STATE OF MISSISSIPPI

STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE MANAGEMENT BOARD

Request for Proposal

Pharmacy Benefit Manager Services

October 16, 2024

Contact information for this request for proposal:
Pharmacy Benefit Manager Services RFP (RFx 3120003010)
c/o MDFA Office of Insurance
501 North West Street
Suite 1201-C Woolfolk Building
Jackson, Mississippi 39201
InsuranceRFP@dfa.ms.gov

TABLE OF CONTENTS

SECTION 1. INTRODUCTION

1.1 Background and Authority

The State of Mississippi State and School Employees' Health Insurance Management Board (Board) seeks a qualified, experienced vendor to provide prescription drug benefit management services to the State and School Employees' Life and Health Insurance Plan (Plan). The Plan's health insurance component is a self-insured, non-ERISA (Employee Retirement Income Security Act of 1974) health insurance plan, currently providing health insurance coverage to approximately 190,000 participants. Eligible participants in the Plan include active, retired, and Consolidated Omnibus Budget Reconciliation Act (COBRA) employees (and their enrolled dependents) of the State's agencies, universities, community colleges, school districts, and public library systems. Plan participants are located primarily within Mississippi, although a small number of participants reside in other states. The 2024 Plan Document provides specific details of the Plan and is located on the Plan's website at https://knowyourbenefits.dfa.ms.gov/publications/. The Board desires to contract with a Pharmacy Benefit Manager (PBM) capable of providing a customized prescription drug benefit management services to a large, self-insured health plan, and has prior experience directly related to the services requested in this RFP. The required services are described in **Request for Proposals (RFP) Section 2, Scope of Services**.

The Plan currently offers options of Base Coverage or Select Coverage for active employees, COBRA participants, and non-Medicare eligible retirees. Each coverage type is independent of the other. Under Select Coverage prescriptions are subject to copayments after a $75 pharmacy deductible has been satisfied. The Base Coverage serves as a high deductible health plan in which pharmacy benefits are subject to copayments after the annual $1,800 deductible has been satisfied. As of July 1, 2023, the Plan's enrollment included 107,639 active employees with 51,615 dependents, 7,471 non-Medicare retirees with 2,007 dependents, and 579 COBRA participants with 311 dependents. The remaining 20,000+ Medicare primary participants and their dependents do not have pharmacy coverage provided by the Plan.

Blue Cross & Blue Shield of Mississippi (BCBSMS) is the current medical Third-Party Medical Claims Administrator (TPA) and has served in this capacity since 1998. The TPA collects and provides the PBM with eligibility data and accumulation data such as deductible and out-of-pocket data, etc. The TPA is responsible for processing medical claims and determining medical necessity guidelines for the Plan. CVS Caremark Pharmacy, Inc. is the current PBM and has served in this capacity since 2021. The Plan currently utilizes CVS Caremark Value Formulary which is a "closed" formulary. The Plan processed over $283 million in 2019 prescription drug charges on approximately 3.3 million claims in 2019. The Plan has a generic utilization rate of approximately 88.2%. Mail order currently represents less than 2% of claims.

The Board's current PBM services contract is scheduled to expire on December 31, 2025, necessitating the need for this RFP. The effective date for this contract will be January 1, 2026. Implementation and/or transition services provided by the selected vendor prior to July 1, 2025, are not compensable; as such, any costs incurred by the Vendor prior to January 1, 2026 may not be invoiced to the Board.

The Mississippi Department of Finance and Administration's (MDFA) Office of Insurance (OI) under the direction of the State Insurance Administrator is responsible for the management and

administration of the Plan and provides administrative support to the Board and is coordinating this RFP with assistance from its consultant, Gallagher Benefit Services, Inc. The Board seeks to enter into a multi-term, fixed price, indefinite quantity contract for the aforementioned services. A draft contract has been included as **Appendix A** of this RFP for your review and comment. This RFP, any amendment thereto, such as Questions and Answer document(s), if any were issued, as well as the awarded vendor's proposal(s), and any requested best and final offer shall constitute the Contract. The Contract will be for five (5) years. This solicitation and any resulting contract shall be governed by the applicable provisions of the *Mississippi Public Procurement Review Board (PPRB) Office of Personal Service Contract Review (OPSCR) Rules and Regulations*, a copy of which is available on the Mississippi Department of Finance and Administration's website (www.dfa.ms.gov). Any vendor responding to a solicitation for personal and professional services and any contractor doing business with a state agency is deemed to be on notice of all requirements therein.

A copy of this RFP, including any subsequent amendments, along with a copy of all questions from vendors and responses to those questions, will be posted on MDFA's website under the heading "Solicitations" at https://www.dfa.ms.gov/bids-and-rfps-notices. Before the award of any contract, the Vendor will be required to document to the Board that it has the necessary capabilities to provide the services specified in this RFP. The Vendor may also be required to provide additional client references, as well as related project experience detail, for OI to determine if the Vendor is qualified. The OI may make reasonable investigations, as it deems necessary and proper, to determine the ability of the Vendor to perform the work, and vendor shall be required to furnish all information that may be requested for this purpose. The OI reserves the right to reject any proposal if the Vendor fails to provide the requested information and/or fails to demonstrate the Vendor is properly qualified to carry out the obligations of the Contract and to complete the work described within this RFP.

1.2 Purpose and Goals

The purpose of this solicitation is to contract with a firm to provide pharmacy benefit management services including network pharmaceutical pricing through financial arrangements with pharmacies. The pharmacy network provided by the PBM must contain a sufficient number of pharmacies to provide all participants adequate access, in-state as well as out-of-state, as determined cooperatively by the PBM and the Board. The pharmacy network will provide the Plan with a cost-effective network of pharmacies contracted at rates that are commensurate with the size of the Plan and its associated purchasing power. The PBM will provide clinical programs cost containment such as prior authorization, step therapy and specialty drug management, and a mail order distribution channel. The Board expects the PBM to be proactive in making recommendations that control costs.

The Board's goal is to partner with a PBM to serve as a fiduciary to provide a well-managed customizable formulary which provides access for our participants to clinically effective Food and Drug Administration or FDA-approved drugs at the lowest net cost and to exclude any drugs with proven low efficacy rates and high-cost drugs when lower cost clinically effective drugs are available. The Board prefers to exclude overpriced drugs which are simply reformulations of lower cost drugs or combinations. The PBM must provide a fully transparent/pass-through financial pricing arrangement with the Board. "Transparency" refers to financial arrangements which represent a direct and complete pass-through of all financial transactions. The Board must receive

the full and complete amount of any discounts and rebates received by the PBM from any and all retail pharmacies, and manufacturer rebates. The PBM will not retain a differential between the amount reimbursed to the PBM by the Board for each transaction and the payments made to the retail pharmacies by the PBM or rebates. (See rebates definition in **RFP Section 1.3, Definitions**.)

The only compensation the PBM will receive from or on behalf of the Board, for the services described in this proposal or any subsequent contract, shall be the PBM's quoted administrative fees listed in the PBM's proposal, or agreed upon in writing through subsequent discussion with the Board.

1.3 Definitions

1.3.1. "**Aggregator**" means the company that helps manage the complex world of formulary and rebate management for pharmacy benefit managers (PBMs), health plans, and employer groups. These aggregators are often PBM owned or affiliated.

1.3.2. "**Allowable Charge**" means the lesser of the amount payable under the terms of the pharmacy's contract with the PBM for a covered drug or the cash price inclusive of all applicable customer discounts which a cash paying customer of the pharmacy pays for a covered drug.

1.3.3. "**AWP**" means the "average wholesale price" for a standard package size of a prescription drug from the most current pricing information provided to PBM by Medi-Span Prescription Pricing Guide, or following approval by the Board, any other nationally available reporting service of pharmaceutical prices as utilized by PBM as a pricing source for prescription drug pricing. The AWP used is based on the date sensitive 11-digit national drug code (NDC) of the actual package size dispensed as set forth by Medi-Span on the date the claim is dispensed.

1.3.4. "**Brand Name Drug**" means drug that has a trade name and is protected by a patent. A brand name drug may only be produced and sold by the pharmaceutical company holding the patent or a pharmaceutical company that has been licensed and authorized by the patent holder to produce and sell the drug. Medi-Span Multi-Source Indicator will be used for calculating aggregate financial guarantees. For prescription drug claims processed where the underlying prescription drug product is identified having a multi-source indicator code identifier of "M", "N", or "O" on the date dispensed, the claim should be considered a Brand claim unless otherwise noted as an exclusion. Claims processed where the multi-source indicator is a "Y" on the date dispensed will be considered as Generic claims.

1.3.5. "**Compound Drug**" shall mean a formulation containing one or more "Drug Products", which is extemporaneously weighed or measured then prepared by a pharmacy in accordance with a physician's prescription order. A compound drug prescription meets the following criteria: two or more solid, semi-solid or liquid ingredients, at least one of which is a covered drug that is not commercially available. Compound drug claims will only be covered for drugs for which the compounded product is not commercially available.

1.3.6. "**Copayment**" means that portion for a covered prescription which, under the terms of the Plan, is required to be paid by the participant directly to the pharmacy. The Employee will pay the lower of:

(i) the copayment, coinsurance or deductible;
(ii) the acquisition cost, plus dispensing fee; or
(iii) the pharmacy's usual and customary charge for the drug product, MAC (maximum allowable cost) or retail cash price.

1.3.7. "**Covered Service**" means a prescription drug provided under the terms of this contract for which payment may be requested under terms of the Plan.

1.3.8. "**Employee**" means an eligible person who has satisfied the specifications of the Plan's Plan Document's eligibility guidelines and has enrolled for coverage under the Plan. Unless otherwise, "Employee" refers to an active employee, a retired employee or a COBRA participant.

1.3.9. "**Formulary**" means the PBM's Performance Drug List (PDL), which is a list of pharmaceutical products and supplies, quantity limits, prior authorization guidelines, and clinical guidelines detailing coverage of such products, created and maintained by the PBM, as amended from time to time, which: (a) has been approved by PBM's pharmacy and therapeutics committee; (b) reflects the PBM's recommendations as to which pharmaceutical products should be given favorable consideration by plans and their participants; (c) includes all standard clinical programs, including but not limited to prescribing guidelines such as prior authorization, step therapy, and quantity level limits, if elected by the Board; and (d) includes any custom request by the Board for addition or deletion of drugs at the sole discretion of the Board.

1.3.10. "**Generic Drug**" means a drug that is therapeutically equivalent (identical in strength, concentration, and dosage form) to a Brand Name Drug and that generally is made available when patent protection expires on the Brand Name Drug. The Board's expectation is that Medi-Span Multi-Source Indicator will be used for calculating aggregate financial guarantees. For prescription drug claims processed where the underlying prescription drug product is identified having a multi-source indicator code identifier of "M", "N", or "O" on the date dispensed, the claim should be considered a Brand claim unless otherwise noted as an exclusion. Claims processed where the multi-source indicator is a "Y" on the date dispensed will be considered as Generic claims.

1.3.11. "**Group Purchasing Organization**" or "**GPO**" is an entity that is created to leverage the purchasing power of a group of businesses to obtain discounts from vendors based on the collective buying power of the members. PBM-lead GPOs are organizations formed by PBMs with one or more members, whose primary purpose is to aggregate purchasing volume to negotiate discounts with biopharmaceutical manufacturers.

1.3.12. "**Health Insurance Portability and Accountability Act**" or "**HIPAA**" shall refer to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

1.3.13. "**Health and Wellness Management Vendor**" means the vendor that provides health and wellness management services to the Plan including, but not limited to, incentive management and wellness promotion management services and at the discretion of the Board may include disease management, maternity management, weight management, tobacco cessation, and a clinical improvement promotion program that includes four wellness coaches strategically located in Mississippi and an online portal, mobile app, and digital coaching.

1.3.14. "**Limited Distribution Drugs**" means specialty drugs which are distributed to either one (1) or a very limited number of pharmacies, distributors or wholesalers.

1.3.15. "**Maximum Allowable Cost**" or "**MAC**" means the unit price that has been established by the PBM for a multi-source generic drug (i.e., a generic drug with more than two sources) included on the MAC drug list applicable to the Board, which list may be amended from time to time by the PBM in maintaining its generic pricing program. A copy of such MAC drug list shall be provided to the Board prior to execution of this contract and thereafter upon the Board's reasonable request.

1.3.16. "**Network Pharmacy**" means a retail pharmacy, home delivery pharmacy, specialty pharmacy or other facility that is duly licensed to operate as a pharmacy and is owned or operated by the PBM (or an affiliate) or has entered into a Network Pharmacy Agreement.

1.3.17. "**Paid Claims**" means all transactions made on eligible participants that result in a payment to pharmacies or participants from the Plan or the Plan participant copayments. (Does not include reversals, rejected claims and adjustments.) Each unique prescription that results in payment shall be calculated separately as a paid claim.

1.3.18. "**Participant**" means an individual eligible to receive prescription drug services for which payment may be sought under the terms of the Plan.

1.3.19. "**Participating Provider**" means a pharmacy or pharmacist which has entered into a contract with the PBM to provide prescription drug services under this contract. All pharmacists employed by a Participating Provider are subject to all requirements imposed on Participating Providers under this Contract.

1.3.20. "**Pharmacy Benefit Manager**" or "**PBM**" means the entity that administers the prescription drug portion of the Plan. The PBM is expected to provide pharmacy claims processing, mail order pharmacy services, and other services, such as rebate administration, development and management of pharmacy networks, formulary management, drug utilization review programs, generic drug substitution, and disease management programs.

1.3.21. "**Plan**" means the self-insured Mississippi State and School Employees' Health Insurance Plan as defined in Mississippi Code Annotated § 25-15-1 et. seq.

1.3.22. "**Plan Document**" means the document that states the benefits and eligibility terms of the Plan. The Plan Document is published and maintained by the Board. All benefits under the Plan are subject to the Plan Document. The 2024 Plan Document is available on the Plan's website at https://knowyourbenefits.dfa.ms.gov/publications/.

1.3.23. "**Rebate**" means any compensation or remuneration of any kind received or recovered by the PBM, or any of its affiliates from a pharmaceutical manufacturer attributable to the purchase or utilization of covered drugs by eligible persons, including, but not limited to, incentive rebates categorized as mail order purchase discounts; credits; rebates, regardless of how categorized; market share incentives; promotional allowances; commissions; educational grants; market share of utilization; drug pull-through programs; implementation allowances; clinical detailing; rebate submission fees; and administrative or management fees. Rebates also include any fees that PBM, or any of its affiliates, receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access.

1.3.24. "**Specialty Drug**" means pharmaceutical products that are typically expensive and require special handling and monitoring such as patient training, care coordination, adherence monitoring. They can be administered orally or through injection, infusion, inhalation, or other non-oral methods. Many are biologically developed (biologics) and can be used to treat chronic, life threatening, and rare conditions.

1.3.25. "**Specialty Pharmacy**" means a contracted pharmacy providing Specialty Drugs, including any specialty pharmacies owned by the PBM.

1.3.26. "**Third Party Claims Administrator**" means the organization under contract to the Board responsible for processing all medical claims, other than claims for prescription drug services, received from participants.

1.3.27. "**Usual and Customary**" or "**U&C**" means the amount a Network Provider would charge to a cash paying customer for same strength, quantity, and dosage form of a covered drug, as of the date the prescription is filled.

1.3.28. "**Utilization Management Vendor**" means the vendor that provides utilization management services to the Plan including, but not limited to, hospital management services (hospital admission, pre-admission and post-discharge outreach, and case management), continued stay management, discharge planning, retrospective review, review of high-cost diagnostic procedures, and medical necessity review for specified medical services.

SECTION 2. SCOPE OF SERVICES

This section contains information on services and procedures the selected vendor must provide, or adhere to, in servicing the Board's account, either directly or through identified subcontractors. **The descriptions are not all-inclusive** but are provided to alert you to services or procedures that may require additional planning or programming on your part. The following is a list of services the Board expects the successful vendor to provide.

