescribed by the Department.
	b. Enrollment File Duplicate Records Report, this report is to notify the Department of enrollment file discrepancies identified by the Service Provider that result in a record being duplicated in the Service Provider's enrollment system: format and detail as prescribed by the Department.
74	**Monthly Reports and Deliverables:**
	a. Paid Claims Report. On a monthly basis the Awarded Respondent shall provide a paid claims report showing paid claims by pharmacy type (retail, mail order, or specialty), number of Subscribers and number of Participants, both by total Plan, PPO Plan, HMO Plans and by Subscriber subgroup (Agency SAMAS Code, Active, OPS, COBRA, Retirees Under 65, Retirees 65 and Over, single coverage level and family coverage level).
	b. RDS Interim Cost Report. On a monthly basis the Awarded Respondent shall calculate and submit Retiree Drug Subsidy (RDS) interim cost reports as described in AR 160 or as otherwise prescribed by the Department.
	c. Complaints to Customer Service. The Awarded Respondent shall provide the Department with a report of complaints received from Participants, healthcare providers, and pharmacies related to the Plan in accordance with the provisions of AR 18n.
	d. Fraud, Waste, Abuse, Misuse, and Suspicious Activity Report. The Awarded Respondent shall provide a report with complete details of all instances of fraud, waste, abuse, misuse, and suspicious activity in accordance with AR 17.
	Quarterly Reports and Deliverables:
	a. Appeals Report. The Service Provider shall provide a report detailing the number of appeals received during the reporting period along with the nature, status, and final determination of such appeals.
	b. Utilization Summary Report. The Service Provider shall provide a utilization summary report in a format subject to customization and approval of the Department to the Department and/or its designee.
	c. Performance Guarantee Summary Report (PG Report). The Service Provider shall deliver the PG Report. Upon delivery of this report, the Service Provider shall include complete detailed backup/supporting documentation, as approved by the Department, for each performance standard (i.e., system generated call center stats/reports, etc.) with the submission of the Performance Standards Guarantee Report. Service Provider shall provide a detailed Corrective Action Plan within thirty (30) Calendar Days of submission of the PG Report that addresses each missed standard and that includes complete details of any proposed corrective action(s), the implementation date of such corrective action(s), the complement or validation date of such corrective action(s), and a schedule for monitoring to ensure future success of any implemented corrective action(s). The Performance Guarantee Report shall be provided in a format customized and approved by the Department. Failure to provide performance for each standard and all required back up documentation shall result in the PG Report being late, inaccurate, or both.
	d. Trend Analysis Report. The Service Provider shall provide a report explaining/detailing any unusual trend results (high/low) relative to the industry, the Service Provider's book of business, best-in-class and similar groups (e.g. large government).

	e. PBM Revenues Report. In accordance with section 626.8825(2)(d), F.S., the Service Provider shall pass 100 percent of all prescription drug manufacturer rebates, including nonresident prescription drug manufacturer rebates, received to the Plan, if the contractual arrangement delegates the negotiation of rebates to the pharmacy benefit manager, for the sole purpose of offsetting defined cost sharing and reducing premiums of covered persons. Any excess rebate revenue after the Service Provider and the Plan have taken all actions required purusant to the preceding sentence must be used for the sole purpose of offsetting copayments and deductibles of covered persons. The Service Provider shall provide in complete detail one hundred percent (100%) of any and all revenue sources of the PBM related to the Plan including all rebates, revenues, payments, compensation, offsets, remuneration and any and all other forms of consideration of any kind. Such report shall provide, at a minimum, details of the following revenues received directly or indirectly in connection with the Plan:
	i. Prescription Pricing Components (e.g., retail, mail and specialty pharmacy AWP, AWP discounts, dispensing fees, etc.);
	ii. Manufacturer Payments (e.g., formulary rebates, administrative fees, educational grants, detailing payments, bonuses, patient assistance dollars, etc.), including amount and source;
	iii. Administrative fees or payments from labelers or wholesalers (e.g., discounts, rebates, grants, detailing payments, bonuses, etc.) including amount and source;
	iv. Outreach and outcomes of any other arrangement(s) from which the PBM may profit; and
	v. The value and nature of any and all other Third-party Consideration from each source.
	f. Preferred Drug List (Formulary Management) Report. The Awarded Respondent shall provide in complete detail quarterly updates of formulary management information, including at a minimum:
	i. Mail Maximum Allowable Cost (MAC) and retail MAC lists that identify changes by drug name, dosage and NDC number. (Note: If the MAC lists are the same for mail and retail, only one set of changes need be provided.)
	ii. Preferred Drug List and Formulary changes that impact the second (i.e., “preferred”) tier and third (i.e., “non-preferred”) tier and shall identify changes by drug name, dosage, and NDC number;
	iii. The rationale used to make the MAC/formulary/PDL changes;
	iv. The process for notifying Participants impacted by the formulary or PDL changes;
	v. Projected Plan and Participant impact (e.g., number of Participants, costs, savings, etc.) by drug; and,
75	vi. Any arrangements with prescribing healthcare providers, medical groups, pharmacy providers, individual practice associations, or other persons associated with activities of the Awarded Respondent to encourage formulary compliance or otherwise manage prescription benefits, including a description of outreach efforts and outcomes.
	g. Maintenance Drug List Report. The Awarded Respondent shall provide in complete detail quarterly updates of its maintenance drug list in a format approved by the Department. The Awarded Respondent shall list separately those maintenance drugs added to the list and those maintenance drugs deleted from the list. The Awarded Respondent shall permit the State to override any additions that do not meet required criteria. Included with each quarterly update, the Awarded Respondent shall provide the following:
	i. The rationale used to make such changes;
	ii. The process for notifying those impacted by the maintenance drug list changes;
	iii. Projected Plan and Participant impact (e.g., number of Participants, costs, savings, etc.) by drug; and,
	iv. Any arrangements of the Awarded Respondent to encourage appropriate use and/or otherwise manage the utilization of the maintenance drug in question, including a description of outreach efforts and outcomes.
	h. Cost Containment Report. The Awarded Respondent shall provide, to the extent applicable to the Plan design in place, full disclosure and quarterly reports of utilization management programs (e.g., prior authorization, drug limitation, etc.) including, but not limited to, affected drugs, costs, savings, outcomes, and number of impacted Participants.
	i. Cost Savings Recommendations. The Awarded Respondent shall provide recommendations to the Department based on Plan experience that would positively impact the costs associated with the Plan.

	j. Pharmacy Audit Results Report. Based on the results of the Awarded Respondent's on-site audits as required by PGs 30a-b, the Awarded Respondent shall provide a report detailing the audit, its findings, and financial impact to the Plan and Participants. The Pharmacy Audit Report shall be subject to the provisions of PGs 30a-b and 31
	k. Benchmark Cost and Utilization Report. The Awarded Respondent shall provide benchmark data on pharmacy costs and utilization for clients of similar size and complexity.
	l. Specialty Drug List Report. The Awarded Respondent shall provide in complete detail quarterly updates of its Specialty Drug List in a format approved by the Department. If any modifications have been made during the reporting quarter, Awarded Respondent shall provide the Department with a revised and complete list noting the effective date(s) of each modification. The Awarded Respondent shall list separately those Specialty Drugs added to the list and those Specialty Drugs deleted from the list. Included with each quarterly update, the Awarded Respondent shall provide the following:
	i. The rationale used to make such changes;
	ii. The process for notifying those impacted by the specialty drug list changes;
	iii. Projected Plan and Participant impact (e.g., number of Participants, costs, savings, etc.) by drug; and,
	iv. Any arrangements of the Awarded Respondent to encourage appropriate use and/or otherwise manage the utilization of the specialty drug in question, including a description of outreach efforts and outcomes.
	m. Pipeline Report. The Awarded Respondent shall provide a report that lists brand drugs which are expected to lose patent protection during the following twenty-four (24) months. The report shall include the expected date of the change in status from brand to generic, and the projected utilization and cost impact to the Plan.
	n. Retail Pharmacy Network Report. The Awarded Respondent shall provide a report of the number of retail pharmacies in the network as of the first and last days of the reporting quarter. Results are subject to the provisions of PGs 28a-c and 29a-c.
	o. Clinical Program Report in general, this report will explain all clinical programs utilized by the Department, participation levels, and outcomes; specific format and content as prescribed by the Department.
76	**Semi-Annual Reports and Deliverables:**
	a. Retail Pharmacy Satisfaction Survey. The Awarded Respondent shall survey a statistically valid sample of Participants using retail prescription services to verify satisfaction levels relating to the Awarded Respondent's customer service unit and other related services and to gauge satisfaction with the Plan. The survey instrument is subject to the customization and approval of the Department. The results shall be reported in a format prescribed or otherwise approved in advance by the Department. Survey results are subject to the provisions of PG 14a. Awarded Respondent shall provide a detailed Corrective Action Plan within thirty (30) Calendar Days of submission of the Satisfaction Survey Report that addresses each survey question where the responses were below the required standard and that includes details of the proposed corrective action(s), the implementation date of such corrective action(s), the complement or validation date of such corrective action(s), and a schedule for monitoring to ensure future success of any implemented corrective action(s).
	b. Mail Order Pharmacy Satisfaction Survey. The Awarded Respondent shall survey a statistically valid number of Participants using the mail order prescription services to verify satisfaction levels relating to the Awarded Respondent's customer service unit and other related services and to gauge satisfaction with the Plan. The survey instrument is subject to the customization and approval of the Department. The results shall be reported in a format prescribed or otherwise approved in advance by the Department. Survey results are subject to the provisions of PG 14b. Awarded Respondent shall provide a detailed Corrective Action Plan within thirty (30) Calendar Days of submission of the Satisfaction Survey Report that addresses each survey question where the responses were below the required standard and that includes details of the proposed corrective action(s), the implementation date of such corrective action(s), the complement or validation date of such corrective action(s), and a schedule for monitoring to ensure future success of any implemented corrective action(s).
	Annual Reports and Deliverables:
	a. RDS Final Reconciliation Report. The Awarded Respondent shall calculate and submit annually the Final Reconciliation cost report for the Retiree Drug Subsidy (RDS) program as described in AR 160.