Please respond by restating each service listed below, including the number, and confirm your intention to provide the service as described by stating "*Confirmed*". If your company can provide the service, but not exactly as described, respond by stating "*Confirmed, but with exceptions*", and state the specific exceptions. If your company intends to provide a listed service through a subcontractor, respond, "*Confirmed, service will be provided through subcontractor*", and name the subcontractor. If your company is currently unable to provide a listed service, respond by stating "*Unable to provide this service*". Any additional details regarding these services should be provided in your responses to the questionnaire, or as additional information included as an appendix to your proposal.

The selected vendor is expected to provide the following services:

2.1 Account Management

2.1.1 Hire and maintain sufficient staff to meet the needs of the Board and the Plan's participants.

2.1.2 Comply with staffing minimum requirements provided in **RFP Section 3.2 through 3.3**.

2.1.3 Maintain an adequate customer service staff to respond to inquiries from participants, providers, and MDFA staff regarding the services provided by the PBM through a toll-free telephone line. The service shall be available 24 hours, 7 days a week, other than scheduled maintenance times, to participants and providers. Currently, the Board's pharmacy customer service center averages 4,300 calls per quarter.

2.1.4 Provide competent and proficient account management staff to promptly address and respond to any staffing concerns with MDFA.

2.1.5 Cooperate with the Board and with all other contractors of the Board with respect to the ongoing coordination and delivery of health care services, and in any transition of responsibilities.

2.1.6 Provide consultative services regarding pharmacy benefit design including, but not limited to, formularies, allowable charges, generic drug incentives, implementation of programs which control utilization and optimize health, utilization review services, and evaluation of drug use and cost data.

2.1.7 Participate in activities with the PBM and/or MDFA staff in responding to participant or provider inquiries or complaints relating to pharmacy benefit services.

2.1.8 Conduct at least one (1) customer satisfaction survey within the third quarter of the initial contract period and one (1) annually thereafter. The contents of the satisfaction survey must be agreed upon by the Board and the PBM.

2.1.9 Participate, at its own expense, in health/benefit fairs to educate participants throughout the State.

2.1.10 All services directly related to this contract must be provided from an office located within the United States.

2.2 Pharmacy Benefit Manager Services

The PBM's duties and responsibilities shall include, but are not limited to, the following:

2.2.1 Comply with mutually agreed service performance guarantees. Refer to **RFP Section 4, Performance Standards**, and **Exhibit B, Performance Standards and Discount Guarantees,** of the proposed contract.

2.2.2 Pharmacy Network Service:

a. The PBM is responsible for the delivery of quality prescription drug services to participants through discount arrangements or other financial contracts with participating pharmacies. The PBM must maintain a pharmacy re-credentialing process at least every three years or as otherwise required by URAC or CMS.
b. The PBM is required to maintain a separate credentialing process for specialty and compound pharmacies. The PBM is required to provide an open credentialing process for specialty network without unnecessary restrictions such as limited application period, licensed in at 50 states, etc.
c. The PBM is required to provide on-line access to a directory of participating pharmacies, including their names, addresses and telephone numbers. Participating pharmacy information must be regularly maintained and updated.
d. The PBM agrees to notify MDFA staff at least 60 days in advance regarding termination of a current pharmacy chain or independent pharmacy. PBM agrees to also notify impacted participants within 15 days of termination.
e. The PBM must include independent pharmacies in the proposed retail network and all guarantees proposed are inclusive of independent pharmacies.

2.2.3 Communication Materials/Forms:

The PBM, at its own cost, is responsible for designing, printing, and distributing brochures, preferred drug lists, and forms, cobranded, and with the Board's approval, as necessary and required to establish and administer pharmacy services and programs. Communication materials/forms will be mailed to participants, employer units, and the Board.

2.2.4 Identification Cards:

The PBM, at its own cost, must provide routine distribution of ID cards, including printing, mailing, and postage. The PBM, at its own cost, will provide ID cards directly to the

participant's home address for (1) the initial enrollment of the Plan, (2) future new enrollees, (3) participants who change coverage category (e.g. single to family), and (4) replacement of lost cards. Participants with single coverage should receive one (1) ID card; participants with dependent coverage should receive at least two (2) ID cards. The information to be printed on each ID card will include, at a minimum, the participant's name and identification number, Plan name, the PBM name and toll-free customer service telephone number.

2.2.5 Claims Processing Services:

a. The PBM's claims processing services must include, at a minimum, verification of eligibility, review of claims in accordance with the Plan benefits, receipt, processing, adjustment, and authorization of claim payments and provision of claim forms.
b. The PBM must maintain, at a minimum, the following information for all claims: participant name, participant identification number, patient name or other specific identifier, claim number, pharmacy number, pharmacy name, service date, mail/retail indicator, formulary flag, specialty indicator, ingredient cost, dispensing fee, sales tax amount, plan paid amount, copayment amount, NDC, and drug name.
c. The PBM must be able to accommodate multiple plan designs such as the Plan's current Base Coverage and Select Coverage as described in the 2024 Plan Document (https://knowyourbenefits.dfa.ms.gov/publications/), and must be able to process claims with a deductible that is integrated with the medical plan deductible (i.e. Base Coverage).
d. The PBM must adjudicate all claims according to "lowest of" logic such that participants and the Plan pay the lowest cost of the contracted price or the pharmacy's usual and customary amount (including the pharmacy's sale price, if any). PBM will not be allowed to adjudicate claims based on 'zero balance logic" or on a minimum copayment amount, and retail pharmacies will not be allowed to collect a minimum payment.
e. Any pharmaceutical provider tax is to be paid by the PBM.

2.2.6 Federal Reporting:

As required by Federal law, the PBM, after discussions and negotiations with the Board, will prepare and file reports required by the Federal Government.

2.2.7 Coordination of Benefits:

The PBM is responsible for providing coordination of benefits (COB) services. The TPA provides information regarding a participant's COB status to the PBM. The PBM must reject primary payment for participants for whom the Plan is secondary and must provide for secondary payment of prescription drug claims submitted, either electronically or by submission of a hard copy claim form to be obtained from the PBM. Benefits for secondary claims, are based upon the allowable charge, less the amount paid by the primary carrier, less the applicable copayment for that prescription drug. Any additional cost for this service must be included in the financial proposal.

2.2.8 Quality Control:

The PBM is responsible for quality control processes to regularly evaluate the performance and accuracy of the claims processing systems and the claims processing staff. Findings of quality control evaluations will be provided to the Board quarterly.

2.2.9 Appeal Resolution:

The PBM must provide an appeal process for claims partially or fully denied for payment upon the request of a participant or provider in accordance with guidelines outlined in the Plan Document at no extra cost to the Board. All appeal processing (e.g. first, second, and third/IRO level appeals) is to be provided by the PBM at no additional cost.

2.2.10 Prior Authorization Program:

The PBM must provide prior authorization services to promote cost management while ensuring that participants can access needed prescription drugs. The prior authorization program must use evidence-based guidelines and the latest clinical literature and outcomes data, as well as FDA guidelines. The PBM will advise the MDFA regarding those drugs for which the Plan may benefit by requiring prior authorization for coverage. The PBM's staff, under the supervision of clinical pharmacists, will review participant prescriptions for those drugs requiring prior authorization and/or medical necessity review in accordance with criteria, definitions and procedures developed by the PBM. The Board shall require prior authorization on drugs at its discretion.

2.2.11 Management Reporting:

The PBM must provide management reports, with content and in a format approved by the Board, at no additional charge. These reports will be provided, at the Board’s request, in a hard copy and/or electronic format. The PBM must provide assigned MDFA staff access to web-based reporting tools for management and other reports. The PBM shall have the capability of providing ad hoc reports at the Board's request.

2.2.12 Drug Utilization Review (DUR):

The PBM is required to provide a concurrent, prospective and retrospective DUR system to assist pharmacy providers in screening certain drug categories for clinically important potential drug therapy problems at the time the prescription is dispensed to the participant. The DUR program must provide an evaluation of drug therapy before each prescription is filled by means of an online, real-time, electronic point-of-sale claims management system. Evaluation must include, at a minimum, monitoring for therapeutic appropriateness, over-utilization and under-utilization, appropriate use of generic products, and screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug interactions, incorrect drug dosage or duration of drug treatment, physician profiling, and clinical abuse/misuse and, as necessary, introduce remedial strategies in order to improve the quality of care of the participant.

2.2.13 Step Therapy:

The PBM is required to provide a step therapy program designed to optimize rational drug therapy while controlling costs by defining how and when a particular drug or drug class should be used based on a patient's drug history.

2.2.14 Dosage Optimization:

The PBM is required to provide a dose optimization program designed to slow the rising cost of prescription drugs and help increase patient compliance with drug therapies. As part of the dose optimization program, the PBM must work with the participant, the health-care provider and pharmacist to replace multiple doses of lower strength drugs with a single dose of higher-strength drugs where appropriate.

2.2.15 Medication Adherence Program:

The PBM is required to provide a comprehensive pharmacy care program to improve medication adherence for participants with chronic conditions. As part of the medication adherence program, the PBM will provide telephonic coaching that will involve calls to participants from a health educator who is specially trained in chronic conditions. The calls will involve coaching participants on behavioral reinforcement strategies that will help them to continue taking their medications on schedule; calls will also include specially tailored education for the chronic condition. Doctors will receive written educational information on the rates of medication adherence, implications of non-adherence, and methods for improving adherence. Doctors will also receive alerts on participants who are not filling their medication prescriptions.

2.2.16 Quantity Limits:

The PBM is required to provide a limitation program for drugs which are indicated only for a specific therapeutic period or are limited to certain amounts. If, based on on-line adjudication, the quantity of a covered drug is not approved by the PBM, the prescribing physician must be allowed to contact the PBM for prior approval of additional quantities based on documentation of medical necessity.

2.2.17 Early Refill:

The PBM is required to process requests from participants, pharmacists, and providers for early refills or advance supplies of a medication due to vacations, dosage changes, or for lost or destroyed medication according to allowance per plan design.

2.2.18 Website:

The PBM will develop and maintain a searchable public website that is accessible to participants and providers. The website contains at a minimum:

a. A current provider directory
b. Ability to conduct a zip-code based pharmacy proximity search
c. Claim forms (Participant submitted paper claim forms) for both primary and secondary coverage
d. On-line mail order refill capabilities

e. Mail order forms
f. Formulary or preferred drug list
g. Total Drug Cost (participant and Plan payment) as well as alternative drug price check functionality
h. Research drug interactions, side effects, and risks of drugs
i. Determine the availability of generic substitutions
j. Health/wellness information

2.2.19 Field and Desk Audits:

The PBM shall conduct regular pharmacy field and desk audit services and the PBM must provide quarterly reports of audit activities and findings. Any errors will be addressed and corrected in a timely manner by the PBM. Any amounts recovered due to a field or desk audit will be 100% refunded to the Board no more than 45 days of the finding. The PBM is required to notify the Board of any provider termination resulting from an audit along with the reason for termination.

2.2.20 Specialty Medication and Supplies:

a. The PBM is required to provide an open Specialty Network for prescription fulfillment and distribution of specialty medications and supplies, pharmaceutical care management services, customer service, utilization and clinical management, integrated reporting, and claims processing. The specialty medication program must include, at a minimum, patient profiling focusing on the appropriateness of specialty medication therapy and care, and the prevention of drug interactions. The program must also include patient education materials, patient monitoring, adherence programs, and compliance programs. Programs such as drug utilization review, drug limitation (step therapy, quantity and supply limits) and prior authorization services must be extended to the specialty medication program. Channel distribution (retail, specialty, mail pharmacy) must be optimized for plan and participant savings.
b. The Specialty Network must open and comply with the State's "any willing provider" statutory requirements (Section 83.9.6 subs 3(b)). Note: An exclusive central fill distribution channel is not acceptable.
c. Specialty medications must be deliverable to the participant's residence or the participant's physician's office. The PBM must provide to participants a toll-free telephone access to a registered nurse, pharmacist, or patient care coordinator (as appropriate) twenty-four (24) hours per day, seven (7) days per week.
d. The Specialty Pharmacies must be properly licensed, certified or credentialed to operate in the applicable states where dispensing specialty operations reside.
e. The Specialty Pharmacies must collect copayments for specialty mail order services with no balance billing of unpaid copayments allowed.
f. The PBM must provide an overall specialty discount guarantee for those drugs dispensed through the exclusive specialty drug program in addition to a claim by claim, the greater of will apply.
g. The PBM agrees during the life of the contract no new therapeutic classes will be added to the specialty drug list without written consent of the State.
h. The PBM will adjudicate all specialty claims at the lesser of: (a) the contracted discount plus dispensing fee or (b) MAC plus dispensing fee.

i. The PBM will guarantee Retail/Specialty unit cost equalization meaning that Specialty unit costs for medications dispensed at non-retail specialty pharmacies prior to participant cost sharing, and dispensing fees will be no greater than the unit cost for the same NDC-11 at Retail.
j. The PBM will produce a date-sensitive comparison report showing unit costs charged to the State at a GCN-level and reimburse the State on a dollar-for-dollar basis for all instances where Specialty unit costs exceed retail unit's costs. Report and reconciliation will be provided on a quarterly basis, without a request being made by the State.
k. The Board may add or remove a drug from the specialty list at its sole discretion.

2.2.21 Mail Order Services:

a. The PBM must make available a mail order prescription drug program to process and dispense covered prescription drugs. Programs such as drug utilization review, drug limitation, and prior authorization services must be applied to mail order services and must be consistent with the retail channel.
b. The PBM's mail order service must provide to participants toll free telephone access to a pharmacist and customer service representative twenty-four (24) hours per day, seven (7) days per week.
c. The PBM will guarantee that discounts provided on mail order claims should meet or exceed those of retail.
d. In no event shall the cost of mail order medications (Plan or participant cost) be more than retail. Mail order is expected to save the Plan and will be monitored accordingly.

2.2.22 Individual Utilization Tracking Report:

The PBM must be capable of providing an annual on-line utilization tracking report to each participant utilizing the prescription drug program. The purpose of the annual utilization tracking report is not only to provide the participant with a complete list of prescription drugs processed through the prescription drug program, but to educate the participant regarding potential savings based on therapeutic and generic substitutions, dosage optimization, etc. At a minimum, the utilization tracking report should include:

a. Name and Address of PBM
b. Toll Free Number for PBM
c. Participant's Name and Address
d. Participant's Identification Number
e. Patient's Name
f. Provider Name
g. Claim Date of Service
h. Type of Service
i. Total Charges
j. Discount Amount
k. Allowed Amount
l. Excluded Charges
m. Amount Applied to Deductible
n. Copayment or Coinsurance Amount
o. Total Patient Responsibility
p. Total Payment Made and To Whom

2.2.23 Rebates:

a. The Board shall be entitled to receive the greater of: (1) the guaranteed minimum per claim rebate amount, or (2) 100% of all rebates, as defined by this RFP, paid by pharmaceutical manufacturers or intermediaries or other similar sources attributable to the Board's utilization that the PBM receives from any and all pharmaceutical manufacturers or intermediaries or other similar sources. These sources may include, but will not be limited to, market share incentives; promotional allowances; commissions; educational grants; Inflation protection; implementation allowances; clinical detailing; or rebate submission fees. The intermediary will pay the PBM 100% of the rebates it receives that are directly attributable to prescription drug claims paid by the Board, allowing the PBM to pay the Board 100% of the rebates collected, regardless of who collected them (the PBM or the intermediary). The Board shall have full unrestricted audit rights to ensure compliance by the PBM and its intermediary with transparency and rebate submission requirements. The PBM must ensure that, to the extent that the Plan's prescription drug purchases are included, any agreement the PBM now has, or subsequently enters into with an intermediary for rebate collection, contain sufficient language to provide the Board free and direct audit access to the financial records, claims data, remittance data, contracts (e.g. pharmacy network, pharmaceutical manufacturer, etc.), reports and other information required by the Board to verify that the Transparency requirement is being met by the PBM and the intermediary. Any fees or cost associated with rebates administration should be included in the PBM's bundled administration fee.
b. The PBM will offer price or inflation protection guarantees.
c. The PBM must pass through price protection received from manufacturers through rebates to the Plan and shall be reported to the Plan quarterly.
d. The PBM will provide an NDC level report on earned rebate dollars and all ancillary fees paid by pharmaceutical manufacturers for medications dispensed for the Plan in addition to the monthly and annual reconciliation reports.
e. The PBM must provide rebate reporting by therapeutic category and by manufacturer on a quarterly basis and down to the NDC level.
f. The PBM will charge one overall administrative fee for all pharmacy services which shall include, but not be limited to, fees for rebate management, retail management, formulary management, and network management.
g. Manufacturer coupons or copay card programs cannot be used or included in the calculation of any rebate guarantees. Savings generated by coupon or copay shall not be used in calculating rebate guarantees. However, in the event a participant utilizes a copay or discount card in addition to their Plan benefits, any savings earned are to be passed back to the Board at 100% of the total value of the rebate or manufacturer reimbursement payments.

2.2.24 Transparency:

a. The Board requires absolute transparency and full pass through of all revenue, whether rebates or not, by the PBM and from the aggregator and/or GPO that the PBM contracts with. All revenue, no matter the form or what it is called or where it comes from, must pass through the Plan.

b. The Board must have a transparent financial pricing arrangement from the PBM. "Transparency" refers to financial arrangements which represent a direct and complete pass-through of all elements of financial payments. The Board must receive the full and complete amount of any discounts received by the PBM from any and all retail pharmacies. The PBM will not retain a differential (i.e. spread) between the amount reimbursed to the PBM by the Board for each transaction and the payments made to the retail pharmacies by the PBM.
c. The Board will not apply the above standard to mail order or specialty pharmaceutical transactions when owned by the PBM. For these mail order or specialty pharmaceuticals, the Board will accept the best possible discount arrangements from the PBM as it relates to discounts from AWP. Rebates generated through mail order and/or specialty pharmaceuticals will be subject to the transparency requirement described herein.
d. The only compensation the PBM will receive, attributable to the Plan's utilization shall be from or on behalf of the Board, for the services described in this proposal or any subsequent contract, shall be the PBM's quoted administrative fees listed in the PBM's proposal or agreed upon in writing through subsequent discussion with the Board.
e. The PBM agrees to disclose details of all programs and services generating financial remuneration from outside entities.

2.2.25 Full Disclosure and Independent Review:

The Board must have access to all of the PBM, aggregator, and/or GPO's financial records including the Maximum Allowable Cost (MAC) list used to adjudicate the Plan's claims, claims data, remittance data, contracts (e.g. pharmacy network, pharmaceutical manufacturer, etc.), reports and other information required by the Board to verify that the transparency requirement is being met by the PBM, aggregator, and/or GPO during the period covered by the contractual term. Full disclosure as used herein would include, but not be limited to, auditing the following types of financial arrangements:

a. Any amount paid for the Plan by the PBM, aggregator, and/or GPO to retail pharmacies under contract with the PBM, aggregator, and/or GPO's retail network is subject to audit even though the PBM, aggregator, and/or GPO may deem said contracts proprietary and confidential;
b. Rebates or any other monies or fees, which include administrative fees, paid to the PBM, aggregator, and/or GPO by pharmaceutical manufacturers are subject to review for audit purposes;
c. Any amount paid for the Plan by the PBM, aggregator, and/or GPO to a mail order or specialty pharmacy, when not owned by the PBM, aggregator, and/or GPO, will be subject to audit, whether or not the contract is considered proprietary and confidential by the PBM, aggregator, and/or GPO;
d. Discounts negotiated directly by the PBM, aggregator, and/or GPO with manufacturers shall be subject to audit; and
e. Aggregate rebate collecting, reporting, and contractual arrangements.

The Board, at its discretion, may use the services of an independent reviewer to perform reviews/audits of the PBM, aggregator, and/or GPO's records on behalf of the Board. The Board and its independent reviewer will comply with all applicable confidentiality laws and will not reveal any confidential information acquired as a result of the review/audit.

The Board has the right to review/audit records for the entire term of the agreement without limitation up to two times per calendar year. Any claims information, documents, etc. which the PBM, aggregator, and/or GPO may deem as containing "trade secrets" will not preclude an examination of such items through the audit process. The PBM, aggregator, and/or GPO will provide the Board assistance in the audit reviews by providing access to records, copies of claims data, access to reasonable support staff, etc. at no cost to the Board. The PBM, aggregator, and/or GPO will cooperate with the independent reviewer and agree to respond to any inquiries by the independent reviewer within the agreed upon schedule. The PBM, aggregator, and/or GPO will, within 60 days of final report being issued by Auditor, complete the final reconciliation and submit any and all reimbursement to the Plan. The PBM, aggregator, and/or GPO will not restrict the size of the claims sample reviewed by the independent reviewer which may include a review of 100% of all claims for the period under review. The Board will bear the cost of any fees charged by its independent reviewer.

2.2.26 Market Checks:

The Board may perform, or have performed on its behalf, following the twelfth (12th) month of the effective date services being provided and annually thereafter, a market check or an assessment of market conditions, pharmaceutical pricing, dispensing fees, and any other matters, services, or price drivers pertaining to this contract to determine if the terms of the contract are competitive with the then current market conditions. The market check will be allowed annually for the life of the contract.

If the Board or its designee provides the PBM with a written report conducted by a third party audit firm that takes into account, in the aggregate, the general plan design, formulary, clinical and trend programs utilized by the Board, participating network, utilization, and demographics for generally comparable plans that indicate a 1% or greater savings, the PBM will have the opportunity to respond, within thirty (30) days of receipt of the third party auditor market assessment, with a proposed amendment to the contract for new pricing terms that are mutually agreed upon and implemented no later than sixty (60) days after the third party audit firm report is completed and provided to the PBM. If the parties cannot come to agreement on the new terms, the Board reserves the right to terminate the contract with 120 days advance notice without penalty.

2.2.27 Formulary Management:

a. The PBM must administer all the provisions outlined in the 2024 Plan Document (https://knowyourbenefits.dfa.ms.gov/publications/).
b. The PBM must adhere to, develop and administer an evidence and value-based formulary program including ongoing pharmacy and therapeutics committee review and maintenance.
c. The PBM must provide a customizable formulary which provides access to clinically effective medications at the lowest net cost.
d. The PBM agrees that drugs will not be excluded from coverage unless required by FDA or the plan sponsor. The Board reserves the right to add or exclude medications from the formulary.

e. The PBM must provide plan design, clinical and utilization management program and formulary modeling service at no charge.

2.2.28 Manufacturer Coupons/Patient Assistance Programs:

a. The PBM agrees to have programs in place to counter the use of manufacturer's coupons/patient assistance programs that promote the dispensing of higher cost brand name drugs when a lower cost generic or alternative is available.
b. The PBM will administer a variable copayment plan design to leverage available specialty drug manufacturer patient assistance programs and is compatible with HDHP.
c. The PBM's variable copayment plan design, if selected, will be in place for the life of the contract.

2.2.29 Data Transfers and File Maintenance Requirements:

a. The PBM will receive updated eligibility information from the Board's TPA based on the current specifications. It is the PBM's responsibility to coordinate the data transfer with the Board's TPA to ensure an efficient and accurate process. The PBM is also responsible for the electronic transfer of prescription drug claim information to the Board's TPA for purposes of coinsurance maximum, out-of-pocket limit, and deductible accumulation.
b. The PBM is responsible for the electronic transfer of prescription drug claim information to the Board's health management vendor.
c. The PBM is responsible for the electronic transfer of prescription drug claim information to the Board's decision support services vendor.
d. The PBM is responsible for the electronic transfer of prescription drug claim information to the Board's Utilization Management Vendor.
e. The Board may request up to five (5) additional data transfers during the life of the Contract at no additional cost.

2.3 Data Management:

2.3.1 Provide to Board staff read-only access to its claims processing and eligibility system, which must include, at a minimum, review of participant claims history and participant eligibility information.

2.3.2 Provide to Board staff read-only access to its participant website with a dummy login prior to the go-live date.

2.4 Claims and Performance Reviews:

The Board, at its own expense, contracts with an independent third-party vendor to conduct claims and performance reviews of the PBM, aggregator, and/or GPO. In addition, the operations of the PBM, aggregator, and/or GPO relative to the Plan are included in annual audits conducted by the State Auditor's Office or its designee. The PBM, aggregator, and/or GPO agrees that upon at least two (2) business days' notice by the Board to the PBM, aggregator, and/or GPO, the Board has the right to audit all records maintained by the PBM, aggregator, and/or GPO relative to the PBM, aggregator, and/or GPO's performance. The Board maintains the right to perform financial,

performance and other special audits on records maintained by the PBM, aggregator, and/or GPO during regular business hours. The PBM, aggregator, and/or GPO will make available all records, as defined by the selected auditor, for review at no cost to the Board. This does not preclude the auditing of other services or additional claims. Any errors detected via the audit will be addressed and corrected in a timely manner by the PBM, aggregator, and/or GPO. Any claim processing error will be adjusted to the proper account and savings from errors will be reimburse to the Plan at 100%.

The PBM must provide the Board with a current annual SOC or similar audit report.

2.5 Standard/Ad Hoc Reporting

The Vendor must furnish standard reports in a form and content approved by the Board. These reports will be provided, at the Board's request, in electronic media format, as well as hard copy if requested by the Board. The Vendor shall provide web-based reporting tools that allow the Board to view, print, and download reports to spreadsheet software. All reports must include report parameters and definitions. Report parameters/definitions must be revised as appropriate when revisions to the report scope occur.

Additionally, the Vendor will provide ad hoc reports at the Board's request. The Vendor shall provide the Board, for the Board's approval, the time and cost for the development of ad hoc reports prior to the development of the report.

All other reports are to be performed and provided as stated in **Exhibit B, PBM Services Vendor Reports**.

2.6 Cooperation with Other Board Vendors

The Vendor will cooperate as required with the Board's other contracted vendors and will work with other vendors to facilitate the provision of the on-going coordination and delivery of services, and in any transfer of responsibility.

SECTION 3. MINIMUM VENDOR REQUIREMENTS

The following minimum vendor requirements are mandatory. Failure to meet any of these requirements will result in disqualification of the proposal submitted by your company. Please respond by restating each minimum requirement, including the number listed below with documentation that proves specifically how your company meets that minimum criterion. **Note that for the purposes of fulfilling the minimum vendor requirements, except as otherwise indicated, "PBM" refers to the primary contracting vendor only, not including any proposed subcontractors.** Please include in your responses the total number of years and types of experience of your company. If, in the opinion of the procurement team, you fail to prove that your company meets any of these minimum requirements, the proposal will be disqualified from further evaluation. If this happens, you will be notified of the decision and will have an opportunity to provide additional information to prove your company does meet the minimum requirements. It is incumbent upon the disqualified vendor to respond timely and completely to any such notice as unreasonable delays and/or non-responsive submissions may result in the disqualification being upheld without further review.

3.1 **References:** References provided by the company must be familiar with the Vendor's abilities in the areas involved with this solicitation. MDFA staff will use these references to determine the Vendor's ability to perform the services. It is the responsibility of the Vendor to ensure that the reference contact information is correct and current. MDFA staff will not track down references. Vendors should verify before submitting their proposal that the contact information provided is correct for each reference. Client references that cannot be contacted for verification will not be considered. The determination of the length of time an entity has provided these services will be based upon the initial date the Vendor established a contractual relationship to provide such services.

For each client provided pursuant to **Subsections 3.1.1 through 3.1.6,** please specify:

a. Client contact information, including the name, title, address, email address, and phone number of a person whom we may contact to confirm as needed,
b. The specific type of work your company provided to the client,
c. The number of covered lives in the client's group and/or size of the account,
d. Contract effective dates (beginning and end dates) for the time period(s) your company provided services to the client.

If two or more of the following reference requirements are met by the same client, list additional clients so there are at least three (3) clients listed for each section. If you are unable to provide three (3) clients for each reference, provide as many as you have and indicate in the response additional references meeting this requirement are not available.

3.1.1 The proposing vendor must possess at least eight (8) years' experience **as of November 1, 2024**, as an organization providing the equivalent or similar in type, requirements, and scale to those required in this RFP. The proposing vendor must provide sufficient detail to demonstrate it has the minimum required experience in working with programs similar in type, size, and complexity to the Plan by providing client reference(s).

3.1.2 The proposing vendor must provide services to at least one million (1,000,000) covered lives in its book of business as of **November 1, 2024**. The proposing vendor must provide sufficient detail to demonstrate it has significant experience in working with programs

similar in size and complexity to the Plan, such providing a list of sufficient clients, including all requested information per client listed, to document the vendor provides within the total book of business the relevant services to at least 1,000,000 covered lives.

3.1.3 The proposing vendor must provide services to one (1) employer client with at least one hundred thousand (100,000) covered lives as of **November 1, 2024**. The proposing vendor must provide sufficient detail to demonstrate it has significant experience in working with programs similar in size and complexity to the Plan.

3.1.4 List up to three (3) clients for whom your company has provided services similar to those requested in this RFP. One (1) of the three (3) must be the longest standing client and one (1) must be the client with the largest employee population.

3.1.5 List at least three (3) governmental clients for whom your company has provided one or more of the services requested in this RFP.

3.1.6 List of all clients that have discontinued use of your company's services in the past five (5) years and your understanding for their discontinued use of your services.

3.2 The proposing vendor must provide a dedicated (but not necessarily exclusive) **account manager**, to participate in activities relative to all aspects of the Contract between the Board and the PBM, and to meet with MDFA staff on a quarterly basis to review Plan utilization, attend the Board's meetings (if requested), make recommendations regarding services and/or programs on a quarterly basis, and discuss performance, address administration issues and review reports. The proposing organization must provide sufficient detail to demonstrate the proposed individual meets this requirement via resumes as an appendix to your proposal in Section 11. Please confirm.

3.3 The proposing vendor must provide a dedicated and exclusive **clinical pharmacist** to advise, consult, and participate in activities relative to all aspects of the Contract between the Board and the PBM. Duties of the clinical pharmacist will include, but are not limited to, reducing wasteful spending through analysis and provider education, providing advice regarding drugs for which the Plan may require prior authorization for coverage, notification of blockbuster or pipeline drugs, FDA approval of new drugs, and education regarding therapeutic substitutions. The clinical pharmacist will be provided office space within the MDFA OI and must reside in the State of Mississippi to participate in employer health/benefit fairs and visit physician offices and pharmacies to discuss the preferred drug list, use of generics, prescribing and utilization patterns, and educate the provider community on the most up-to-date drug therapies. Though not an employee, nor under the direct supervision of the State, the clinical pharmacist will be expected to be physically present in the MDFA OI office during normal business hours to facilitate direct access by Board staff, except when offsite fulfilling other duties for the Plan. PBM must provide computer and other necessary equipment. The proposing organization must provide sufficient detail to demonstrate the proposed individual meets this requirement via resumes and license as an appendix to your proposal in Section 11. Please confirm.

3.4 The proposing vendor must agree that all services performed must be provided (performed) within the United States. Please confirm.

3.5 The proposing vendor must comply with Mississippi Code Annotated § 25-15-301(6) below. Please confirm.

"Any corporation, association, company or individual that contracts with the board for the administration or service of the self-insured plan shall remit one hundred percent (100%) of all savings or discounts resulting from any contract to the board or participant, or both. Any corporation, association, company or individual that contracts with the board for the administration or service of the self-insured plan shall allow, upon notice by the board, the board or its designee to audit records of the corporation, association, company or individual relative to the corporation, association, company or individual's performance under any contract with the board. The information maintained by any corporation, association, company or individual, relating to such contracts, shall be available for inspection upon request by the board and such information shall be compiled in a manner that will provide a clear audit trail."

3.6 The proposing vendor must comply with Mississippi Code Annotated § 79-4-15.01 regarding authorization to transact business in Mississippi. Please confirm.

3.7 **Implementation Guarantee:** The proposing vendor must agree to provide a One Million Dollars ($1,000,000.00) **Implementation Bond or Escrow Account**, naming the Board as exclusive beneficiary, to guarantee timely and complete establishment of the Contract and related services. Such bond or escrow account must be obtained or established within thirty (30) days of contract award. The bond shall be a corporate surety bond issued by a surety company authorized to do business in the State of Mississippi; while an escrow account is subject to approval by agency legal counsel. Any failure of the PBM to perform timely and complete establishment of such services shall result in damages recoverable by the Board against the implementation bond or escrow account. This requirement will not apply if the incumbent PBM Vendor with services established under the current contract is selected through this procurement process to enter negotiations for the new contract. Upon the agreement by the Board that the PBM has complied with its implementation responsibilities, the implementation bond shall be released. Please confirm.