	b. Best Pricing / Contribution Development Report. The Awarded Respondent shall deliver to the Department written verification that it continues to provide the Department its Best Pricing as prescribed in section 11.29 of the Draft Contract which, at the discretion of the Department, may be verified by an independent third party with audit expertise in the PBM industry. Such written verification shall be provided to the Department by September 30, 2024, and every September 30th thereafter that this Contract is in effect. The written verification shall include at a minimum:
77	i. The affidavit on Best Pricing in Section 10.20 of the Draft Contract
	ii. Projected costs for renewal year;
	iii. Estimate of IBNR at end of current year, including the most recent thirty-six (36) months of incurred / paid triangular report
	iv. Complete documentation of the methodology and assumptions used to develop the projected costs; and
	v. Disclosure of supporting data and assumptions used in the calculations, including monthly paid claims, enrollment, large claims analysis, trend analysis, demographic analysis, etc.
	c. Performance Bond and Insurance Report. The Awarded Respondent shall provide the Department with verification of sufficient coverage and that a sufficient bond is valid and will remain in force for the calendar year as prescribed in section 8.2 of the Draft Contract (Attachment E).
	d. Awarded Respondent shall provide an annual list of any Participants living in a county as prescribed by Section 2719 of the PHSA in accordance with AR 7g.
	e. The Awarded Respondent shall provide an annual report of manufacturer-funded clinical or medication adherence programs in accordance with AR 124.
	f. Statement on Standards for Attestation Engagements 18 (SSAE 18) Report. The Service Provider shall undergo, at its expense, an annual audit in accordance with the AICPA Statement of Auditing Standards, A.U. Section 324-Reports on Processing of Transactions by Service Organizations, specifically reporting on the policies and procedures placed in operation and tests of operating effectiveness. The report shall cover the twelve (12) month time period of October 1st through September 30th of each year; the report for the first year will cover January 1st through June 30th. The audit shall be performed by an independent auditing firm.
	g. RxDC reporting requirements would fall under the standard IRC §4980D penalty scheme, which is $100 per day per affected individual for noncompliance. RxDC Report Preparation and Submission – The Contractor agrees to prepare (Data Files D3-D8) of the RxDC Report and timely submit prior to the RxDC Report deadline the complete RxDC Report to CMS in accordance with governing law and CMS' RxDC Report Instructions on behalf of the Department for the 2024 calendar year, and each year thereafter on a recurring basis, during the term of the Contract including any renewals or extensions thereto. The Contractor shall be responsible for the preparation and submission of any addendums or corrections to the RxDC Report as required by CMS, the Department, the RxDC Report Instructions, or governing law, at no additional cost to the Department.
IX.	**Claims Processing**
78	Claims Processing and Adjudication. The Awarded Respondent shall establish and perform all aspects of Claims processing, coordination of benefits, claims reimbursement, point-of-sale transactions, adjudication, and payment in accordance with the Benefits Document. The Awarded Respondent shall verify benefits and eligibility before authorizing prescriptions and billing the Department.
79	The Awarded Respondent shall maintain computerized control of ingredient pricing through the use of a single, auditable industry resource (e.g., Medi-Span) and applicable to both mail order (including Specialty) and retail prescriptions.
80	Awarded Respondent shall select and disclose to the Department, the single source selected to price and classify covered drugs at retail, mail order and specialty pharmacy.
81	Explanation of Benefits Statement (EOB). The Awarded Respondent shall furnish an Explanation of Benefits Statement (EOB) to the Participant via regular U.S. Mail to the last known address within seven (7) days or less following each paper claim processed. Such EOB design is subject to the customization and approval of the Department. The EOB shall include all specific claim details including accumulative balances, as applicable. A per-claim electronic EOB is permitted in lieu of a hard copy EOB, subject to the authorization of the Participant.
82	Appeal Services. The Awarded Respondent shall, at no additional cost, administer Level I appeals for Plan Participants in accordance with the appeals process described in the Benefits Document and as otherwise specifically required and determined by the Department. Appeal services include medical review/assistance to the Department for Level II appeals (including disposition or documentation related to the original appeal), administrative hearings, and external reviews by the Awarded Respondent's Independent Review Organization (IRO) subsequent to the denial of a Level II appeal. Any and all correspondence, letters, communications, etc. related to any part of the appeals process is subject to the customization and approval of the Department.

83	Independent Review Organization. The Awarded Respondent shall, at no additional charge to the Department, contract with an independent vendor or vendors to assist the Department in resolving appeals following the denial of a Level I appeal specific to medical necessity opinions, consistent with the appeals program as described in the Benefits Document. The Awarded Respondent agrees it will enter into contracts with independent vendor(s) that reflect the Department's statutory requirement to resolve all Level II appeals. Through its independent vendor, the Awarded Respondent shall, at no additional charge to the Department, assist with Participant requested reviews of prescription drug denials as allowed by and in accordance with the Patient Protection and Affordable Care Act (PPACA).
84	Awarded Respondent shall provide copies of any and all clinical and/or medical policy guidelines upon the request of the Department.
85	**Medical Necessity Determination and Review.** a.) Prior to any denial of an appeal as not-medically-necessary, experimental and/or investigational, the appealed claim shall be reviewed by an appropriate medical professional. Awarded Respondent shall apply the definition of "Medically Necessary," as set forth in the Benefits Document and in accordance with Awarded Respondent's medical policy guidelines then in effect. The Awarded Respondent shall create, maintain and annually update medical guidelines that are thoroughly researched using current published medical literature. Such guidelines shall be publicly available via the Awarded Respondent's website, and available to Participants through the U.S. mail, upon request, and provided immediately to the Department upon Department's request. Except for eligibility appeals, Department may request a medical review in any other instance. Department shall have full and final decision making authority concerning eligibility, coverage, benefits, claims and interpretation of the Benefits Document.
86	Coordination of Benefits. The Awarded Respondent shall provide coordination of benefits as secondary payor for Medicare Part B and Medicare Part D enrollees at no additional cost to the Department. This includes, but is not limited to, differentiating Medicare Part B vs. Part D claims. The Awarded Respondent shall have in place all necessary systems and processes to ensure accurate electronic (real time) and paper claim submissions for processing and coordination of benefits in accordance with all COB provisions of the Plan.
87	Accounting System. The Awarded Respondent shall maintain an accounting system and employ accounting procedures and practices conforming to generally accepted accounting principles and standards. The Awarded Respondent's accounting records and procedures shall be open to inspection by the Department, or its authorized representatives, at any time during the Contract period and for so long thereafter as the Awarded Respondent is required to maintain records. Any such inspections shall be subject to confidentiality protocol requirements. All charges, costs, expenses, etc., applicable to the Contract shall be readily ascertainable from such records. Supporting documentation for all charges, fees, guaranteed savings and rebate payments including reimbursement invoices for prescription drug payment shall be readily ascertainable from such records.
	General Pricing Requirements.
	a. Awarded Respondent's pricing offer shall be based on and shall not require any changes to the Department's Rx Plan design(s), clinical programs, rules, and edits. Awarded Respondent's pricing offer shall not be contingent upon implementing any additional step therapy, prior authorization, and/or therapeutic switch programs.
	b. Awarded Respondent shall administer the days' supply currently allowed for Specialty and non-specialty Drugs by the Department's plans without penalty, additional charge, or reduction in rebates.
	c. Awarded Respondent shall provide pricing for an Exclusive specialty benefit (Specialty Drugs are only covered if filled by Awarded Respondent's specialty mail pharmacy).
	d. Awarded Respondent shall disclose the pricing and guarantee reconciliation methodology that will be applied for the Department in its entirety, including but not limited to any pricing methodologies applied during claims adjudication, any definition or any contractual clause that might cause a drug to be billed and filled under different drug classifications, the use of re-bucketing drugs during reconciliation to affect any guarantee (e.g. classifying drugs adjudicated as brands as generic under the GDR guarantee) exclusion of any drugs from the reconciliation calculation, and any other pricing or reconciliation strategy that is not specifically requested or covered within the Contract.
	e. Awarded Respondent's proprietary brand/generic drug algorithm(s) shall not be used to classify drugs as Brand or Generic when reconciling Awarded Respondent's aggregate Semi-annual Brand or Generic AWP Discount Guarantees.
	f. Awarded Respondent shall not use its "standard" or "book of business" practices when reconciling the Department's pricing guarantees unless they are clearly outlined in the Contract. If there is a dispute regarding a practice that is not outlined in this Contract, Awarded Respondent shall agree to stop such practice immediately and comply with the terms of the Contract.