3.8 The proposing vendor must agree to provide and maintain, throughout the term of the Contract, at its own expense, **Professional Liability** insurance that covers any damages caused by an error, omission or any negligent acts related to the services to be provided under this Contract. Such policy of insurance shall provide a minimum coverage in the amount of One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annual aggregate issued by an insurance company authorized to do business under the laws of the State of Mississippi, meaning the insurance carrier must be licensed or hold a Certificate of Authority from the Mississippi Insurance Department. The Board must be named as Certificate Holder on the policy. The PBM shall annually provide the Board a current Certificate of Insurance. Please confirm.

3.9 The proposing vendor must agree to provide and maintain, throughout the term of the contract, at its own expense, a One Million Dollars ($1,000,000.00) **Employee Dishonesty or Fidelity Bond** with third party liability coverage and with the Board named as exclusive beneficiary for the duration of the Contract. Pursuant to such bond, any losses incurred by the Board due to theft or dishonesty of a PBM Vendor employee shall be fully reparable to the Board. The PBM shall be responsible for procuring any such recovery and reimbursing the Board accordingly. Insurance policy shall be issued by an insurance company authorized to do business under the laws of the

State of Mississippi, meaning the insurance carrier must be licensed or hold a Certificate of Authority from the Mississippi Insurance Department. Please confirm.

3.10 The proposing vendor must agree to provide and maintain, throughout the term of the Contract, at its own expense, **Cyber Liability** insurance. Such policy of insurance shall provide a minimum coverage in the amount of Two Million Dollars ($2,000,000.00). Coverages must include security and privacy liability, incident response expenses, business interruption, business interruption waiting period, data recovery, regulatory proceedings, and cyber extortion. Insurance policy shall be issued by an insurance company authorized to do business under the laws of the State of Mississippi, meaning the insurance carrier must be licensed or hold a Certificate of Authority from the Mississippi Insurance Department. The Board must be named as Certificate Holder on the policy. The PBM shall annually provide the Board a current Certificate of Insurance. Please confirm.

3.11 The proposing vendor must agree to adjudicate all claims incurred up to twelve (12) months prior to the effective date of the contract as well as any claims processed by Medicare or Medicaid for which the Plan receives a demand notice for payment regardless of the incurred date.

3.12 The proposing vendor must agree to adjudicate and process all claims with service dates prior to the termination date of the contract that are received by the PBM for one (1) year after the termination date with claim payments funded by the Board in accordance with the terms and conditions of the terminated contract. Please confirm.

3.13 The Plan shall receive 100% of any and all rebates received by the PBM attributable to the Board's utilization of any medications. Rebates are defined as any compensation or remuneration of any kind received or recovered by the PBM, or any of its affiliates from a pharmaceutical manufacturer or intermediary attributable to the purchase or utilization of covered drugs by Plan participants, including, but not limited to, incentive rebates discounts; credits; regardless of how categorized; market share incentives; promotional allowances; commissions; market share of utilization; clinical detailing; rebate submission fees; and administrative or management fees. Rebates also include any fees that PBM, or any of its affiliates, receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access. Any fees or cost associated with rebates administration should be included in the PBM's bundled administration fee. Please confirm.

3.14 The Board must receive the greater of: (1) the guaranteed minimum per claim rebate amount, or (2) 100% of all rebates, as defined by this RFP, paid by pharmaceutical manufacturers or intermediaries or other similar sources attributable to the Board's utilization that the PBM receives from any and all pharmaceutical manufacturers or intermediaries or other similar sources. These sources may include, but will not be limited to, market share incentives; promotional allowances; commissions; educational grants; inflation protection; implementation allowances; clinical detailing; or rebate submission fees. The intermediary will pay the PBM 100% of the rebates it receives that are directly attributable to prescription drug claims paid by the Board, allowing the PBM to pay the Board 100% of the rebates collected, regardless of who collected them (the PBM or the intermediary). The Board shall have full, unrestricted audit rights to ensure compliance by the PBM and its intermediary with transparency and rebate submission requirements. The PBM must ensure that, to the extent that the Plan's prescription drug purchases are included, any agreement the PBM now has, or subsequently enters into with an intermediary for rebate

collection, contain sufficient language to provide the Board free and direct audit access to the financial records, claims data, remittance data, contracts (e.g. pharmacy network, pharmaceutical manufacturer, etc.), reports and other information required by the Board to verify that the transparency requirement is being met by the PBM and the intermediary. Any fees or costs associated with rebates administration should be included in PBM's bundled administration fee. Please confirm.

3.15 The proposing vendor must agree to perform all services required in this RFP in accordance with customary and reasonable industry standards as well as in strict conformance to all laws, statutes, and ordinances and the applicable rules, regulations, methods and procedures of all government boards, bureaus, offices, and other agents whether currently in place, updated and replaced, or newly created. The proposing vendor shall be responsible for the complete performance of all work; for the methods, means, and equipment used; and for furnishing all materials, tools, apparatus, and property of every description used in connection therewith. No statement within this RFP shall negate compliance with any applicable governing regulation. The absence of detail specifications or the omission of detail description shall be recognized as meaning that only the best commercial practices are to prevail, and that only first quality materials and workmanship are to be used. Please confirm.

SECTION 4. PERFORMANCE STANDARDS

Please respond by restating each performance standard listed and confirm your agreement to be bound by this standard by stating, "*Confirmed*". If your company has exceptions to the standard, respond by stating, "*Confirmed, but with exceptions*" and include your exceptions in **Section 5, Statement of Compliance and Exception(s) form**. If your company cannot agree to the standard, respond by stating, "*Do Not Agree*" and include your reason for not agreeing in **Section 5, Statement of Compliance and Exception(s) form**.

The PBM must agree to the following minimum performance standards and applicable liquidated damages. At the Board's discretion, an audit of the accuracy of the PBM's results will be performed via a randomly selected, statistically verifiable sample of claims by a qualified, independent third party. The results of the audit after appropriate review and comment by the PBM will be the final determinant of performance standard compliance. When sampling methods are used to estimate performance for the universe of claims, audit samples will be large enough to ensure a confidence interval whose deviation is no greater than plus or minus three percent (3%) and whose confidence level is at least ninety-five percent (95%). The Board will consider the point estimate for the sample as the PBM's performance level in calculating liquidated damages.

The Board reserves the right to reduce or waive any fees at risk if, in the Board's sole discretion, failure to meet a performance standard was due to extraordinary circumstances.

All payments made on behalf of the Board for approved services, shall be in accordance with rules, regulations, and restrictions of the Board and the laws of the State of Mississippi. The PBM shall identify claims that have been incorrectly processed and initiate appropriate action to correct processing outcomes. The PBM shall notify OI in writing immediately upon discovery of any systems problem that has caused multiple overpayments, duplicate payments, or incorrect payments, irrespective of cause, prior to initiating recovery or corrective action. The PBM shall notify OI by letter of any system errors that result in a potential overpayment or other incorrect payment and describe in detail the plan and deadlines for corrective action.

PERFORMANCE GUARANTEES

It is the intent of the Board to assess liquidated damages to any PBM vendor who fails to meet the minimum performance standards listed below. The final contract between the Board and the PBM vendor will incorporate the specific terms and conditions under which such damages may be assessed, including the measurement methodology, amounts, and recovery provisions. Unless otherwise agreed to in writing, an independent claim reviewer/performance auditor contracted by the Board will evaluate the PBM vendor's compliance with these standards. Any objections, suggestions, or proposed conditions you have to these standards and this process should be included in your signed Statement of Compliance and Exception(s) form (Section 5).

The following performance standards and discount guarantees will apply separately to each year of the resulting contract. These metrics are specific to the State and calculations should not include the PBM's BoB experience.

Performance Standard Topic	Description of Standard	Guarantee	Amount at risk
1. Pharmacy Network Access	95% of all participants within 5 miles of 1 participating pharmacy Notify MDFA staff at least 60 days in advance regarding termination of a current pharmacy chain or independent pharmacy as well as notify impacted participants within 15 days of said termination		$25,000 Annually $25,000 Annually
2. Network Pharmacy POS Compliance	99% of time internal on-line system available		$20,000 Quarterly
3. Retail Paper Claims Processing Time	95% of prescriptions reimbursed or responded to within 15 business days of receipt		$20,000 Quarterly
4. Retail Claims Financial and Processing Accuracy	99.5% of all claims paid with NO errors (i.e. correct drug, correct form, correct strength, correct patient, correct AWP, correct copayment, or correct deductible). Retail claims adjudication accuracy is the total number of retail claims paid correctly divided by the total number of retail claims paid. The PBM will maintain an internal audit process to quarterly self-report the results.		$20,000 Quarterly
5. Mail Order Claims Processing Time	95% of prescriptions requiring NO intervention to be shipped within 2 business days (as measured from date order received at the PBM to date order shipped) 95% of prescriptions requiring administrative or clinical intervention to be shipped within 5 business days (as measured from date order received at the PBM to date order shipped)		$20,000 Quarterly $20,000 Quarterly
6. Mail Order Claims Financial and Processing Accuracy	99.5% of all claims paid with NO errors (i.e. correct drug, correct form, correct strength, correct patient, correct AWP, correct copayment, or correct deductible). Mail order claims adjudication accuracy is the total number of mail order claims paid correctly divided by the total number of mail order claims paid.		$25,000 Quarterly
7. Rebate Remittance Time	100% of all rebate dollars remitted to the Board within 60 days of the rebates being received by PBM. The Board must receive the greater of: (1) the guaranteed minimum per claim rebate amount, or (2) 100% of all rebates, as defined by this RFP, paid by pharmaceutical manufacturers or intermediaries or other similar sources attributable to the Board's utilization that the PBM receives from any and all pharmaceutical manufacturers or intermediaries or other similar sources. These sources may include, but		$20,000 Quarterly

Performance Standard Topic	Description of Standard	Guarantee	Amount at risk
	will not be limited to, market share incentives; promotional allowances; commissions; educational grants; inflation protection; implementation allowances; clinical detailing; or rebate submission fees. The intermediary will pay the PBM 100% of the rebates it receives that are directly attributable to prescription drug claims paid by the Board, allowing the PBM to pay the Board 100% of the rebates collected, regardless of who collected them (the PBM or the intermediary).		
8. Customer Service	90% of calls answered by a live customer service representative within 30 seconds during open hours <5% of calls abandoned 99% of written inquiries responded to within 10 business days		$5,000 Quarterly $5,000 Quarterly $5,000 Quarterly
9. Account Service	Subjective satisfaction of Board with the contractual and administrative relationship based on mutually agreed satisfaction survey. Conduct at least one (1) customer satisfaction survey within the third quarter of the initial contract period and one (1) annually thereafter. The contents of the satisfaction survey must be agreed upon by the Board and the PBM.		$40,000 Annually $25,000 Annually
10. ID Card Distribution	95% of ID cards mailed within 15 days of receipt of eligibility data (for monthly changes) or request for replacement card Average time to mail ID cards for ongoing eligibility (from the clean eligibility information provided) is ≤ 5 business days		$10,000 Quarterly $5,000 Quarterly
11. Reporting Requirements*	Quarterly reports provided to Board ≤ 30 calendar days after the end of the quarter Quarterly report quality control evaluation findings to the Board ≤ 30 calendar days after the end of the quarter Quarterly report the audit activities and findings of the pharmacy field and desk audit services Quarterly report all pass through price protection received from manufacturers through rebates to the		$10,000 Quarterly $10,000 Quarterly $10,000 Quarterly $10,000 Quarterly

Performance Standard Topic	Description of Standard	Guarantee	Amount at risk
	Plan by therapeutic category and by manufacturer and down to the NDC level Monthly and annual report of all reconciliations Monthly and annual NDC level report on earned rebate dollars and all ancillary fees paid by pharmaceutical manufacturers for medications dispensed for the Plan Annual SOC or similar audit report to the Board		 $1,000 per each day of delay $1,000 per each day of delay $25,000 Annually
12. Written and Telephone Inquiry Response Rate*	98% response within 5 business days + 100% within 7 business days		$10,000 per each 1% below standard Quarterly
13. Data Transfers*	99% of error transactions from the data transfer sent to the PBM will be corrected and returned to the PBM via data transfer within two (2) business days of receipt of the error report. 100% will be corrected and returned with 15 business days.		$10,000 Quarterly $10,000 Quarterly
14. Field & Desk Audit	100% refund of any amounts recovered due to a field or desk audit to the Board no more than 45 days		$1,000 per each day of delay
15. Annual Independent Audit **	Finalize the audit schedule with the Independent Auditor/MDFA during the month of December each year and meet the agreed to deadlines.		$1,000 per each day of delay
16. Annual Independent Audit Reconciliation ***	Within 60 days of final report being issued by the Independent Auditor, the PBM, aggregator, and/or GPO will complete the final reconciliation and remit any and all reimbursement to the Plan.		$50,000 + $1,000 per day after deadline

*The Board will use the PBM's internal reports to measure the PBM's performance relative to the standards included in this table. The PBM's internal reports and/or data (including detailed claims data) supporting the PBM's internal reports may be reviewed/audited by the Board, or at the Board's discretion, by an independent reviewer. The report and determination of the independent reviewer shall be final, binding and conclusive as to an administrative review on PBM and the Board; provided, however, that before a final report and determination is issued, the Board and PBM shall each have a reasonable

opportunity to review the non-proprietary supporting documentation and proposed report of the independent reviewer and to provide any comments to the independent reviewer.

The Board will rely on the collaboration with the successful use proposer and contracted vendor in accordance with **RFP Section 2.2.25, Full Disclosure and Independent Review, to determine if the performance standards related to the annual independent audit are satisfied.

Payment of Liquidated Damages

In the event the Board determines that the PBM has not met a given Performance Standard, under which liquidated damages are payable to the Board for failure to comply, PBM shall remit the applicable at-risk fees for failing to meet the corresponding Performance Standard to the Board within forty-five (45) days after the end of the measurement period.

The proposing vendor must also include an Implementation Performance Plan within their proposal:

EXHIBIT ___
IMPLEMENTATION PERFORMANCE GUARANTEE

The PBM agrees to provide an implementation performance guarantee in the amount of One Million Dollars ($1,000,000.00) to ensure timely and complete establishment of pharmacy benefit manager services. Failure by the PBM to perform timely and complete implementation of the pharmacy benefit manager services may result in damages recoverable by the Board as described in the table below. The final implementation plan will be agreed to by both parties during contract negotiations.

Performance Standard Topic	Description of Standard	Deliverable Date	Amount at Risk

PBM will provide appropriate documentation to the Board to substantiate compliance with the aforementioned implementation guarantees. In addition, the Board reserves the right to perform one or more site visits to the PBM to verify compliance.

In the event the PBM fails to successfully complete a task by the stated deliverable date due to the action or inaction of the Board, or one or more of the Board's other vendors, the PBM can request that the associated liquidated damage(s) be waived. Reasonable approval of such a request by the Board will not be withheld. It is the PBM's responsibility to promptly notify the Board of any such third-party action or inaction that is reasonably expected to impact the PBM's ability to successfully complete an implementation task.