88	g. Awarded Respondent shall agree that the financial attachment or section in the Contract shall encompass all aspects of pricing and reconciliation, and Awarded Respondent shall not be allowed to add, remove, change or otherwise alter these methodologies during the life of the Contract unless there is a corresponding change in state or federal law that necessitates such change. In the event such a change in law occurs, Awarded Respondent shall agree that any change made will maintain the relative economics of the Contract and shall be disclosed to the Department in writing within ninety (90) days advance notice or as much notice as is reasonably allowed in the event that ninety (90) days' notice is not possible.
	h. Any dollars associated with copay or patient assistance programs and/or copay accumulator programs shall not be treated in any way as discounts on claim costs. These dollars shall be tracked separately and shall not be used to reconcile guaranteed discounts, rebates, or dispensing fees.
	i. There shall be no additional fees to the Department if the Department elects to enroll in Awarded Respondent's copay accumulator program.
	j. All monies received from copay or patient assistance programs, not directly offsetting Participant's liability, shall be reimbursed to the Department.
	k. Awarded Respondent's shall provide a "Pass-Through Pricing" arrangement, whereby all claims adjudicated and dispensed by retail network pharmacies shall be the same as the actual discounted ingredient costs and dispensing fees billed by the retail pharmacy, which in turn shall be passed through and billed by Awarded Respondent in the same amount to the Department. Spread pricing shall not be used at retail. In addition, Awarded Respondent shall provide aggregate Semi-annual discount guarantees and dispensing fee guarantees for retail brand and retail generic drugs as outlined below.
	l. Claims filled at retail network pharmacies in Rural Areas shall be treated as any other retail network pharmacy for purposes of all "Retail" pricing guarantees noted below.
	m. Each and every Dispensing Fee and AWP Discount Guarantee quoted in the Cost Reply (Appendix B) shall be measured, reconciled, and guaranteed semi-annually on an individual component basis (e.g. each brand/generic and mail/retail guarantee independent of others). There shall be no cross subsidization among guarantees, within a distribution channel, or among distribution channels.
	n. Guaranteed Semi-annual AWP discounts and dispensing fees shall be measured, reported, and reconciled separately by Awarded Respondent, and Awarded Respondent shall pay or credit the Department one hundred percent (100%) of any shortfall between the actual result and the guaranteed results, with no offsets, reductions or adjustments. the Department shall not accept pricing offers that payout shortfalls based on "sponsor's net cost", limited to claims with "sponsor liability", or with any zero-balance due (ZBD) adjustment. the Department shall retain one hundred percent (100%) of any additional savings achieved above each guarantee, with no cross-subsidization within distribution channel, or among distribution channels. Shortfalls in one guarantee shall not be offset by overages in any other guarantee, with the exception of rebates which shall be reconciled in aggregate across all channels.
	o. All aggregate Semi-annual AWP discount guarantees shall exclude 340b claims, Participant submitted claims, compound drugs, vaccines, and flu shots. Aggregate Semi-annual AWP discount guarantees shall include covered OTC prescriptions.
	p. "Limited Distribution Drugs" means those Specialty Drugs only available through select pharmacy providers as determined by the drug manufacturer.
	q. "New to Market" Specialty Drugs are Specialty Drugs that are newly introduced for sale by pharmaceutical manufacturers and made available for dispensing at pharmacies and that are not included on the current Specialty Drug Price List. Once a drug meeting the criteria outlined in Specialty Drug definition is added to the Department's Specialty Drug Price List, it will be considered a Specialty Drug and no longer considered "new to market".
89	**AWP Discount Guarantees for Brand Drugs. The Awarded Respondent's minimum aggregate guarantee shall be calculated as (1- [(total discounted Brand Drug ingredient cost of applicable Brand Drug Claims, excluding dispensing fees and prior to application of co-payments) divided by (total undiscounted Brand Drug AWP cost of such Claims based upon the eleven (11) digit NDC as submitted by the Pharmacy)]).**
	a. This guarantee shall include all Brand Drugs dispensed at retail network pharmacies, and the minimum aggregate Semi-annual mail order AWP Discount Guarantees for Brand Drugs shall include all Brand Drugs dispensed at Awarded Respondent's mail order pharmacy.
	b. At retail, this guarantee shall exclude Specialty Brand Drug claims dispensed at retail network pharmacies and shall include Brand Drug claims priced at U&C. When calculating the retail AWP Discount Guarantee, the ingredient cost for U&C claims shall [redacted]
	c. At mail order, this guarantee shall exclude Specialty Drugs dispensed at Awarded Respondent's specialty mail pharmacies.
	d. Awarded Respondent will measure these guarantees and pay/credit the Department [redacted] any shortfall within ninety (90) days of each Semi-annual period, with the Department [redacted] of any additional savings achieved; shortfalls in one guarantee may not be offset by a surplus in any other guarantee.

	AWP Discount Guarantees for Generic Drugs. The Awarded Respondent's guarantee shall be calculated [redacted] Claims based upon the eleven (11) digit NDC as submitted by the Pharmacy)]).
90	a. Awarded Respondent's minimum aggregate Semi-annual retail AWP Discount Guarantees for Generic Drugs will [redacted]
	b. At retail, this guarantee shall exclude Specialty Drugs dispensed at retail network pharmacies and shall include U&C claims. When calculating the retail AWP Discount Guarantee, [redacted]
	c. At mail order, this guarantee shall exclude Specialty Drugs dispensed at Awarded Respondent's specialty mail pharmacies.
	d. Awarded Respondent shall measure these guarantees and pay/credit the Department [redacted] any shortfall within ninety (90) days of each Semi-annual period, with the Department retainin [redacted] of any additional savings achieved; shortfalls in one guarantee shall not be offset by a surplus in any other guarantee.
	Retail Specialty Drug AWP Discount Guarantees. The Awarded Respondent's guarantee shall be calculated [redacted] Claims based upon the eleven (11) digit NDC as submitted by the Pharmacy)]).
91	a. Awarded Respondent's minimum aggregate Semi-annual Retail Specialty Drug AWP Discount Guarantees shall include all covered Specialty Drug Claims including all New to Market Specialty Drugs, biosimilar products, as well as all exclusive distribution and Limited Distribution Drugs dispensed at retail network pharmacies.
	b. The minimum aggregate Semi-annual Retail Specialty Drug AWP Discount Guarantees shall exclude the value of rebates, manufacturer coupons, and monies associated with copay or patient assistance programs, and shall not be subject to day supply proration, reduction or adjustment.
	c. Awarded Respondent shall measure these guarantees and pay/credit the Department [redacted] any shortfall within ninety (90) days of each Semi-annual period, with the Department retaining [redacted] of any additional savings achieved; shortfalls in one guarantee shall not be offset by a surplus in any other guarantee.
	Specialty Pharmacy AWP Discount Guarantees. The Awarded Respondent's guarantee shall be [redacted] based upon the eleven (11) digit NDC as submitted by the Pharmacy)]).
92	a. Awarded Respondent's minimum aggregate Semi-annual Specialty Pharmacy AWP Discount Guarantees shall include all covered Specialty Drug Claims including all New to Market Specialty Drugs, biosimilar products, as well as all exclusive distribution and Limited Distribution Drugs dispensed at Awarded Respondent's specialty mail order pharmacy.
	b. The minimum aggregate Semi-annual Specialty Pharmacy AWP Discount Guarantees shall exclude the value of rebates, manufacturer coupons, and monies associated with copay or patient assistance programs, and shall not be subject to day supply proration, reduction or adjustment.
	c. Awarded Respondent shall measure these guarantees and pay/credit the Department [redacted] any shortfall within ninety (90) days of each Semi-annual period, with the Department retaining [redacted] of any additional savings achieved; shortfalls in one guarantee shall not be offset by a surplus in any other guarantee.
93	For prescriptions dispensed via Retail pharmacies, AWP shall be based on the actual package size submitted by the retail pharmacy for the eleven (11) digit NDC, on the date dispensed.
94	For prescriptions dispensed via Mail Order and Awarded Respondent's specialty mail pharmacy, AWP shall be based on the larger of the following pack sizes for the drug dispensed:
	a. The actual package size
	b. Covered Drugs will be priced based on the package size from which the product is dispensed. All compound drugs dispensed at retail and mail order will be processed using the National Council for Prescription Drug Programs (NCPDP) multi ingredient transaction; compound drugs will not be subject to a mark-up.
95	**Generic Drugs at Mail Order.** If a multi-source brand medication is dispensed at mail order in lieu of a generic equivalent, such claims shall always be adjudicated as generic regardless of DAW coding, whereby:
	a. The ingredient cost billed will always reflect the generic drug pricing (e.g., the MAC price or the non-MAC generic discount applied to the generic AWP cost); and

	b. The Participant's cost share (e.g., deductible, copay, coinsurance) shall always be determined as if the generic equivalent was dispensed.
96	**Compound Drugs.** Compound drugs dispensed at retail, mail order and specialty pharmacy shall be reimbursed using the National Council for Prescription Drug Programs (NCPDP) multi-ingredient transaction. Compound claims shall be adjudicated based on an allowable ingredient costs for each NDC using lesser of logic—comparing the discounted AWP cost, MAC price (if applicable), and the submitted ingredient cost for each ingredient of the compound. The individual allowable ingredient costs for each NDC are added to create a Total Final Ingredient Cost for the claim. The Total Calculated Cost shall equal the Total Final Ingredient Cost, plus the pharmacy's contracted dispensing fee, plus the pharmacy's contracted Professional Service Fee (if any). The final gross charge for the compound claim shall equal the lesser of the Total Calculated Cost and the pharmacy-submitted total Usual & Customary price for the compound.
	Zero Pay Claims. The calculation of all proposed AWP discount guarantees (e.g., retail brand, retail generic, mail brand, mail generic, specialty pharmacy) shall include zero pay claims (claims where the participant pays the full cost of the drug, and the Plan pays zero) based on the actual adjudicated Ingredient Cost; the AWP discount for zero pay claims shall not be included at one hundred percent (100%) discount.
	Any claims where the dispensing pharmacy does not provide a charge to either the Participant or the Plan shall not be included in the AWP discount guarantees.
97	**Member Pay the Difference Claims.** For any instance where Participants must pay the difference between the brand and generic gross drug cost when choosing a brand name drug when a generic alternative is available, such gross drug cost difference shall not be treated as a discount when reconciling Awarded Respondent's proposed AWP discounts or Ingredient Cost discounts.
	Retail Refill Limits/Penalties. For any plans where Participants are charged a higher cost-share when filling a prescription at retail rather than via mail order or specialty pharmacy, such cost-share shall not be treated as a discount when reconciling AWP discount guarantees, nor be used in any way to lower the amount otherwise due to the Department.
	Fill vs. Bill. Awarded Respondent agrees that if a single source generic drug is dispensed (filled), the Participant shall be financially responsible for the generic copayment/coinsurance and the Department's discount (bill) shall be the generic discount. Awarded Respondent agrees that if a multi-source brand drug is dispensed, the Participant shall be financially responsible for the brand copayment/coinsurance and the Department's discount shall be the generic discount.
98	**Dispensing Fees.** Dispensing Fees processed at the retail pharmacies shall be based on paid claims, NOT claims that are reversed, rejected or not billed to the Department. Awarded Respondent shall measure all Dispensing Fee guarantees annually and pay/credit the Department [redacted] of any shortfall within ninety (90) days of each annual period, with the Department retaining [redacted] any additional savings achieved; shortfalls in one guarantee shall not be offset by a surplus in any other guarantee.
99	Mandatory Maintenance ninety (90) claims filled at retail shall be adjudicated at the lesser of: [redacted]
100	Awarded Respondent shall ensure that Participants always pay the lower of the contracted price, applicable copayment/coinsurance, or the actual cost of the drug. Participants shall never be charged more than the "cash" price for a drug.
X.	**Clinical Services**
101	The Awarded Respondent shall provide ongoing utilization management including monitoring and enforcement of compliance with best industry practices using nationally recognized standards.
102	The Awarded Respondent shall, at no cost to the Department, implement Plan design system, program and process / procedural changes at the direction of the Department. Generally, plan design changes are a result of changes to Florida or federal law.
103	Returned Drug Process. The Awarded Respondent, subject to the Department's approval and in compliance with state law, shall have in place a process for handling prescription drugs returned to its facility. This policy shall document the entire process including but not limited to how credit for returned drugs is applied to the Department.
	Preferred Drug List (PDL) Management. The Awarded Respondent shall actively manage and maintain the PDL, at no additional cost, including but not limited to:
	a. Maintaining independence with respect to decisions about the PDL if the Awarded Respondent is owned by a pharmaceutical manufacturer or drug store chain.
	b. The Awarded Respondent shall immediately notify the Department of any drug removed from the PDL due to safety concerns or regulatory action requiring that the Awarded Respondent remove the drug.

104	c. The PDL is subject to the review and the approval of the Department. The PDL shall be updated at least quarterly. The Awarded Respondent shall provide the Department at least thirty (30) days advance notice of any additions or deletions to the PDL. The Awarded Respondent shall provide affected Participants at least thirty (30) days prior written notice and no more than a ninety (90) day grace period following receipt of such notice. Additionally, an updated PDL shall be mailed to the Department and posted on the Awarded Respondent's Plan specific website. Upon request an updated PDL shall be mailed to a Participant.
	d. Exclusions of drugs from the benefit Plan are considered Plan design decisions. Therefore, exclusions of medication may not be implemented in PDL changes, unless the Department implements formulary control management including drug exclusions.
	e. If the Department implements formulary control management including drug exclusions, Awarded Respondent shall provide its formulary drug list exclusions to the Department no later than October 1st preceding the following January 1st effective date. Such list shall identify the excluded drugs and the associated alternative covered drug.
105	**Specialty Drug List.** The Awarded Respondent shall actively maintain and provide immediate and unlimited access to a listing of drugs that are considered Specialty Drugs that must be obtained through the specialty pharmacy. The Awarded Respondent shall list separately those Specialty Drugs added or deleted from the list. Updated specialty drug lists shall be immediately provided to the Department and posted to the Awarded Respondent's website.
106	**Maintenance Drug List.** The Awarded Respondent shall actively maintain and provide immediate and unlimited access to the Department of a listing of drugs that are considered long-term and/or maintenance drugs. The maintenance drug list is subject to the review and the approval of the Department and shall be updated no more frequently than quarterly. The Awarded Respondent shall provide the Department at least 30 days advance notice of any additions or deletions to the maintenance drug list.
107	The Awarded Respondent shall maintain any and all drug lists, Preferred Drug List, Specialty Drug List, Maintenance Drug List, and Excluded Drug Lists on any and all Participant-facing website required by this Contract. Such drug lists shall be posted and available to Participants and providers on the effective date of such drug list.
108	**Auto-generic Substitution Programs**. The Awarded Respondent shall provide, at no additional cost to the Department, an auto-generic substitution program. The savings from the auto-generic substitution program shall not be included in any other program savings calculations.
109	**Generic Drugs.** The Awarded Respondent shall create and provide MAC pricing at both mail order and retail pharmacies (MAC List(s)). The MAC List(s) shall be made available to the Department upon request. The MAC pricing applied at mail shall be at least equivalent to the MAC pricing applied at retail but in no case shall it produce a higher cost to the Plan than the retail MAC on a drug by drug basis.
110	**Generic Substitution Rate.** The Awarded Respondent shall meet or exceed the Generic Substitution Rate prescribed in PG 26.
111	If a written prescription is returned to a Participant, a written explanation as to why it could not be dispensed shall be provided to the Participant.
112	**Utilization and Benefit Management Program Decisions.** Any and all utilization and benefit management program decisions shall be made solely to determine coverage and benefits, if any, for the Plan. The Parties shall do nothing to restrict the options of healthcare pharmacy providers to consult fully with patients about treatment options.
113	The Awarded Respondent shall provide, upon request of the Department, a description of all Drug Utilization Review (DUR) Programs available to the Department, the protocols for each program, a complete list of drugs subject to these programs and the cost to the Department, if any, for the implementation of any such programs.
114	**Concurrent Drug Utilization Review (DUR).** The Awarded Respondent shall perform at no additional fee concurrent utilization review by contracting with participating pharmacies using an online system prior to dispensing drugs. The Awarded Respondent's mail order and specialty pharmacy services shall also be required to process prescriptions through an online system prior to dispensing drugs.
115	The Awarded Respondent shall provide, at no additional cost to the Department, a computerized Concurrent DUR Program that monitors Participant's drug therapies in a real-time, online data processing environment. The system shall provide concurrent DUR capabilities to the participating retail, mail order and specialty pharmacies to allow intercession and counseling of Participants regarding their drug therapy. Criteria to be analyzed during the concurrent review include but are not limited to:
	a. Drug-drug interactions;
	b. Drug-age contraindications;
	c. Drug-disease contraindications;
	d. Drug-allergy contraindications;
	e. Over utilization or under-utilization;
	f. Early refills (defined as cases where seventy-five percent (75%) of previous prescription would have been depleted if used as prescribed to prevent early refills);
	g. Inappropriate or excessive dosages;