SAMPLE IMPLEMENTATION GUARANTEE

Performance Standard	Description of Standard	Deliverable Date	Amount at Risk
Implementation Plan	PBM to submit detailed implementation plan outlining all action items required for successful "go live" on July 1, 2026, in accordance with the Scope of Services.	Implementation plan is due within five (5) working days of contract execution.	$150,000.00
Historical Claim Data Migration	PBM to test and load historical claim data into their claim system.	PBM testing and loading of historical data through September 30, 2025 is to be completed by November 14, 2025 (assumes PBM receives client hierarchy and complete, accurate claim data by September 12, 2025)	$75,000.00
Open Refill File Transfer	PBM to load Open Refill File Transfer into their pharmacy system.	PBM loading of Open Refill prescriptions within one week upon receipt of file.	$50,000.00
Prior Authorization Override Transfer File	PBM to load Prior Authorization Override Transfer File into their claims system.	PBM error testing and loading of Prior Authorization Overrides with expectation that PBM will obtain corrected files if initial loads are less than 100% completed.	$50,000.00
Communication and Agency Training	PBM to successfully train client, including field agency personnel, on their system.	To be completed before December 12, 2025	$75,000.00
Staff Hiring	PBM to fill all positions as required in Scope of Services	Staff to be in place by December 16, 2025	$75,000.00
Staff Training	PBM to train all positions as required in Scope of Services	Training of all positions completed by December 26, 2025	$75,000.00
Go-Live*	PBM to be fully operational to perform all items in Scope of Services	January 1, 2026 - All components fully operational and functioning.	January 1, 2026 - $100,000.00; Each calendar day after January 1st - $25,000.00

*Penalty will be assessed at $25,000.00 per calendar day for failure to meet this task.

In the event the PBM fails to successfully complete a task by the stated deliverable date due to the action or inaction of the Board, or one or more of the Board's other vendors, the PBM can request that the

associated liquidated damage be waived. Reasonable approval of such a request by the Board will not be withheld. It is the PBM's responsibility to promptly notify the Board of any such third-party action or inaction that is reasonably expected to impact the PBM's ability to successfully complete an implementation task.

SECTION 5. STATEMENT OF COMPLIANCE AND EXCEPTION(S) FORM

If a vendor objects to any terms, conditions, or requirements listed in the *MDFA OI's Request for Proposal for Pharmacy Benefit Manager Services, dated October 16, 2024*, including all RFP attachments and amendments, the Vendor must list and explain the exceptions taken. If no exceptions are taken, then the Vendor shall state on the form "No Exceptions Taken." Failure to indicate any exception will be interpreted as the Vendor's intent to comply fully with the requirements as written. Failure to complete and/or sign may result in vendor being determined nonresponsive. Please carefully review the information located in **RFP Section 5, Statement of Compliance and Exception(s) Form,** and include a copy **signed by an officer, principal, or owner** of your company with your completed proposal. Failure to submit a signed Statement of Compliance and Exception(s) form may result in your proposal being eliminated from further consideration. If you object to any of the terms and conditions included in the *Draft Pharmacy Benefit Manager Services Contract* (refer to **RFP Appendix A**), or any requirements listed in this RFP, please note and explain your objection(s) on the Statement of Compliance and Exception(s) form. Clauses in **blue** type in the *Draft Contract* are deemed mandatory. While edits may be limited, reasonable requests may be considered.

Conditional or qualified proposals, unless specifically allowed, shall be subject to rejection in whole or in part. The proposal must contain a high degree of acceptance of contract terms and conditions listed in the draft contract provided as **Appendix A** of this RFP. Refer to **RFP Section 10.16**.

A proposal response that includes terms and conditions that do not conform to the terms and conditions in the RFP and the draft contract is subject to rejection as non-responsive. The MDFA reserves the right to permit the Vendor to withdraw nonconforming terms and conditions from its proposal response prior to a determination by the MDFA of non-responsiveness based on the submission of nonconforming terms and conditions. As a precondition to proposal acceptance, the MDFA may request the Vendor to withdraw or modify those portions of the proposal deemed non-responsive that do not affect the quality, quantity, price, or delivery of the service.

Statement of Compliance and Exception(s) Form

Vendor taking exception to any part or section of the solicitation shall indicate such exceptions on the table below. If no exceptions are taken, then the Vendor shall state in this section "No Exceptions Taken." Failure to indicate any exception will be interpreted as the Vendor's intent to comply fully with the requirements as written. Conditional or qualified proposals, unless specifically allowed, shall be subject to rejection in whole or in part.

We agree to adhere to all terms, conditions, and requirements as set forth in the *MDFA OI's Request for Proposal for Pharmacy Benefit Manager Services, dated October 16, 2024,* including all RFP amendments, and the conditions contained in the draft contract included as **RFP Appendix A, Draft Pharmacy Benefit Manager Services Contract**, except as listed below:

Procurement Section and Page Number		Original Language	Requested Change/Exception	MDFA Decision
1.				
2.				
3.				

An original signature is required below. This statement must be signed by an appropriate vendor officer, principal, or owner and returned as part of your proposal.

Company Name: _____

Printed Name of Representative, Title: _____

Date: _____

Signature: _____

Note: Failure to sign this form may result in the proposal being rejected as non-responsive. Modifications or additions to any portion of this proposal document may be cause for rejection of the proposal.

SECTION 6. STATUTORY REQUIREMENT DISCLOSURE STATEMENT

In accordance with § 25-15-9(1)(a) of the Mississippi Code Annotated, each entity that submits a proposal in response to this RFP **must provide a disclosure statement detailing any services or assistance it provided during the previous fiscal year to the Board and/or OI in the development of the Plan including any resulting compensation for these services.** The statement must include a detailed description of the vendor's participation in the development of the Plan, as well as any resulting compensation received from the Board and/or OI during the previous fiscal year. **If you did not provide such assistance to the Board and/or OI, indicate in your statement that this provision does not apply to you.**

Mississippi Code Annotated § 25-15-9(1)(a) states in part:

> *"…The board may employ or contract for such consulting or actuarial services as may be necessary to formulate the plan, and to assist the board in the preparation of specifications and in the process of advertising for the bids for the plan. Those contracts shall be solicited and entered into in accordance with Section 25-15-5. The board shall keep a record of all persons, agents and corporations who contract with or assist the board in preparing and developing the plan. The board in a timely manner shall provide copies of this record to the members of the advisory council created in this section and those legislators, or their designees, who may attend meetings of the advisory council. The board shall provide copies of this record in the solicitation of bids for the administration or servicing of the self-insured program. Each person, agent or corporation that, during the previous fiscal year, has assisted in the development of the plan or employed or compensated any person who assisted in the development of the plan, and that bids on the administration or servicing of the plan, shall submit to the board a statement accompanying the bid explaining in detail its participation with the development of the plan. This statement shall include the amount of compensation paid by the bidder to any such employee during the previous fiscal year. The board shall make all such information available to the members of the advisory council and those legislators, or their designees, who may attend meetings of the advisory council before any action is taken by the board on the bids submitted. The failure of any bidder to fully and accurately comply with this paragraph shall result in the rejection of any bid submitted by that bidder or the cancellation of any contract executed when the failure is discovered after the acceptance of that bid…."*

Failure to provide this disclosure statement may result in your proposal being eliminated from further consideration.

The following is a list of persons, agents, and corporations who have contracted with or assisted the Board in preparing and developing the State of Mississippi State and School Employees' Health Insurance Plan within the past fiscal year:

Vendors:

ActiveHealth® Management, Inc.	Health & Wellness Management Services
Blue Cross & Blue Shield of Mississippi	Third Party Medical Claims Administrator
Caremark PCS Health (CVS Pharmacy, Inc)	Pharmacy Benefit Manager
Cavanaugh Macdonald Consulting, LLC	Other Post-Employment Benefits Actuary
Brown & Brown f/k/a Claims Technologies Inc.	Medical Claims & Perf. Audit Services
Gallagher Benefit Services, Inc.	Health & Life Insurance Consulting Services
Health Data & Management Solutions, Inc.	Decision Support Services

Acentra Health f/k/a Keystone Peer Review Organization, Inc. (Kepro)	Utilization Management Review Services
Minnesota Life Insurance Company	Life Insurance Services
PillarRx Consulting, LLC	Pharmacy Claim & Perf. Audit Services
Wm. Lynn Townsend, FSA, MAAA	Consulting Actuary

State and School Employees Health Insurance Management Board Members:

Liz Welch (Chairman) – Executive Director, Department of Finance and Administration
Christopher J. Burkhalter (Vice-Chairman) – Consulting Actuary, Burkhalter Consulting Actuaries
Commissioner Mike Chaney – Commissioner, Mississippi Insurance Department
Dr. Alfred Rankins, Jr. – Commissioner, Institutions of Higher Learning
Mark Formby – Chairman, Workers' Compensation Commission
Kelly Hardwick – Executive Director, State Personnel Board
Kell Smith – Executive Director, Mississippi Community College Board
Ray Higgins, Jr. – Executive Director, Public Employees' Retirement System
The Honorable J. Walter Michel – Chairman, Senate Insurance Committee
The Honorable Jerry Turner – Chairman, House Insurance Committee
The Honorable W. Briggs Hopson – Chairman, Senate Appropriations Committee
The Honorable John Read – Chairman, House Appropriations Committee

MDFA OI Staff:

Bert Emrick – State Insurance Administrator
Carlotta Edwards – Director, Benefits & Participant Services
Alicia Coleman – Director, Procurement and Contracts
Cindy Bradshaw – Contractual Consultant

SECTION 7. GENERAL QUESTIONNAIRE

Failure to answer the following general questionnaire completely will result in Vendor being determined nonresponsive. In preparing your written response to the narrative questionnaire below, you are required to repeat each question, including the number, or requirement followed by your response. Please provide complete answers and explain all issues in a concise, direct manner. If you cannot provide a direct response for some reason (e.g., your company does not collect or furnish certain information), please indicate the reason rather than providing general information that fails to answer the question. "Will discuss" and "will consider" or other similar indirect responses are not appropriate answers.

7.1 Provide the name, title, mailing address, email address, and telephone number of the contact person for this proposal.

7.2 Provide the physical location and mailing address of your company's home office, principal place of business, and place of incorporation.

7.3 State the full legal name of your company, and provide the web address, address, and telephone number of your principal place of business.

7.4 List the office that will service the Board. If it is located at a different address than the home office, provide the complete address, phone number, and facsimile number for this office.

7.5 Describe your organizational structure. Indicate whether your company operates as a corporation, partnership, individual, etc. If it is incorporated, include the state in which it is incorporated, and list the names and occupations of those individuals serving on your company's Board of Directors. Also, list applicable parent organizations and subsidiaries of your organization.

7.6 List the name and principal occupation or business of any person or entity owning ten percent (10%) or more of your company.

7.7 List the name(s) of any organization(s) of which your company owns or controls ten percent (10%) or more.

7.8 Is your company currently for sale or involved in any transaction to expand or to become acquired by another business entity? If the answer is yes, please discuss the impact both in organizational and directional terms.

7.9 Describe any ownership or name changes your company has been through in the past three (3) years. Are any ownership or name changes planned?

7.10 Describe any changes in the organizational structure that have occurred within your company over the past twenty-four (24) months or are anticipated during the next twenty-four (24) months including, but not limited to, addition or elimination of product or business lines, mergers, acquisitions, etc.

7.11 What was the average number of employees of your firm during calendar year 2023? Please list the net change in the number of employees in your firm from December 2022 to December 2023, with explanation if change is significant.

7.12 How long has the company been providing the equivalent or similar services in requirements and scale to those pharmacy benefit manager services described within this RFP? Indicate the month and year in which your company was established.

7.13 State if the proposed account manager, any officers or principals and/or their immediate families are or have been within the preceding twelve (12) months, employees of the State of Mississippi.

7.14 Provide a brief description of any outside vendors or subcontractors (including aggregator and/or GPO) that will be involved in providing key services detailed within your proposal. Please include the term of your current contract with each vendor or subcontractor (including aggregator and/or GPO). Describe the nature of the relationship with the vendor or subcontractor (including aggregator and/or GPO), including any ownership interest. Please include a copy of the current contract as an appendix to your proposal in Section 12.

7.15 Has your company ever been involved in a lawsuit involving any area covered by this RFP? If the answer is yes, please provide details including dates and outcomes.

7.16 During the past five (5) years, has your company, related entities, principals, or officers ever been a party in any material criminal litigation, whether directly related to this RFP or not? If the answer is yes, please provide details including dates and outcomes.

7.17 Has your firm been cited or threatened with citation within the last three (3) years by federal or state regulators for violations of any federal, state, or local law or federal, state or local regulation? If the answer is yes, please describe the circumstances in detail.

7.18 Has your firm had any HIPAA breaches or incidents determined to be reportable to the U.S. Department of Health and Human Services (DHHS) within the last three (3) years? If the answer is yes, please describe the circumstances and the corrective action in detail.

7.19 Provide proof your company is licensed or authorized to provide the proposed services in the State of Mississippi.

7.20 Does your company currently perform any work for, services to, or receive compensation from any third-party administration company or any insurance company? If the answer is yes, please describe the circumstances in detail.

7.21 List your company's accreditation or service/quality ratings, including year obtained and certification duration, if applicable.

7.22 Confirm the proposal is valid for one (1) year after the date of submission.

SECTION 8. TECHNICAL QUESTIONNAIRE

Failure to answer the following questionnaire completely will result in Vendor being determined nonresponsive. In preparing your written response to the narrative questionnaire below, you are required to repeat each question, including the number, or requirement followed by your response. Please provide complete answers and explain all issues in a concise, direct manner. If you cannot provide a direct response for some reason (e.g., your company does not collect or furnish certain information), please indicate the reason rather than providing general information that fails to answer the question. "Will discuss" and "will consider" or other similar indirect responses are not appropriate answers.

Responses to the questions should reflect only those pharmacies currently under contract with your network and not include projections for future growth or expansion. If more than one network is proposed, address each question separately relative to each network.

8.1 Account Management

8.1.1 Describe the team dedicated to providing the requested scope of services for the Board. Specifically,

a. Identify the dedicated account manager who will serve as the primary contact for the Board and OI.
b. Provide a job description including experience requirements of the claims manager/supervisor, claims adjusters, and any supervisory and/or support personnel who will be assigned to this contract, and include resumes as an appendix to your proposal in Section 11.
c. Provide the name(s) and resumes of all key personnel who will oversee and provide the services rendered to the Board, a brief statement as to why each person is qualified relative to this work and identify area(s) of expertise for each key person, detailed information on any special training or designation, and each person's respective total number of years of experience related to the services being requested in this RFP. Specifically identify the account manager who will serve as the primary contact for the Board, tort claims manager/supervisor, claims adjusters, and the optional loss control consultants. Include all resumes as an appendix to your proposal in Section 11.

8.1.2 How many additional clients will the dedicated account manager assigned to this account routinely handle and what is the average size (in participants covered) of the accounts?

8.1.3 Describe the consultative services the account manager provides.

8.1.4 The Board and OI must have prompt and direct access to the PBM throughout the contract period. Describe in detail how your organization will provide this access.

8.2 Pharmacy Benefit Manager Services

8.2.1 **Network Operations** Refer to **RFP Appendix D, Top 50 Pharmacies Utilized by Participants,** for a listing of the top 50 pharmacies utilized by our participants.

8.2.1.1. Participant Access

8.2.1.1.1. Do you have an operating network of pharmacies in Mississippi? When was it established? How many pharmacies are currently under contract in Mississippi?

8.2.1.1.2. For the network you are proposing to use, what is the total number of network pharmacies within the State of Mississippi? How many are independent pharmacies? How many are chain pharmacies?

8.2.1.1.3. Please provide a copy of your directory of participating pharmacies in the State of Mississippi for each network proposed.

8.2.1.1.4. Do you charge any fees to pharmacies for participation in your network? If yes, please describe the nature of the fees and provide the amount of the fee charged.

8.2.1.1.5. Do you charge pharmacies transaction fees, directly or indirectly (e.g., "click" or "switch" fees) for submitting claims to your firm? If so, please describe all such fees, including any differences between paid and rejected claim submissions, and the fees you receive from retail pharmacies for this arrangement.

8.2.1.1.6. How would your network provide PBM services to out-of-state retirees and other out-of-area plan participants?

8.2.1.1.7. Do you own the network to be used or do you contract for another PBM's network? If contracted, how long has this relationship been in place?

8.2.1.2. Quality Control

8.2.1.2.1. Confirm that you follow URAC or CMS credentialing guidelines.

8.2.1.2.2. What are the criteria for acceptance of a pharmacy into your network?

8.2.1.2.3. How often do you re-credential pharmacies in your network? Describe the credentialing and re-credentialing process.