	h. Therapeutic duplication; and,
	i. Other situations that may endanger the health and welfare of program Participants.
116	**Retrospective Drug Utilization Review (DUR). The Awarded Respondent shall perform, at no additional cost to the Department, retrospective DUR that analyzes drug prescribing, dispensing and utilization patterns of practitioners and Participants. Critical components of the retrospective review include but are not limited to:**
	a. The appointment of a multi-disciplinary committee of relevant healthcare professionals comprised of physicians and pharmacists skilled in drug therapy, pharmacology and medical therapeutics to oversee retrospective reviews.
	b. The multi-disciplinary committee shall analyze detailed system-generated patient and practitioner profiles based on the top one hundred (100) prescribing practitioners (physician profiling).
	c. A comprehensive educational intervention program shall be used to notify practitioners of potential therapeutic complications, duplications or other situations that may endanger the health and welfare of Participants.
	d. The objective of the retrospective DUR program includes but is not limited to:
	i. Duration of therapy;
	ii. Therapy duplication;
	iii. Drug and disease appropriateness;
	iv. Contraindications;
	v. Preferred Drug List compliance;
	vi. Generic utilization;
	vii. Fraud and abuse; and
	viii. Monitoring the interaction among various treatments, medicines, and therapies.
	e. Geriatric management services shall be included as part of the Awarded Respondent's retrospective DUR concurrent case management program at no additional cost to the Department.
117	**Clinical Program Savings. With respect to clinical program savings included in Attachment D or any other programs implemented during the term of the contract, the Awarded Respndent shall:**
	a. Return one hundred percent (100%) of actual savings to the Department from clinical programs;
	b. Not use any savings achieved in excess from one clinical program to subsidize short falls in savings resulting from any other clinical program in any contract year;
	c. Exclude savings from Concurrent DUR and administrative edits (including but not limited to "refill too soon"), from Awarded Respondent's proposed bundled clinical savings guarantee; and
	d. Provide the Department with full authority to reject or "turn-off" any edits (e.g., quantity limit, step therapy) that the Department does not want to implement or continue.
118	**Other Utilization Management/Concurrent Case Management. The Awarded Respondent shall administer a Concurrent Case Management or individual benefits management program. Concurrent Case Management is defined as the management of cost-effective pharmacy services and supplies prior to or during the use of such services and supplies for Participants having catastrophic or chronic health conditions.**
119	The Awarded Respondent shall provide clinical resources to the Department to assist in interpreting pharmacy data and developing cost management strategies.
120	The Awarded Respondent shall disclose by October 1st of each year all manufacturer-funded clinical or medication adherence programs administered by Awarded Respondent at retail, mail, specialty pharmacy or through direct participant solicitation, and for which Awarded Respondent proposes to include Participants for the following calendar year. the Department reserves the right to decline participation without adversely affecting the financial guarantees applicable for that calendar year.
121	The Awarded Respondent shall provide quarterly reporting of clinical programs which shall include the number of participant specific encounters, the impact of such encounters and savings calculated from real vs. inferred data.
XI.	**Audits**
122	Readiness Assessment. the Department and/or its authorized third party may conduct or have conducted a readiness assessment of specific claims or other areas of the Awarded Respondent as determined by the Department prior to the Effective Date. Such assessment may include, but shall not be limited to, procedures, computer systems, claims files, customer service records, accounting records, internal audits, and quality control assessments.
123	The Awarded Respondent shall require and guarantee that all retail pharmacy claims, and subsequent paid claim files will include any and all information, data elements, and codes to support an audit and clearly identify the reason the claim was approved or denied. Any and all coding (i.e. DAW codes, overrides, exceptions, modifiers, etc.) shall be submitted to and approved by the Department in advance and all such codes shall be included on the mail order pharmacy, specialty pharmacy and retail pharmacy paid claim files of any and all type including those files used for audits and other reporting requirements.

124	The Awarded Respondent shall be financially responsible for any and all claims paid by and identified by the Department, or its authorized representative (i.e., consultant/auditor) without all previously approved appropriate and identifying codes. All such codes shall be addressed, explained and documented in complete detail and signed off by the Department during Implementation.
125	**Inaccurate Payments**
	The Awarded Respondent is prohibited from recouping overpayments to network pharmacies and retaining such recoupments.
	a. Upon discovery, notification, or recoveries as part of audits or other activities, the Awarded Respondent shall fully rectify the inaccurate payment or other situation, including but not limited to collecting overpayments or mis-payments, whenever payment is made that is not in accordance with the terms of the Benefit Document and/or the Certificate of Coverage and to the extent such recoveries are attributable to the Plan. The Awarded Respondent shall assume full liability and recover these overpayments and refund 100 percent to the Department regardless of recovery status. The Awarded Respondent shall be responsible for correcting inappropriate payment issues. Such overpayments shall not be reduced by contingency fees or other fees charged by an auditor or other recovery service.
	b. The Awarded Respondent shall reimburse the Participant in the event that a recovery impacts the Participant's cost share.
	c. The Awarded Respondent shall refrain from initiating litigation to recover such overpayment unless authorized by the Department.
126	d. If the inaccurate payment or other situation is systemic in nature, the Awarded Respondent shall submit a corrective action plan to the Department for approval, including a written plan for implementation and a timeline, which will resolve the issue within thirty (30) Calendar Days. If a thirty (30) Calendar Day resolution is not reasonably possible, the Awarded Respondent shall propose a resolution date to the Department for approval. The Awarded Respondent shall also provide to the Department weekly status updates and/or other documents (i.e., project plan, system test results, written status report, etc.) related to the corrective action to the Department.
	The Awarded Respondent shall give the Department full access rights to perform audits or reviews, or have audits or reviews performed by a third party, as determined necessary or required to ensure and validate that the State and its Participants are receiving best value, that State funds are being expended timely, efficiently and within compliance of all governing Florida Statutes, and the contract between the Awarded Respondent and the Department. the Department's audit rights include, but are not limited to:
	a. Pre-implementation audit to include but not be limited to the accuracy of plan set up, application of contractual discounts and benefit design, pricing, cost share, clinical edits, exclusions, communications, file transmissions, mail order transition, refill override code edits and triggers, DAW override codes and triggers, call center and customer service readiness, set up of CMS RDS subsidy management or any other operational, analytical or data necessary to validate accurate implementation.
	b. Compliance and Performance Audits to include but not be limited to:
	i. Verification of the validity of submitted claims;
	ii. Verification of claim adjudication and reimbursement based on benefit design and contract pricing;
	iii. Verification of pharmacy reimbursement based on contracted agreement with no limitation on the number of contracts that can be reviewed. The full contract will be provided for each pharmacy selected;
	iv. Verification of Awarded Respondent compliance with reimbursement to the Department all financial benefits the Awarded Respondent receives including but not limited to rebates, discounts, credits, fees, grants, chargebacks, or other payments based on contracts between Awarded Respondent and manufacturers, retailers, third parties and all others from which the Awarded Respondent receives financial benefits;
	v. Verification of validity and accuracy of administrative fee invoices;
	vi. Verification of self-reported Performance Guarantees;
	vii. Verification of Medicare Part D coordination of Benefits, management of CMS RDS program, accuracy of program eligibility, claims pricing, subsidy payments and reconciliation;
	viii. Review of all operational controls, policies and procedures; and
127	ix. Review of facilities including but not limited to mail order facilities, customer service and call center operations, training facilities, clinical and therapeutic service delivery centers, and all other facilities identified for review by the Department.
128	Awarded Respondent shall provide all claim data in an industry-standard format within ten (10) Business Days of request. Data files shall include but not be limited to billed ingredient amount, discount, dispensing fees (where applicable), taxes, member copays and penalties, DAW codes (if applicable), refill override codes (mail, retail, and specialty), and all other data elements identified at the inception of or during the audit.
129	Awarded Respondent shall make a designated, internal audit representative available to the Department or its designee throughout the entire audit process.

130	Awarded Respondent shall provide copies of, or if considered confidential and proprietary, make available all physical documents, contracts pertaining to Rebates and/or Manufacturer Payments or network arrangements, agreements and records requested for audit within ten (10) days of request.
131	Awarded Respondent shall provide copies of pharmacy records including original prescriptions related to Participant prescriptions within ten (10) Business Days of receiving the request.
132	Awarded Respondent shall research discrepancies identified during the audit and report the results of this research within ten (10) Business Days of the identification of the discrepancies. If claim error sample quantity exceeds 100 claims, the Department may allow a longer timeframe at the Department's discretion.
133	Awarded Respondent shall review a statistically valid sample of all audit findings within each specific category or test scenario of the audit whereby the electronic data and supporting documentation cannot prove the results of all potential financial errors within that specific category or test scenario.
134	Awarded Respondent shall review draft audit reports and provide written responses within ten (10) Business Days of receipt. Awarded Respondents response will be included in final report. The Department may allow a longer timeframe at the Department's discretion.
135	Awarded Respondent shall provide one non-redacted response to the audit and one redacted response to the audit in the event confidential or proprietary information is contained within the report. Only confidential or proprietary information should be redacted.
136	Awarded Respondent shall provide a corrective action plan to address all audit findings in the manner and timeframe designated by the Department. All audit findings are to be completely remediated (system corrections, financial impact analyses and reimbursement – where applicable) within sixty (60) Calendar Days of the issuance of the audit report.
137	Awarded Respondent shall reimburse the Department for any financial findings identified during the audit within twenty (20) Calendar Days of notification from the Department as to the final amount due.
138	**Audit Trail. The Awarded Respondent shall establish and maintain an effective audit trail for each claim/ prescription received/filled. Each data element in any paid claim file used for the purpose of audit shall be populated with codes, data, etc. approved by the Department during the Implementation Period. The Awarded Respondent shall be financially responsible for the inclusion of any coding not previously approved by the Department.**
139	the Department and/or its designee(s) shall have the right to perform onsite case reviews for randomly selected specialty pharmacy patients. These reviews do not qualify as an annual audit (claims audit or performance audit).
140	The Awarded Respondent shall perform, no less frequently than quarterly, internal audits of a statistically valid sample of claims and shall report results to the Department quarterly. Results shall be used to validate self-reported quarterly performance metrics for claim timeliness, processing accuracy, payment accuracy and financial accuracy. Awarded Respondent's results shall include any and all system generated reports, source documents, etc. used to support the audit results. Such supporting documentation must be made available to the Department immediately upon request.
141	the Department shall not be responsible nor assessed a charge for any of the Awarded Respondent's expenses related to operational or financial audits and CMS compliance audits, including the costs to provide necessary records.
	Quality Assurance Reviews for the Auditors. On a regularly scheduled basis, the Awarded Respondent shall review its procedures and processes to assess quality performance on claims, suspense, adjustments, overrides, prior authorization, as well as customer service inquiries by telephone, mail, email, etc. At the time of the audit, the Awarded Respondent shall advise the Department on how the following areas are handled to ensure quality:
	a. Technical;
	b. Mail order prescription fill;
	c. Prescription and inquiry turnaround times;
	d. Financials;
	e. Telephone and customer service; and,
XII.	f. Paper claims payments and reimbursement.
142	**Payment Specifications**
	The Awarded Respondent shall accept payment processed through normal State transmittal process (i.e., EFT transfer to the Awarded Respondent) and timeliness guidelines.
	Methods of Payment

	a. The Awarded Respondent shall provide the Department a detailed (itemized) invoice for Prescription Drug administrative and clinical program fees and other charges no later than the 15th Calendar Day of each month following the month services were rendered. Required supporting documentation for such invoices shall be as specified by the Department and shall provide sufficient detail for pre- and post-audit. Invoices shall be based on the last weekly eligibility file of the coverage month and shall separately include detail regarding any enrollment adjustments (i.e., to capture manual adds/deletes). Each fee type, e.g. Medicare Retiree Drug Subsidy fee, shall be identified individually on the invoice. Invoices and supporting documentation shall be provided electronically and, upon request, via paper hard copy.
143	b. Upon determination by the Department that the invoices are satisfactory, and that payment is due, the Department shall process each invoice in accordance with the provisions of section 215.422, Florida Statutes. the Department shall forward payment through electronic funds transfer to the Awarded Respondent for the invoiced amount. If the Department contests the invoice charges as submitted, additional documentation may be requested, and payment will not be processed until contested charges are resolved.
	c. Such payment method is contingent upon specific annual legislative appropriation in the General Appropriations Act (GAA). In the absence of any such appropriation, an insufficient appropriation, or upon notification by the Department, the parties agree payment shall be made using method two (2).
	d. For payment method two (2): The Awarded Respondent shall net approved monthly administrative and clinical program fees against the quarterly minimum guarantee rebate payment. Any such netting shall: (1) be fully disclosed and identified on the corresponding minimum guarantee rebate payment documentation; (2) shall be based on the last weekly eligibility file of the coverage month; and (3) shall separately include detail regarding any enrollment adjustments (i.e., to capture manual adds/deletes). Each fee type, e.g. Medicare Retiree Drug Subsidy fee, shall be identified individually. Supporting documentation shall be provided electronically and, upon request, via paper hard copy. Required supporting documentation shall be as specified by the Department and shall provide sufficient detail for pre- and post-audit.
	e. Supporting documentation, invoice or fee, and rebate information/ documentation shall be customized and approved by the Department.
144	**Invoicing for Prescription Costs. The Awarded Respondent shall furnish the Department with an itemized PPO Plan and HMO Plans invoice and corresponding claims detail files (in such detail as required for AR-63) for reimbursement of prescription claims costs on a weekly basis for mail, retail and specialty prescriptions separately and in the aggregate. The invoice shall include but not be limited to appropriate dispensing fees, the agreed upon discounted ingredient costs, and net member out-of-pocket costs. The design, format and documentation for invoices is subject to the customization and approval of the Department.**
	a. Weekly invoices shall be specific to a given month with the last invoice perhaps being less than a full seven days to capture the period from the ending date of the previous invoice to the end of the specific month.
145	b. Invoices and supporting documentation shall be provided electronically and, upon request, via paper hard copy.
146	All invoices (e.g., weekly prescription cost invoices, monthly fees' invoices) shall be as specified by the Department for a proper pre-audit and post-audit.
147	The Awarded Respondent agrees that, upon contract termination or expiration, the cost of any work required by a new provider to bring records in unsatisfactory condition up to date shall be the obligation of the new provider and such expenses shall be reimbursed by the Awarded Respondent within three (3) months of the end of the contract term. Records shall be requested in and industry standard format; and if such records are provided by the Awarded Respondent in an industry standard format, the Awarded Respondent shall not be required to reimburse the new provider any costs associated with converting or revising such records.
	Remittance of Manufacturer Payments. Quarterly payments for the minimum Guaranteed Rebate Amounts shall be paid to the Department no later than the 60th day following the end of the calendar quarter. The first minimum guarantee rebate payment shall be due May 30, 2024, if the Awarded Respondent is different from the Vendor in 2023. If the Awarded Respondent in 2024 is the Vendor in 2023 for this Contract, then the first minimum guarantee rebate payment is due Feb 28th. Subsequent payments shall be due each August 28th, November 29th, February 28th and May 29th. Payment shall be made through electronic funds transfer. The Awarded Respondent shall provide the Department a detailed report, as specified and customized by the Department, and supporting documentation, as specified and customized by the Department, for each rebate payment.
	Remittance of Manufacturer Payments in excess of Minimum Guaranteed Rebate Payment.