8.2.1.2.4. How often do you physically visit your network pharmacies? Which elements of performance are audited?

8.2.1.2.5. Describe your pharmacy network auditing programs and services, clearly indicating how frequently the program is run and the process to investigate any findings that are deemed potentially fraudulent. Also describe all programs (and interventions) available for retail, specialty, and long-term care pharmacy networks to:

a. Identify potential abuse patterns by participants,
b. Identify over-prescribing by doctors, and
c. Identify potential fraud by dispensers and/or participants.

8.2.1.2.6. Describe ongoing assessments used to monitor quality and performance of pharmacies in the network.

8.2.1.2.7. Do you agree to accept responsibility for collecting overpayments from the retail pharmacy if the pharmacy charges more than the contracted price for any and all prescription drug claims, and reimbursing the Board for any overpayments?

8.2.1.2.8. Do your network contracts include any incentives for retail pharmacies regarding the dispensing of generics or preferred products?

8.2.1.3. Mail Order Operations

8.2.1.3.1. Describe your mail order program.

8.2.1.3.2. List all of your mail order locations (include pharmacy name, location, length of operation, average fill accuracy for Calendar Year 2022 and 2023, facility prescription capacity and current volume).

8.2.1.3.3. Do you own mail order facilities or contract with another PBM? If contracted, how long has this relationship been in place?

8.2.1.3.4. Describe by what methods your mail order pharmacy is able to accept prescriptions (e.g. mail, fax, phone, email, e-prescribing, etc.).

8.2.1.3.5. What delivery service does your mail order use to deliver prescriptions? Do you offer alternative delivery options (e.g. priority overnight, etc.)? If so, what is the cost of these services?

8.2.1.3.6. Describe your process for transitioning a client from an existing mail order facility to your facility.

8.2.1.3.7. Will lost or damaged orders be fulfilled with no additional cost to the Plan and its participants? How does the PBM handle prescriptions returned by the participants?

8.2.1.3.8. Describe your process for notifying participants of the expiration date of their current script, next refill date, number of remaining refills, medications not on formulary, generic substitution availability, etc.

8.2.1.3.9. Describe any programs for participant outreach to encourage switching of maintenance drug prescriptions to mail order from retail, or for optimization of savings for both the plan and participant.

8.2.1.3.10. Describe your mail order "auto fill" program if one is available. Describe the day supply refill metric to manage the "auto-fill" program and controls in place to avoid wastage or stockpiling?

8.2.1.3.11. Describe the type and frequency of reports routinely provided to your clients relative to your mail order pharmacy program. Advise if your reports contain the number of discontinuations during the first month of therapy by drug, reason for discontinuation, patient interventions for side effects, and adherence outcomes.

8.2.1.3.12. Describe or confirm that PBM will not charge the state for uncollected member share.

8.2.1.4. Specialty Operations

8.2.1.4.1. How do you define a specialty drug?

8.2.1.4.2. Does your firm provide a specialty pharmacy program?

8.2.1.4.3. Do you own a specialty pharmacy or contract with one? If contracted, how long has this relationship been in place?

8.2.1.4.4. Identify the location(s) of the specialty pharmacy facility (if specialty drugs are dispensed from separate facilities) that will primarily service the Plan. Include pharmacy name, location, length of operation, average fill accuracy for 2022 and 2023, facility prescription capacity and current volume.

8.2.1.4.5. What delivery service does your specialty program use to deliver prescriptions? Do you offer an alternative delivery option (e.g. priority overnight, etc.)? If so, what is the cost of these services?

8.2.1.4.6. Will lost or damaged orders be fulfilled with no additional cost to the Plan and its participants? How does your company handle prescriptions returned by the participant?

8.2.1.4.7. Describe your process for notifying participants of expiration date of their current prescript, next refill date, number of remaining refills, prescriptions not on formulary, generic substitution availability, etc.?

8.2.1.4.8. Describe any programs for participant outreach to encourage switching specialty medications for optimization of savings for both the plan and participant.

8.2.1.4.9. Describe your "auto fill" program if one is available. Describe the day supply refill metric to manage the "auto-fill" program and controls in place to avoid wastage or stockpiling?

8.2.1.4.10. Does the specialty pharmacy contact the participant prior to shipping each prescription to ensure medication is still required?

8.2.1.4.11. Describe the shipping process and quality controls utilized by the specialty pharmacy to assure stability of temperature sensitive medications.

8.2.1.4.12. Can specialty be shipped directly to the doctor's office for administration?

8.2.1.4.13. Describe any initiatives your firm has that are designed to assist plan sponsors in lowering the cost of specialty drugs dispensed or administered in the doctor's office and reimbursed through the medical plan?

8.2.1.4.14. Describe your ability to monitor and align specialty utilization between the medical and pharmacy channels, including assessing, monitoring, and optimizing participant cost sharing and clinical rule parity.

8.2.1.4.15. What chronic diseases are managed through your specialty pharmacy program?

8.2.1.4.16. Describe your specialty pharmacy program including the frequency of contact, telephonic and other, with patients and physicians, the qualifications of staff, etc.

8.2.1.4.17. Describe how your specialty pharmacy program manages the appropriate dispensing of medications to minimize the waste of prescription drugs. Does your specialty pharmacy have any cycle management programs for potentially toxic medications, that would include aspects such as enhanced communication, adverse drug event monitoring, therapy response monitoring, participant's adequate supply monitoring, new start partial fill (to increase adherence and potential cost savings), adherence monitoring, and physician outreach to corroborate doses taken, dosage changes, side effects experienced, and pharmacist recommended interventions.

8.2.1.4.18. Describe the type and frequency of reports routinely provided to your clients relative to your specialty pharmacy program. Advise if your reports contain the number of discontinuations during the first month of therapy by drug, reason for discontinuation, patient interventions for side effects, and adherence outcomes.

8.2.1.4.19. Provide a list of drugs included in your variable copayment plan design.

8.2.1.4.20. Confirm you provided the most recent Limited Distribution Drug Indicator in the attachment for the previous question. If not, please provide your proposed Limited Distribution Drug List with NDC in an Excel File.

8.2.1.4.21. Provide a list of any specialty drug products that are excluded from your specialty drug pricing guarantees (OED, Dispensing Fee, and/or Rebate).

8.2.1.4.22. Confirm that your specialty discount guarantees, fees, and rebates include limited distribution medications and new to market medications.

8.2.1.4.23. Provide an AWP-based pricing list in Excel of all specialty pharmaceuticals, including Limited Distribution Drugs that your company dispenses and distributes to providers and patients for your proposed specialty pharmacy program. Your pricing must include adequate supplies of ancillaries such as needles, swabs, syringes, and containers. The following items must be included in your list:

a. Product Name
b. Therapeutic Group/Therapeutic Category
c. NDC
d. Guaranteed Minimum AWP Discount and Dispensing Fee for all specialty pharmacy program prescriptions for the specialty arrangement.
e. Limited Drug Designation

8.2.1.4.24. Describe your strategy for controlling the increasing cost of the specialty

medications.

8.2.1.4.25. Describe the participant enrollment process in the patient assistance program and describe the claims adjudication process under the variable copayment plan, including the role of the participant, PBM, and pharmacy.

8.2.1.4.26. Confirm the state will not be billed for unpaid member cost share. If not confirmed, describe or explain.

8.2.1.5. Compounding Operations

8.2.1.5.1. Does your firm provide a compounding pharmacy program? How do you define compounding medications?

8.2.1.5.2. List all of your compounding pharmacies (include pharmacy name, location, length of operation, average fill accuracy for 2022 and 2023, facility prescription capacity and current volume). Do you own compounding pharmacy facilities or contract with another PBM? If contracted, how long has this relationship been in place?

8.2.1.5.3. Does your firm exclude compounds derived from bulk powders?

8.2.1.5.4. Does your firm exclude compounding kits?

8.2.1.5.5. Describe any initiatives your firm has that are designed to assist plan sponsors in lowering the cost of compounding medications?

8.2.1.5.6. Describe the type and frequency of reports routinely provided to your clients relative to your compounding pharmacy program.

8.2.2 Plan Design and Formulary Management

8.2.2.1. Please describe the formulary being utilized for this proposal. Please provide your recommended formulary in an electronic format in Section 12 of your proposal.

8.2.2.2. Please describe your formulary development process. Is your formulary approved by a committee? If so, provide the committee profile including the profession of each participant.

8.2.2.3. How often is your formulary updated? Would you be willing to establish a formulary specific to the Plan's program? Please provide your recommended formulary in an electronic format in Section 12 of your proposal.

8.2.2.4. Will you agree to allow customization to a formulary if specifically requested by the Plan? If so, please explain the process.

8.2.2.5. To what extent do you use evidence-based effectiveness studies in the development of your preferred drug list(s)? What are the sources of research used?

8.2.2.6. Will you agree to grant the Board prior notice for the addition or deletion of drugs from the Plan's prescription drug formulary or preferred drug list?

8.2.2.7. Will you agree to grant the Board prior notice for the addition or deletion of drugs from the Plan's prescription drug formulary or preferred drug list?

8.2.2.8. Describe your process for administering a generic incentive.

8.2.2.9. Can you administer a plan design where the participant's cost for a brand drug is the generic copayment plus the difference in cost between the generic and brand drug?

8.2.2.10. Can you administer a generic incentive plan design where the participant's cost for a brand drug is the brand copayment plus the difference in cost between the generic and brand drug?

8.2.2.11. Can you administer a generic incentive plan design where the participant's cost for a brand drug is the generic copayment plus the difference in cost between the generic and brand drug when there are different generic copayments?

8.2.2.12. Confirm that you can administer the benefits as outlined in the 2024 Plan Document.

8.2.3 Client/Participant Services

8.2.3.1. Describe your customer service structure for clients and participants for all programs (i.e., mail order, specialty drugs, and prior authorization). Include organization, hours and days of operation, staffing, and training.

8.2.3.2. Would you be willing to assign a dedicated, but not necessarily exclusive, customer service representative team to the Board's account?

8.2.3.3. Confirm that participants have access to a toll-free number for claim/participant services inquiries. Provide the hours the toll-free number is staffed. How will after-hours calls be handled? Confirm that your proposal provides a fee quotation for supplying this service.

8.2.3.4. The Board requires that you assign a dedicated, but not necessarily exclusive, account manager to meet with MDFA staff on a quarterly basis to review Plan utilization, attend the Board's meetings (if requested), make recommendations regarding services and/or programs on a quarterly basis, to discuss performance, address administration issues and review reports. Please confirm that you agree to this.

8.2.3.5. Confirm you are willing to assign one (1) dedicated and exclusive pharmacist residing in the State of Mississippi to visit physician offices and pharmacies and participate in health/benefit fairs to work out of the Office of Insurance office?

8.2.3.6. What services are available to accommodate special populations, including non-English speaking, hearing and vision impaired?

8.2.3.7. Please provide a sample of the most recent customer survey and the results in Section 12 of your proposal. Confirm that your proposal includes a fee for supplying this service and is included in the bundled administrative fee.

8.2.3.8. Does your firm provide communication/patient education materials to participants? How often? Would you be willing to customize these materials for the Plan? Please provide a sample of the most recent communications release. Confirm that your proposal includes a fee for supplying this service and is included in the bundled administrative fee, including the cost of mailing any communication materials to participant home locations.

8.2.3.9. Confirm that you are willing to develop and maintain a website as described in **RFP Section 2, Scope of Services**. Please provide a web address to view as an example of the website you propose for the Plan. The Board does not require that you develop a website for exclusive use by the Plan.

8.2.3.10. Please refer to **RFP Section 2, Scope of Services**, for the Board's website requirements. Describe your web-based program available to participants. Does the program allow participants to check to status of a claim, view and print submitted claim activity, confirm the price of medications, review therapeutic alternatives, check the preferred/non-preferred, generic status of a medication, etc.?

8.2.3.11. Describe any online tools available for comparing drug pricing between pharmacies.

8.2.3.12. Describe any online/mobile tools for demonstrating to participants savings associated with changing medications from their current prescriptions.

8.2.3.13. Does your online tool display the total cost of the drug?

8.2.3.14. Describe areas of innovation that your firm has developed and implemented that improve the quality of care provided to participants or improve cost control for your clients.

8.2.3.15. Does your firm release communications to participants that are negatively impacted by changes to the preferred drug list? How often? Please provide a sample of the most recent communications release in Section 12 of your proposal. Confirm that your cost is included in the bundled administrative fee for supplying this service, including the cost of mailing any preferred drug list changes to participant home locations.

8.2.3.16. How do you track and monitor participant and provider inquiries? What is your turnaround time in responding to participant complaints?

8.2.3.17. Define your telephone service objectives in terms of:

a. Average call pick-up time;
b. Average time on hold;
c. Percentage of calls receiving busy signals; and
d. Abandonment rates.

In each of these service areas, please provide the actual results for the last twelve months that were measured by your firm.

8.2.3.18. Describe your formal grievance procedure for addressing participant problems.

8.2.3.19. Please describe the process participant appeals process. Specifically, your response should indicate how appeals are managed, who is responsible for making the determination and the timing for issuing a response.

8.2.3.20. Please describe the process for independent external appeals.

8.2.3.21. What information is required to be contained on the ID card given to participants? Include a sample ID card. Can the ID card be customized for the Board? At a minimum, ID cards must include the participant's name, participant identification number, the network name (Plan and PBM names) and the toll-free customer service line number. Can the medical identification number be used as the pharmacy card identification number if provided by the TPA?

8.2.3.22. You are required to generate ID cards and distribute the ID cards to participants. Confirm that your cost is included in the bundled administrative fee for all costs related to ID cards, including the cost of mailing the ID cards to participant home addresses.

8.2.3.23. Do you provide an annual individual utilization tracking report to participants? Does the explanation of pharmacy benefits include cost saving alternative recommendations for the participant? Please provide a sample including a list of all messages that can be displayed on the individual utilization tracking report.

8.2.3.24. The PBM shall maintain on file, at a minimum, the following information relative to each processed claim: the claimant's name, claim number, provider number, provider name, service dates, type of services, amount of charges, amount allowed, amount applied to the deductible, and reason codes. Confirm that you will comply with this requirement.

8.2.4 Claims Administration

8.2.4.1. Describe your procedure for processing paper and out of network claims submissions. Provide turnaround statistics for paper and out-of-network claims processed in 2023.

8.2.4.2. Describe your process and capabilities for real time, point of sale coordination of benefits?

8.2.4.3. Describe the situations where you would utilize a retrospective (off-line) process for coordinating benefits and payments. Describe your process for retroactive collection of payments from primary payers identified. If your firm does not perform such collections directly, describe your process for collecting information about other primary payment amounts.

8.2.4.4. Does your claims system have the capability to identify approval of prescription drugs by exception? (e.g. normally excluded by the plan, excluded by participant group)

8.2.4.5. Does the system comply with the National Council on Prescription Drug Program (NCPDP) standards?

8.2.4.6. What process is required from your network pharmacies when submitting claims for compounded drugs? What pricing algorithm do you use for pricing these drugs? Do you support and does your network use the NCPDP D.0 transaction standard format which allows listing of all ingredients?

8.2.4.7. Does the pharmacist have the capability to override the system? Please provide an example of a situation where the pharmacist might apply the override capability.

8.2.4.8. Describe the online systems access that will be granted to the Board for viewing data including, but not limited to: participant benefits, eligibility, participant and group records, prescription information, formulary lists, prior authorizations, accumulators, claim detail, claim data as submitted at point-of-sale, point-of-sale denials, COB data, drug pricing, historical data, mail service prescription data, transaction audit trails, MAC pricing files, specialty drug lists, etc.

8.2.4.9. Describe your capability to administer a plan design that includes the use of Health Reimbursement Accounts and integrated deductibles with the health plan.

8.2.5 System Interface

8.2.5.1. You are required to work with the TPA to develop system interfaces for accepting eligibility information, including ongoing additions/deletions of participants. Please confirm your ability to comply with this requirement.

8.2.5.2. Does your system flag participant ID numbers when an ID card is reported as lost or stolen to prevent fraudulent claims? What procedures are pharmacies instructed to follow when an individual tries to use a lost or stolen card?