	a. The Awarded Respondent shall pay to the Department, no later than the 90th day following payment for the minimum Guaranteed Rebate Amounts, any Manufacturer Payments received by the Awarded Respondent and not previously remitted to the Department, that are in excess of the minimum Guaranteed Rebate Amount for each of the previous quarters of the Contract. The first "additional actual Manufacturer Payments collected" payment shall be due September 28, 2024, if the Awarded Respondent is different from the Vendor in 2023. If the Vendor in 2024 is the Awarded Respondent for this Contract, payments shall continue as established. Subsequent payments shall be due each September 28th, December 29th, March 31st, and June 29th. Payment shall be made through electronic funds transfer. The Awarded Respondent shall provide the Department a detailed report accompanying and supporting the "additional" Manufacturer Payment based upon a format specified by the Department.
148	b. Awarded Respondent shall provide the Department the greater of one hundred percent (100%) pass-through of actual Manufacturer Payments (as defined in section 1.2 of the ITN) or specified Per Prescription Rebate Guarantees or Per Brand Prescription Rebate Guarantees (as defined below). Whether Awarded Respondent will provide the Department with Per Prescription Rebate Guarantees or Per Brand Prescription Rebate Guarantees is determined at the sole discretion of the Department. the Department shall communicate its election of Per Prescription Rebate Guarantees or Per Brand Prescription Rebate Guarantees in writing annually, on a calendar year basis, prior to the start of the applicable calendar year. Annual election will remain as is if Department does not notify the Awarded Respondent prior to September 15 for January 1. If notification occurs after September 15, then election will become effective the first of the month following next calendar quarter (For example, if notified December 1, election change will be effective April 1.)
	c. Awarded Respondent shall not assess a rebate management fee to the Department.
	d. Under Awarded Respondent's proposed "Per Prescription Rebate Guarantees", specified amounts shall apply to all covered prescriptions (e.g., all Generic Drugs regardless of generic exclusivity status, formulary brand, non-formulary brand, and specialty drug prescriptions regardless of delivery channel) dispensed under the Plan; including covered prescriptions where the participant paid the full cost of the drug and the Plan paid zero.
	i. Per Prescription Rebate Guarantees shall be provided without minimum average days' supply requirements; there shall be no day supply proration, reduction or adjustment to the Per Brand Prescription Rebate Guarantees.
	ii. Per Prescription Rebate guarantees shall also include all New to Market Specialty Drugs, Exclusive Distribution, and Limited Distribution Drugs.
	iii. Per Prescription Rebate Guarantees shall not apply to Participant submitted paper claims, claims pursuant to a 100% Member Copayment or assistance plan, and or 340b pharmacy claims.
	iv. Per Prescription Rebate Guarantees shall apply to all Brand Drug products based on channel/network that was used to dispense the prescription. The Specialty Pharmacy Per Prescription Rebate Guarantees shall apply to all Specialty Claims dispensed at Awarded Respondent's specialty mail pharmacy (including but not limited to HIV and Hep-C).
	e. In lieu of the "Per Prescription Rebate Guarantees" the Department may, at its sole discretion, choose the Awarded Respondent's proposed "Per Brand Prescription Rebate Guarantees". Under the Per Brand Prescription Rebate Guarantees option, specified amounts will apply to all Brand Drug prescriptions (e.g. all formulary brand drugs and all non-formulary brand drugs,) dispensed under the Plan; including OTC Brand Drug products and covered prescriptions where the Participant paid the full cost of the drug and the Plan paid zero; and excluding brand drugs dispensed in lieu of a generic at generic pricing levels (House Generics).
	i. Awarded Respondent's proprietary brand/generic drug algorithm(s) shall not be used to classify drugs as Brand or Generic for determining Per Brand Prescription Rebate Guarantees.
	ii. Per Brand Prescription Rebate Guarantees shall be provided without minimum or average days' supply requirements; there shall be no day supply proration, reduction or adjustment to the Per Brand Prescription Rebate Guarantees.
149	iii. Per Brand Prescription Rebate guarantees shall also include: DAW 1&2 claims that process with a mandatory generic penalty, all New to Market Specialty Drugs., Exclusive Distribution, and Limited Distribution Drugs.
	iv. Per Brand Prescription Rebate Guarantees shall not apply only exclude to Participant submitted paper claims, claims pursuant to a one hundred percent (100%) Member Copayment or assistance plan, and or 340b pharmacy claims.
	v. Per Brand Prescription Rebate Guarantees shall apply to all Brand Drug products based on channel/network that was used to dispense the prescription. The Specialty Pharmacy Per Brand Prescription Rebate Guarantees shall apply to all Brand Drug claims dispensed at Awarded Respondent's specialty mail pharmacy (including but not limited to HIV, PCSK9 and Hep-C).
	f. The Awarded Respondent agrees that the rebate process, including the agreements with Pharmaceutical Manufacturers, can be audited by the State or the State's independent designated representative.

	g. The Awarded Respondent shall be subject to rebate payment and reconciliation standards as prescribed in PG 27.
150	h. All rebate payments shall, at a minimum, be reported by corresponding quarter and by the following groups: Total Plan, Total PPO, Total by each PPO Plan (standard and high deductible health plan), Total HMOs, Total by each HMO and each HMO Plan type (standard and high deductible health plan), Minimum Guaranteed Rebate amount, Other Manufacturer Payments Amount. Reporting categories shall be updated if there are changes to the number / types plans (i.e. PPO, HMO) offered by the Department.
	Rebate Availability. If one or more of the following changes relative to the Department's population, then Awarded Respondent or Department may initiate a review to determine if the relative economics of the current contract require revision as a direct result of the below change(s):
	• Industry-wide or universal marketplace changes regarding rebate availability;
	• Pharmaceutical company revision of rebate payment policy; or,
	• Governmental policy change on tax laws related to rebate payments.
	Such revision shall be limited to an equitable adjustment to the "Pricing Guarantees" (guaranteed AWP discounts, dispensing fees, administrative fees, and/or rebate guarantees), solely as necessary to maintain the contracted economic position of both parties prior to such change(s). This review may be initiated by Awarded Respondent or Client. Awarded Respondent will give thirty (30) days' notice to Client and Client will complete its review of relative economics within forty-five (45) days of said notice or as soon as administratively possible. Said revised Pricing Guarantees shall only apply to future utilization, with an effective date no sooner than thirty (30) days after Awarded Respondent and Client agree to such revision.
	Awarded Respondent shall provide Client details of and reason for the proposed change, an explanation of the manner in which the proposed change will account for the impact of the event triggering the proposed change, with an illustration that details the impact of the proposed change. The illustration shall be specific to Client utilization and will show the impact of the Client-specific change(s). The illustration shall show current utilization and costs based on current Client utilization and the impact to Awarded Respondent and Client as a result of the proposed change. Awarded Respondent shall disclose any necessary facts and data for Client and/or Client's benefit consultant to conduct an independent analysis. Such facts may include (but is not limited to) rebate contractual amendments in cases where rebate-ability is compromised by the Awarded Respondent. If both parties agree to revised Pricing Guarantees, then the revised pricing guarantees shall be implemented and shall be monitored on a quarterly basis to assure that Client-specific economics are preserved.
XIII.	Awarded Respondent shall ensure that the value of any lost rebates will be negotiated into the purchase price of medications between Awarded Respondent and Pharma. Any such value shall be passed back to Client once changes go into effect to ensure the relative economics of the agreement are maintained.
151	**Special Provisions**
152	All claim records and eligibility data used by the Awarded Respondent shall remain the property of the State as Plan sponsor and Plan administrator.
	In the event of a change in vendors, expiration of this Contract, or termination of this Contract with or without cause, the Awarded Respondent shall, at the direction of the Department and at no additional charge provide any such new vendor with all participant and plan information reasonably required to successfully transition services, including:
	a. Claims History Files: a complete claims history file for at least twenty-four months in the industry standard NCPDP PAL 700-byte layout or if requested in another industry standard at the time of the file transfer;
	b. Open Mail Service, including Specialty, Refill Files: one (1) test file and two (2) post-transition files that do not include compounds or controlled drugs in the industry standard NCPDP PTS v2.0 1600-byte layout or if requested in another industry standard at the time of the file transfer;
	c. Prior Authorization Files: one (1) test file and up to two (2) post-transition files in the industry standard 600-byte layout or if requested another industry standard at the time of the file transfer;
	d. Accumulation Files: one (1) test file and up to two (2) post-transition files in the industry standard format.
	Medicare Modernization Act (MMA) Services. The Respondent will work with Department decision-makers in understanding and maximizing their options in serving the retiree health benefit market, e.g., accessing federal subsidies for qualified employer-sponsored coverage, or employing health savings account (HSA) strategies. The Awarded Respondent must support the Department's needs in the following areas:
	a. Enrollment and eligibility;
	b. Marketing and communication outreach;
	c. Reporting;
	d. Compliance;
	e. CMS connectivity;
	f. Website capabilities;

153	g. Benefits and Plan design; h. Retail network set-up and management; i. Claims processing (including coordination of benefits, electronic prescribing, and rebates/discounts); j. Drug lists and clinical management; k. Finance; l. Customer Care Centers; m. Grievance and appeals processes; n. Mail service and specialty pharmacy; o. Accreditation; p. Record retention; q. Administrative matters; r. Additional Medicare Part D services include: i. Differentiating Medicare Part B vs. Part D claims; ii. Reporting; iii. Audit accountability (False Claims Act issues); iv. RDS Subsidy Calculations; v. Subsidy Report Submission to CMS; vi. Eligibility Tracking and Reconciliation; and
154	vii. Other Part D support as agreed to between the Department and the Awarded Respondent (e.g. Employer Group Waiver Plan (EGWP)).
155	The Awarded Respondent shall be knowledgeable of actual or pending State and federal laws, regulations, policies, procedures, and rules specific to employee benefit plans, pharmacy benefit management, pharmacy and prescription drugs, and other topics related to the provisions of this Plan and shall, at no additional cost, provide the Department with interpretation as to the impact of such laws or regulations on the Plan.
	The Awarded Respondent shall stay up-to-date with notices, announcements, developments, etc. from the U.S. Food and Drug Administration (FDA).
	a. Awarded Respondent shall immediately notify the Department of any development from the FDA that impacts or touches the Plan or the Plan's membership.
156	b. Failure to timely notify the Department of such action by the FDA shall be considered a material breach of the Contract.
	The Awarded Respondent shall absorb the cost of programming any benefit design changes.
157	Retiree Drug Subsidy Program. While the State is participating in the Retiree Drug Subsidy program, the Awarded Respondent shall calculate and submit to CMS the RDS Final Reconciliation cost report for each plan year and interim subsidy cost reports on a monthly basis, or as required by the Department or CMS, which includes at least the following:
	a. At least Semi-monthly eligibility submission to CMS, in CMS-required formats, and response file management/coordination with the Department;
	b. At least Semi-monthly extraction of data elements from the CMS response files and the load of that data into the maintained eligibility records;
	c. Monthly submission of claims data to CMS via the Retiree Drug Subsidy website pertaining to the Plan's Participants, application for subsidy, and the submission of the final reconciliation file due within fifteen (15) months after the end of the Plan Year. (Such claims shall be in the format specified by CMS and shall be sent at a frequency required by CMS in future guidance so that the State will receive payments on a timely basis).
	d. The Awarded Respondent shall upon receipt of weekly and monthly notification and response files from CMS 1) forward immediately forward all files to the Department through secured protocols, 2) perform processes as determined by the Department for handling participant records included in the files, and 3) notify the Department when all files have been processed accordingly.
158	e. The Awarded Respondent shall begin working with the Department on the annual reconciliation at the request of the Department, which shall be no earlier than June 1st.
159	the Department reserves the right to move from the Retiree Drug Subsidy Plan to an Employer Group Waiver Plan
160	The Awarded Respondent shall "hold harmless" the Department for audit liabilities as a result of the Awarded Respondent's management of the retiree drug program, including any penalties imposed by CMS.
	In the event of a change in vendors or expiration of this Contract, at the termination with or without cause or expiration of this Contract, the Awarded Respondent shall be responsible for the administration of claims incurred through the termination or expiration date for a run-out period of one hundred eighty (180) Calendar Days.

161	The Awarded Respondent agrees to adhere to leading industry practices in the development, implementation and application of administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the protected health information that the Awarded Respondent creates, receives, maintains or transmits in the Awarded Respondent's administration of the Plan, as required by the HIPAA security standards. Records shall be retained for ten (10) years after the later of :
	(i) the final disposition of a claim,
	(ii) the expiration of this Contract,
162	(iii) the conclusion of any judicial or administrative proceedings or audits or other action. Records may be retained in a digital imaging format. Prior to the destruction of any such claims records, Awarded Respondent shall consult with and obtain the prior written approval of the Department.
163	The Awarded Respondent shall comply with Chapter 717, Florida Statutes, governing unclaimed property and/or escheatment.
	Disaster Recovery Plan
	The Awarded Respondent shall develop, implement, and maintain a Disaster Recovery Plan for all programs which shall be delivered to the Department on or before the effective date of this Contract. At a minimum, the plan shall maintain backup of State files/data and shall be fully operational within twenty-four (24) hours of a disaster. The plan shall guarantee the same or better level of service as before the Disaster Recovery Plan was activated. Any revisions to the Awarded Respondent's Disaster Recovery Plan shall be delivered to the Department as soon as administratively possible. The Awarded Respondent shall activate and/or test its Disaster Recovery Plan at least annually.

ATTACHMENT 2 - REVISED PERFORMANCE GUARANTEES AMENDMENT 1

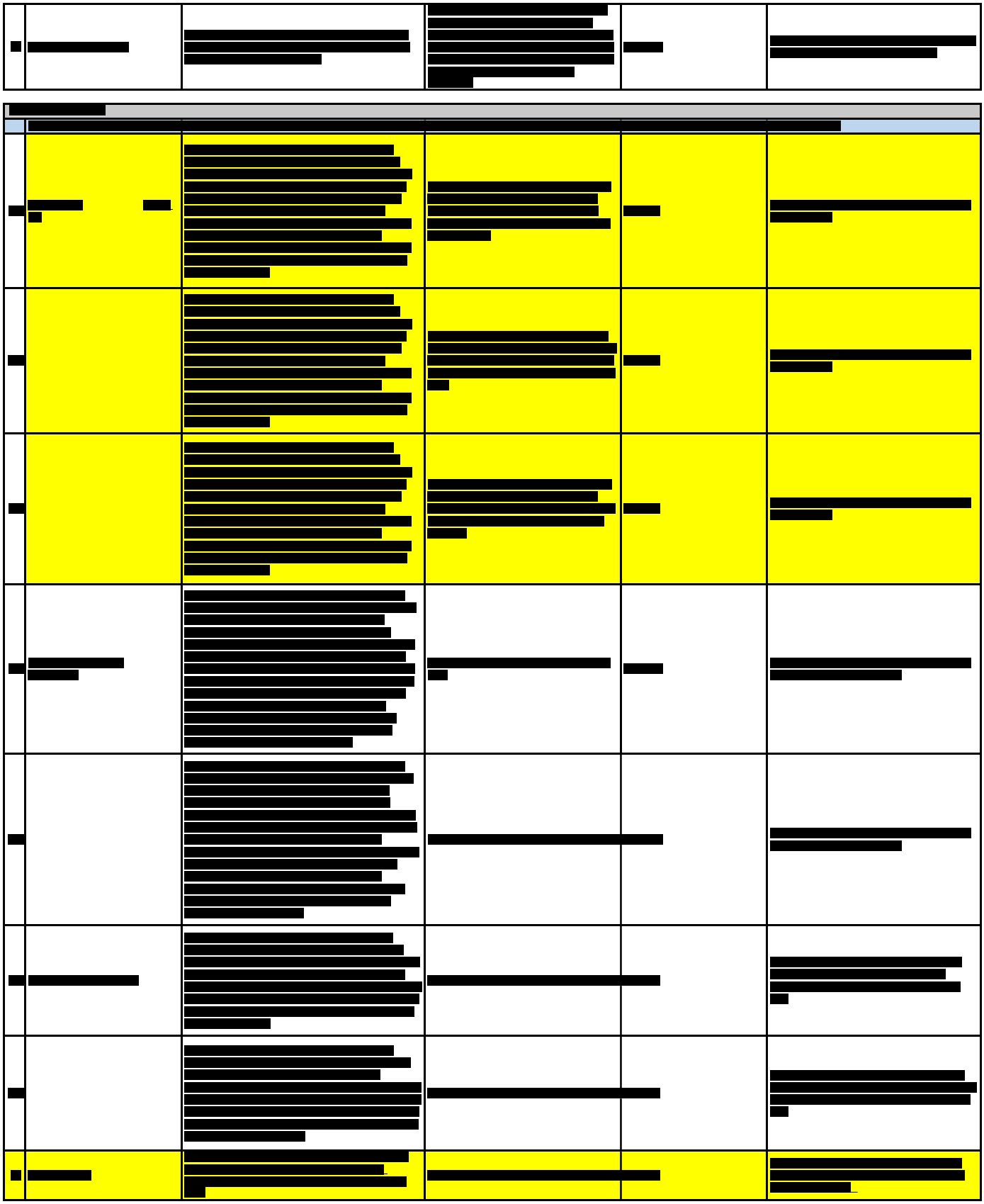
Respondent Name:
OptumRx, Inc.

Instructions: By submitting a Reply, the Respondent accepts the following Performance Guarantees (PG) as written for purposes of evaluation. During the Negotiation phase, the Parties may negotiate alternatives to achieve best value; however, the Department is not obligated to accept any alternatives to the Performance Guarantees.

[redacted]

from Eligible Persons that are processed by Selected Respondent.

later than the number of days specified in advance of



ATTACHMENT 3a – SUPPLEMENTAL COST REPLY
DMS-22/23-047, AMENDMENT 1

No.	Description	Year 1	Year 2	Year 3	Renewal Year 1	Renewal Year 2	Renewal Year 3
1.	Annual RxDC Report	[redacted]					[redacted]
2.	Intentionally Left Blank						
3.	Intentionally Left Blank						
4.	Intentionally Left Blank						
5.	Intentionally Left Blank						

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