8.2.5.3. Does your system monitor and flag early drug refills? What consumption percentage is your standard policy? Can this function be overridden for vacations, lost medicine, etc.?

8.2.5.4. Does the system track physician-specific data and dispensing patterns? How is this information used to change physician behavior? Are you willing to share this information with the Board?

8.2.5.5. Do you issue report cards on physicians? What information is captured on these report cards? Explain how this information is shared with physicians and how frequently. Are you willing to share this information with the Board? Provide an example, if applicable.

8.2.5.6. Does the system maintain patient medication profiles? What information is captured on these profiles? Provide an example, if applicable.

8.2.5.7. Discuss situations where your participating pharmacists have been unable to access the system and the number and frequency of such incidents. Describe the procedures used for dispensing prescription drugs to participants in cases where there are problems accessing the computer network system. What was the percentage of time your system was unavailable to pharmacies during calendar year 2023?

8.2.5.8. Confirm that you have the capability to coordinate deductible accumulations with the TPA for participants covered under a High Deductible Health Plan and include any data interface costs in your proposal.

8.2.6 Data Reporting

8.2.6.1. Due to potential time delays associated with the existing eligibility reporting process, do you have a standard report that would capture claims data for employees who receive prescription drugs after their termination under the Plan?

8.2.6.2. Describe the type and frequency of reports routinely provided to your clients. Provide examples in an appendix to your proposal.

8.2.6.3. Does your system provide web-based reporting tools that allow the client to view, print, and download reports? If so, please describe reporting capabilities, claim look-up functions, standard report writers, and any associated costs assuming five users. Describe any ad hoc reporting capabilities provided through these web-based tools. In what formats can the reports be downloaded? How many months of reports are maintained online? Also, explain what type of security is offered to protect the information.

8.2.6.4. Confirm that you can interface with the Board's data management vendor, Health Data and Management Solutions, Inc. (HDMS). Confirm that your proposal includes the cost of this requirement.

8.2.6.5. Describe your capability to produce ad hoc reports. Provide examples of previously prepared ad hoc reports and associated programming charges. What is the typical turnaround time for producing ad hoc reports?

8.2.6.6. Do you sell or report any data from your clients, either specifically or in aggregate, to any organizations? If so, please disclose these arrangements in detail.

8.2.7 Clinical Programs and Utilization Management

8.2.7.1. Describe your drug utilization review (DUR) and management services, such as:

a. Physician profiling
b. Case Management
c. Dosage and Quantity Limitations
d. Step Therapy
e. Dose Optimization

8.2.7.2. Describe your DUR problem identification process for all three levels of DUR (Prospective, Concurrent, and Retrospective), the intervention process, including methods, frequency, and success rates. Please describe three significant retrospective DUR cases that demonstrate the value of such services in terms of tangible results.

8.2.7.3. What is the average percentage savings from your DUR interventions? For purposes of this statistic, percentage savings is defined as DUR savings compared to total claims

actually paid.

8.2.7.4. Describe how you manage requests from participants for early refills or advance supplies of medications.

8.2.7.5. Describe the dedicated clinical resources that support your DUR and cost containment efforts. Provide names and résumés of key staff members (in Section 11 of your proposal).

8.2.7.6. Does your firm perform internal analyses of client specific data to develop recommendations for program improvement? What factors do you take into consideration when evaluating recommendations? Specifically address those who would be conducting the analysis and provide their qualifications and experience.

8.2.7.7. How are physicians educated about drug utilization? Formularies and preferred drug lists? Generic therapeutic substitution? Provide samples of provider educational materials. Do you conduct any detailing of physicians? What have been the results of these efforts?

8.2.7.8. Describe your ability to conduct provider prescribing profile to identify patterns of non-formulary products and irregular prescribing patterns and what steps are taken to correct these.

8.2.7.9. Please describe your medication adherence program including your experience in positively impacting physician and participant behavior relating to medication adherence. How long has your medication adherence program been in place?

8.2.7.10. Describe your drug limitation program for medications which are indicated only for a specific therapeutic period or are limited to certain amounts.

8.2.7.11. Describe your process for ensuring medications are covered only for the FDA approved indications.

8.2.7.12. Do you have the capability to collect the diagnosis on claims?

8.2.7.13. Do you currently or have plans to use the diagnosis code to determine if the drug is being described for the approved indication?

8.2.7.14. Please describe your prior authorization process including who performs the medical authorization function.

8.2.7.15. Confirm that utilization management rules will apply to all channels (retail, mail, and specialty), and then also across channels.

8.2.7.16. Describe available medication therapy management (MTM) programs.

8.2.7.17. Do you contact patients to remind them of upcoming refills, to verify receipt of medications, to confirm the patient's understanding of proper administration of

medications, etc.? Please describe these interactions.

8.2.7.18. Provide examples of communications that are distributed to patients and physicians through your specialty pharmacy program.

8.2.7.19. Are you offering clinical guarantees to the Board? If yes, please describe the guarantee and your savings calculation methodology.

8.2.8 Full Disclosure and Independent Review

8.2.8.1. Any resulting contract will include a Business Associate Agreement between the selected Pharmacy Manager and the Board. The Board's contract for audit services will also include a Business Associate Agreement. Will you require a separate NDA with our contracted auditor? If so, please explain the rationale behind this requirement.

8.2.8.2. Please detail your process for participating in an audit including staff assignment.

8.2.8.3. What is your lead time for supplying information for an audit?

8.2.8.4. If there is a delay in the audit, caused by the PBM not meeting the agreed schedule, are you willing to deploy resources to shorten the time for other sections of your response to get the audit back on the timeline? If so, please explain this process.

8.2.9 Legal and Liability Issues

8.2.9.1. Please indicate the liability insurance requirements that each pharmacy must maintain to be considered a participant in your network. How does your firm verify that each participating pharmacy has complied with the insurance requirements, and how do you monitor the renewal of insurance protection each year?

8.2.9.2. Please provide a copy of the most recent annual report for your organization, and for your parent organization (if applicable).

8.2.9.3. Please provide your firm's (and those of your parent organization, if applicable) most recent audited financial statements including any auditor's recommendations or opinions.

8.2.9.4. Please attach a copy of your standard contract with participating pharmacies.

8.2.10 Financial

8.2.10.1. What is your firm's approach to ensuring the benefit of low-cost generic retailers that sell discounted generics (e.g. $4 maintenance generics)? Does your firm have the ability to capture these claims for reporting and clinical editing purposes?

8.2.10.2. What is the data source you currently use for drug reimbursement (e.g., Medi-Span, etc.)?

8.2.10.3. Does your PBM engage in any cost shifting from either external or internal sources which improve the actual or perceived price of one service while increasing the actual or

perceived price of another service provided by the PBM to the Board? Explain.

8.2.10.4. What percentage of retail and mail order claims are currently priced at MAC? Are you willing to guarantee a MAC inclusion rate for retail and/or mail if applicable? If so, state the guarantee.

8.2.10.5. Do you apply MAC pricing for any specialty medications? If so, how many?

8.2.10.6. What percent of your total claims paid in Calendar Year 2023 have been paid at U&C? What is the average discount for U&C brand claims? What is the average discount for U&C generic claims?

8.2.10.7. Confirm that for every claim paid at the provider's U&C amount, the PBM shall allocate the entire U&C amount to the Ingredient Cost and shall not allocate any of the U&C amount to the dispensing fee.

8.2.10.8. Provide a detailed methodology for the calculation of each of the guaranteed financial terms listed in **Section 9, Administrative Cost and Network Proposal Section**. Describe any variation in the calculation of the guaranteed financial terms from the methodology required to re-price the claim file that is required for this RFP.

8.2.10.9. Describe how/if specialty medication guaranteed discounts are updated and the frequency of the updates?

8.2.10.10. The Board describes a "script" as a paid prescription only (excludes duplicates, reversals, etc.). Confirm you will abide by this definition in calculating any fees based on a per script basis.

8.2.10.11. Confirm that all discount guarantees are direct savings off of AWP and not the result of incremental savings due to repackaging of prescriptions or other clinical services. Does your mail order pricing assume a specific package size? If so, describe the package size used in mail order.

8.2.10.12. When a prescription costs less than the copayment amount at either retail or mail, how do you ensure that the participant will pay the lowest amount?

8.2.10.13. For your current book of business, please provide the following annual statistics. Please indicate the time period represented and whether data reflects active employees only, or active employees and retirees, dependents.

a. Cost per participant (paid claim)
b. Cost per insured employee (paid claim)
c. Number of prescriptions per participant
d. Number of prescriptions per insured employee
e. Average day supply per prescription
f. Average ingredient cost – per brand, generic

8.2.10.14. For your current book of business, what is the most recent statistic (percentage) of medications which were dispensed as generic? If possible, distinguish between clients

who include any pharmacy incentive programs or MAC plan designs. Please indicate any new program that might be employed by the Board to improve this statistical average.

8.2.10.15. Please summarize how you handle (a) MAC; (b) lower of U&C and plan pricing, and (c) acquisition package size pricing compliance by pharmacies in the network you propose.

8.2.10.16. Do you maintain more than one MAC list? If so, will more than one MAC list be used for the Board's program? Please describe how more than one MAC list is utilized.

8.2.10.17. For the Board's program, confirm you apply the same MAC list and MAC pricing for both the retail and mail channels?

8.2.10.18. How many drugs are on your MAC list? How often do you change MAC pricing? What method do you use to communicate with clients any updates in your MAC pricing and MAC lists?

8.2.10.19. Confirm that you have provided the minimum rebate guarantees you will provide the Board. The rebate guarantee should be based on a per brand script basis only. You may list separate guarantees for retail, specialty, and mail.

8.2.10.20. Confirm that you are willing to make the Board whole in the event you fail to meet pricing and/or rebate guarantees by individual guarantees without offsets of one financial guarantee's potential under-performance with another financial guarantee's potential over-performance.

8.2.10.21. Describe the payment cycle for compensating pharmacies.

8.2.10.22. Describe your preferred billing cycle for claims, and for administrative fees to the Board.

8.2.11 Rebate Administration

8.2.11.1. Describe your rebate administration process.

8.2.11.2. How do you negotiate rebates with pharmaceutical manufacturers?

8.2.11.3. What strategies do you employ to maximize rebate yields?

8.2.11.4. Detail how you ensure all rebates are accurately tracked and reported?

8.2.11.5. Do you use a rebate aggregator or processor? If so, please describe your relationship with the aggregator or processor. Is the aggregator an independent company or is it owned or controlled by your company or subsidiary?

8.2.11.6. How is the aggregator compensated for their services?

8.2.11.7. Confirm that all monies paid to the aggregator by a manufacturer in any way related to the Plan's utilization will be reimbursed to the Plan.

8.2.11.8. Outline the timeline for processing rebates and reimbursing the rebates to the Plan.

8.2.11.9. How do you ensure accurate and efficient distribution of rebate funds?

8.2.11.10. Confirm that rebates will be reported down to the NDC level.

8.2.11.11. Confirm that rebates earned will be submitted to the Plan no more than 60 days of the quarter in which they were earned.

8.2.11.12. Confirm that you agree to the definition of rebate as defined in the RFP.

8.2.11.13. What options do we have for customizing rebate agreements to align with our specific goals and priorities?

8.2.11.14. How does your rebate system integrate with our existing pharmacy and claims systems?

8.2.11.15. Describe your process for rebate audits and how often they occur.

8.2.11.16. Define the dollars at risk your organization will commit to in your price or inflation protection guarantees.

8.2.11.17. Confirm your manufacturer agreements contain provisions that limit the amount the manufacturer can raise the AWP price of prescription drugs each year.

8.2.12 Manufacturer Coupons/Patient Assistance Programs

8.2.12.1. Describe the PBM's strategy to combat the use of manufacturer's coupons.

8.2.12.2. Describe any programs you provide to counter the use of manufacturer's coupons/patient assistance programs that promote the dispensing of higher cost brand name drugs when a lower cost generic or alternative is available.

8.3 Implementation

8.3.1 Describe your plan set-up testing and controls procedures to ensure accurate plan set-up.

8.3.2 Describe the most frequent problems you have encountered during previous transitions for plans of this size. How were these resolved?

8.3.3 Confirm you have provided a copy of your implementation project plan that indicates a service start date of January 1, 2026. Identify tasks/actions, critical events, timelines, and the responsible parties during each phase.

8.3.4 Confirm that if your organization is selected by the Board and the Contract is executed by July 1, 2025, you will be fully operational and have all contractual processes and procedures in place by January 1, 2026.

8.3.5 Would you be willing to assign a dedicated (not necessarily exclusive) team to assist with the

implementation process? How many dedicated (not necessarily exclusive) service representatives would be assigned for the initial implementation, as well as ongoing servicing of the Board's program?

8.3.6 Please confirm that you will be able to accept prior approval requests beginning in December 2025 for services that are to occur after December 31, 2025.

8.3.7 What is the minimum amount of lead time you believe is necessary to implement the Plan in an efficient and effective manner?

8.3.8 Please confirm that your fee proposal includes all costs associated with implementation services.

8.4 Audit

8.4.1 The Board reserves the right to audit all records maintained by the PBM and/or its affiliates relative to the PBM's performance under this Contract (including aggregator and/or GPO). At least two (2) business days' notice by the Board will be given to the PBM of the intent to audit. The Board shall have the right to perform financial, performance, and other special audits on such records maintained by the PBM during regular business hours throughout the contract period. The PBM agrees that confidential information including, but not limited to, medical and other pertinent information relative to third party claimants, shall not be disclosed to any person or organization for any purpose without the expressed, written authority from the Board. The selected PBM will make available all records, as defined by the selected auditor, for review at no cost to the Board. Indicate your acceptance of this proposal requirement and willingness to cooperate. Any ancillary fees that may be assessed to the Board for onsite audits should be included in your proposed fee for administrative services. For the purposes of this section, the term "audits" refers to financial, performance, and other special audits on such records maintained by the PBM and/or its affiliates relative to the PBM's performance under this Contract (including aggregator and/or GPO). Confirm you will comply with this requirement.

8.4.2 What auditing standards does your organization adhere to?

8.4.3 Does your company routinely undergo SOC audits? If yes, when was the last such audit completed, and were there any material findings? Provide a copy of your most recent audit. Indicate how often these audits are performed.

8.5 Performance Standards

8.5.1 The Board requires guarantees of performance.

a. Please review the performance standards included in **Section 4, Performance Standards**, of this RFP and confirm your willingness to accept the performance standards.

b. If you are not agreeable to the provided performance standards, please detail your objections and propose recommendations in **Section 5, Statement of Compliance and Exception(s) form**, of this RFP.

8.6 Federal No Surprises Act and Final Health Care Transparency Rule

8.6.1 General

8.6.1.1 Describe how your company will assure that the Plan will be in compliance with federal law and regulations concerning surprise billing and transparency with respect to the services provided by your company.

8.6.1.2 List any subcontractors or third parties who are providing your assistance in complying with the law and regulations, or who will be involved in work you may perform on behalf of the Plan.

8.6.1.3 List any technical specifications that the Plan will need to meet in order to use any solution you intend to offer to comply with the law and regulations, including software, hardware, or other information technology.

8.6.1.4 Do you expect to be fully compliant with the law and regulations by the statutory and regulatory due dates? If not, please explain.

8.6.2 Transparency Rules

8.6.2.1. The Board requires absolute transparency and full pass through of all revenue, whether rebates or not, from the PBM and from the aggregator that the PBM contracts with. All revenue, no matter the form or what it is called or where it comes from, must pass to the Plan. Please confirm concurrence with this requirement.

8.6.2.2. Describe your general process for complying with the Transparency in Coverage Final Rule.

8.6.2.3. Will you be prepared to provide an internet-based self-service tool that makes available to plan participants real time cost-sharing information in accordance with the rule?

8.6.2.4. Do any contracts you are a party to contain a claim prohibiting disclosure of pricing terms? If yes, please describe and state how you will ensure they are removed. Indicate your timeline for removing gag clauses from contracts.

SECTION 9. ADMINISTRATIVE COST AND NETWORK PROPOSAL

The Administrative Cost and Network Proposal Section must be submitted as described herein. Modification or addition to any portion of the Administrative Cost and Network Proposal Section may be cause for rejection of the proposal. The costs quoted shall be inclusive of, but not limited to the following: all required labor; all required equipment/material; all required insurance, bond, or other surety; all required overhead/profit; all required applicable taxes; all required vehicles; all required fuel and mileage; all required travel; all required labor and supervision; all required training; all required business and professional certifications, licenses, permits, or fees; general office expense; and, any and all other direct or indirect costs, incurred or to be incurred. Costs include maintaining a toll-free telephone number for calls from claimants, employer units, providers, the Board, and MDFA. All pricing shall include all associated costs with no additional or hidden fees. The costs quoted shall constitute the entire compensation due to the Vendor for services rendered and must be firm and must contain quotes for each of the five (5) years. Complete all light blue shaded cells as described within **RFP Appendix F**, **Financial Offer**; **RFP Appendix G**, **Specialty Pharmacy Offer**; **RFP Appendix H**, **Claims and Trend Assumptions**; **RFP Appendix I**, **Exclusions**; **RFP Appendix J**, **Mcf Coupon Programs**; **RFP Appendix K**, **Administrative Ancillary Fees**; and **RFP Appendix L**, **Formulary Disruption Results**.

If you object to any of the requirements included in the **RFP Appendix E**, **Financial Requirements**, please select "Not Confirmed" and provide further explanation in the additional column.

Pharmacy Benefit Manager Cost

The pricing quoted within **RFP Appendix F**, **Financial Offer**, shall constitute the entire compensation due to the selected vendor for services and all of the selected vendor's obligations hereunder regardless of the difficulty, materials, or equipment required. No additional compensation will be provided by the Board for any expense, cost, or fee not specifically authorized by the resulting contract. The Board shall not provide any prepayments or initial deposits in advance of services being rendered. Fees for services provided by the selected vendor shall be billable/invoiced to the Board in arrears on a monthly basis. Only those services agreed to by contract shall be considered for reimbursement/compensation by the Board. Payment for any and all services provided by the selected vendor to the Board and/or Plan shall be made only after said services have been duly performed and properly invoiced. The fees listed above are firm for the duration of the resulting contract and are not subject to escalation for any reason unless the resulting contract is duly amended.

The PBM shall submit all invoices in a form acceptable to the Board with all of the necessary supporting documentation prior to the payment to the PBM of allowable costs (administrative fees). Such invoices will, at a minimum, include the appropriate descriptions of the services being billed or other bases for charges included in **RFP Section 9, Administrative Cost and Network Proposal**, the quantity or number of hours billed, the compensation rate, the time period in which services were provided, total compensation requested for each individual service being billed, and total administrative fees requested for the period being invoiced.

The payment of an invoice by the Board shall not prejudice the Board's right to object or question any invoice or matter in relation thereto. Such payment by the Board shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any costs invoiced therein. PBM's invoice or payment shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Board, on the basis of audits, not to constitute allowable costs. Any payment

shall be reduced for overpayment or increased for underpayment on subsequent invoices. For any amounts which are or shall become due and payable to the Board and/or the Plan by the PBM, the Board reserves the right to (1) deduct from amounts which are or shall become due and payable to the Board under contract between the parties; or (2) request and receive payment directly from the PBM within fifteen (15) days of such request, at the Board's sole discretion.

The Board reserves the right to deduct from amounts which are or shall become due and payable to the PBM under the Contract between the parties. Notwithstanding anything to the contrary herein, any reduction of payments to shall be made only with the prior agreement of both parties. In addition, in the event of termination of the Contract for any reason, the PBM shall be paid for services rendered and allowable expenses incurred up to the effective date of termination.

Compensation to PBM for travel expenses for quarterly meetings and annual onsite trainings are included in the bundled fees quoted above. In the event the Board requests and authorizes the PBM for the performance of any of the services covered under the resulting contract for which travel expenses are note already included, compensation to the PBM for this outside travel must be approved in advance and shall be subject to the following criteria:

1. To be compensable by the Board, travel expenses must be reasonable and necessary for the fulfillment of the project and contractual obligations;
2. Air travel reimbursement will be limited to "economy" class rates, and must be supported by a copy of an original invoice;
3. Meals and lodging expenses will be reimbursed in the amount of actual costs, subject to the maximum per diem as defined in the Federal Register. A copy of all hotel and meal receipts must be provided.
4. Taxi fares, reasonable rental car expenses, and airport parking expenses will be reimbursed in the amount of actual costs, and must be supported by a copy of an original receipt/invoice;
5. Personal automobile mileage and related costs are not compensable expenses; and
6. Time spent in "travel status" is not compensable.

By submitting a proposal, the vendor certifies that all pricing, fees, and/or costs submitted were independently arrived at without collusion.

Formulary Disruption

1. The PBM must complete and submit a Formulary Disruption analysis for your proposed formulary in the format below. In addition, please provide an excel file with the detail of the formulary disruption for each drug by NDC 11 code for your formulary with exclusions and without exclusions in the format described within **RFP Appendix L**, **Formulary Disruption Results**.

Type of Change	Participant Impact	% of Total Participants	Number of Scripts Impacted	% of Total Scripts (including all brands and generics)
No Change				
Positive (higher-cost tier to lower tier)				
Negative (lower tier to higher-cost tier)				

Moving from covered to not covered/Excluded				
Total				
Name of #1 Drug that is Moving from Covered to Not Covered/Excluded based on impacted Participants: [Indicate Member and Script Impact.]				
Name of #2 Drug that is Moving from Covered to Not Covered/Excluded based on impacted Participants: [Indicate Member and Script Impact.]				
Name of #3 Drug that is Moving from Covered to Not Covered/Excluded based on impacted Participants: [Indicate Participant and Script Impact.]				

2. The completed files shall be submitted with proposals.

SECTION 10. RFP PROCESS OVERVIEW FOR VENDORS

10.1 Instructions to Vendors

- Proposals must be submitted by **2:00 PM CST on December 12, 2024**.

- Proposals may be submitted in a paper format via the two address options below or electronically via the State of Mississippi's Accountability System for Governmental Information and Collaboration (MAGIC). Registering as a supplier with the State of Mississippi allows businesses to register for upcoming RFx opportunity notifications by the products or services they supply, search the system for upcoming RFxs, respond to RFxs electronically, and receive purchase orders by email. In order to register, please go to the following website: https://www.dfa.ms.gov/vendor-information. Electronic proposals submitted through MAGIC shall follow the same format as specified within this section.

- **Paper Format** - To prevent opening by unauthorized individuals, all proposal submissions must be sealed in an envelope or package and marked, "**SEALED PROPOSAL – DO NOT OPEN**". The sealed envelope or package shall be marked with the Proposal opening time and date, and the RFx number. Proposals are subject to rejection unless submitted with the information included on the outside the sealed proposal envelope or package.

  Sealed proposals should be mailed or hand-delivered to and labeled as follows:

  Address if mailing proposals:

  RFP RFx Number 3120003010 for Pharmacy Benefit Manager Services
  Opening Date: 3:00 PM CST, December 12, 2024
  Mississippi Department of Finance & Administration, Office of Insurance
  Attention: Alicia Coleman, MDFA OI Procurement and Contracts Director
  P.O. Box 24208
  Jackson, Mississippi 39225-4208
  SEALED PROPOSAL – DO NOT OPEN

  Address if hand delivering proposals:

  RFP RFx Number 3120003010 for Pharmacy Benefit Manager Services
  Opening Date: 3:00 PM CST, December 12, 2024
  Mississippi Department of Finance & Administration, Office of Insurance
  Attention: Alicia Coleman, MDFA OI Procurement and Contracts Director
  501 North West Street, Suite 1201-C Woolfolk Building
  Jackson, Mississippi 39201
  SEALED PROPOSAL – DO NOT OPEN

  The time and date of receipt will be indicated on the sealed proposal envelope or package by Agency staff. The only acceptable evidence to establish the time of receipt at the office identified for proposal opening is the time and date stamp of that office on the proposal wrapper or other documentary evidence of receipt used by that office.

If submitted in a paper format, the original written proposal shall be signed with two identical copies of the original each submitted in a three-ring binder. The two (2) file versions of their proposal described below (Complete and Redacted) must be clearly labeled/identified. One electronic copy must be included with the two (2) separate/distinct files in a searchable Microsoft Office® format, preferably in Word® or Portable Document Format (PDF®) on flash drive or compact disk.

- Proposals submitted by facsimile (fax) machine will not be accepted/considered.

- All vendors are urged to take the possibility of delay into account when submitting a proposal. Timely submission of the proposal package is the responsibility of the Vendor. Proposals received after the specified time will not be considered. It is suggested that if a proposal is mailed to MDFA, it should be posted in certified mail with a return receipt requested. MDFA will not be responsible for mail delays or lost mail. All risk of late arrival due to unanticipated delay – whether delivered by hand, U.S. Postal Service, courier or other delivery service or method – is entirely on the Vendor.

- Proposals received after the specified time will be rejected. At the sole discretion of the Agency, any late proposal may be returned to the vendor or maintained in the procurement file. A proposal received at the place designated in the solicitation for receipt of proposals after the exact time specified for receipt will not be considered unless it has been determined by the Agency that the late receipt was due solely to mishandling by the Agency after receipt at the specified address.

- **Submission Format** – Each vendor must submit their proposal in the style and format outlined herein.

  The three units of the proposal shall be comprised of the following twelve (12) sections. It is the Vendor's responsibility to organize and separate the information into units and sections accordingly. **Cost Unit is Section 9; Technical Unit consists of Section 8; and Management Unit consists of Sections 1-7 and 10-12.**

  The proposal should be labeled and submitted as applicable per file version:

  Section 1 – Introduction/Signed Proposal Cover Letter

  Section 2 – Scope of Services Confirmation

  Section 3 – Minimum Vendor Requirements Confirmation

  Section 4 – Performance Standards

  Section 5 – Signed Statement of Compliance and Exception(s) form

  Section 6 – Signed Statutory Requirement Disclosure Statement

  Section 7 – General Questionnaire

  Section 8 – Technical Questionnaire

  Section 9 – Administrative Cost and Network Proposal Section

Section 10 – Signed Acknowledgement of RFP Amendments (if any)

Section 11 – Résumés for Key Staff: Provide a complete résumé of key vendor staff who will be assigned to render services to the Board, including detailed information on any special training or designations and each person's respective total number of years of experience related to the services being requested in this RFP.

Section 12 – Any Additional Information Not Specifically Requested: If you have additional information you would like to provide, include it as Section 12 of your proposal. It is the Vendor's sole responsibility to submit information relative to the evaluation of its proposal and the MDFA is under no obligation to solicit such information if it is not included in the proposal.

- Each page of the proposal should be numbered. Multiple page attachments and samples should be numbered internally within each document, and not necessarily numbered in the overall page number sequence of the entire proposal. The intent of this requirement is for the Vendor to submit all information in a manner that is clearly referenced and easily located.

- Vendors shall submit the following two (2) versions of their proposal as separate/distinct files:

  1. **Complete Unredacted Proposal File** - Provide one (1) electronic copy of the complete unredacted proposal including all attachments in a searchable Microsoft Office® format, preferably in Word® or Portable Document Format (PDF®);

  2. **Redacted Proposal File** - Provide one (1) "redacted" electronic copy of the complete proposal including all attachments and referenced documents in a searchable Microsoft Office® format, preferably in Word® or PDF®, if the proposal contains confidential information, as described below. If any portion of the proposal is considered confidential or proprietary, the Vendor shall also include an additional electronic "redacted" copy in PDF® of the complete proposal, including all appendices and exhibits, with all trade secrets or confidential commercial or financial information redacted. If the proposal does not contain any confidential information to be redacted, please state such in your Introduction/Signed Proposal Cover Letter. Failure to submit an electronic "redacted" copy of your proposal or include a statement that no information will be redacted may cause your proposal to be considered incomplete and it may be rejected from consideration.

     Any vendor claiming that its response contains information exempt from the Mississippi Public Records Act (Mississippi Code Annotated §§ 25-61-1 *et seq.*, 75-26-1 through 75-26-19, and/or 79-23-1), shall segregate and mark the information as confidential and provide the specific statutory authority for the exemption. If the proposal contains confidential information, one (1) redacted electronic copy of the complete proposal including all attachments shall be submitted in a searchable Microsoft Office® format, preferably in Word® or PDF®.

     If a redacted copy is not submitted, OI shall consider the entire Proposal to be public record. The redacted copy should identify which section or information has been redacted and the Vendor shall provide the specific statutory authority for the exemption. Per Mississippi Code Annotated § 25-61-9(7), the type of service to be provided, the price to be paid, and the term of the Contract cannot be deemed confidential.

Notice Regarding Redacted Version as Public Record: The redacted copy, or if the vendor did not provide a redacted version, the complete unredacted version, shall be considered public record and released, without notification to the Vendor, and will be produced as public record exactly as submitted. Redacted copies shall also be used/released for any reason deemed necessary by OI, including but not limited to, posting to the Transparency Mississippi website, etc.

Notice Regarding Redactions Made in Bad Faith: The vendor may be subject to exclusion pursuant to Chapter 15 of the *PPRB OPSCR Rules and Regulations* if the Agency or the PPRB determine that redactions made by the vendor were made in bad faith in order to prohibit public access to the portions of the proposal which are not subject to Mississippi Code Annotated §§ 25-61-1 et seq., 75-26-1 through 75-26-19, and/or 79-23-1.

Any party seeking a protective order on a procurement contract awarded by state agencies shall give notice to and provide the reasons for the protective order to the party requesting the information in accordance with the Mississippi Rules of Civil Procedure. The notice and reasons for the protective order must also be posted on the Mississippi Procurement Portal for a minimum of seven (7) days before filing the petition seeking the protective order in a chancery court. Any party seeking a protective order in violation of this subsection may be barred by a state agency from submitting bids, proposals or qualifications for state procurements for a period not to exceed five (5) years. Any records requested through a public records request shall be released no later than twenty-one (21) days from the date the third parties are given notice by the public body unless the third parties have followed the notification requirements and also filed in chancery court a petition seeking a protective order on or before the expiration of the twenty-one (21) daytime period.

- All documentation submitted in response to this RFP and any additional information submitted in response to subsequent requests for information pertaining to this RFP shall become the property of OI and will not be returned to the Vendor.

- All information requested is considered important. Failure to provide all requested information and in the required format may result in disqualification of the Proposal. OI has no obligation to locate or acknowledge any information in the proposal that is not presented under the appropriate outline and in the proper location according to the instructions herein.

- If determined that the Vendor has altered any language in the original RFP, the Board may, at its sole discretion, disqualify the Vendor from further consideration. The RFP issued by the Board is the official version and will supersede any conflicting language subsequently submitted in proposals.

10.2 Important Dates and Deadlines

October 16, 2024	Request for Proposal released
October 31, 2024, 5:00 PM CST	Questions and Requests for Clarification due to OI
November 7, 2024, 5:00 PM CST	Anticipated responses to vendor questions to be posted
December 12, 2024, 2:00 PM CST	Proposals submission deadline
December 12, 2024, 3:00 PM CST	Proposal Opening
January 10, 2025	Anticipated Finalists selected
January 16-17, 2025	Anticipated Presentations by finalists*

January 2025 Board Meeting	Anticipated Notice of Intent to Award distributed
2 Days following Board Meeting	Anticipated Notice of Contract Award published
3 Business Days of Notice of Intent to Award	Anticipated Post-Award Debriefing Request Due Date
3 Business Days of Debriefing Request	Anticipated Post-Award Debriefing Held by Date
7 Calendar Days of Notice of Intent to Award	Anticipated Request for Reconsideration of the Intent to Award Deadline Date
January 1, 2026	Contract(s) Effective Date/Services Begin

* Adjustments to the schedule may be made as deemed necessary by OI. The Board anticipates vendors selected as finalists will make presentations (possibly virtual) in Jackson, Mississippi. **Due to the constraints of the RFP timeline and the relative importance of presentations in the evaluation process, interested vendors are encouraged to be prepared to accommodate this schedule.**

10.3 Contact, Questions/Requests for Clarification, and Acknowledgment of Responses/RFP Amendments

Vendors must carefully review this solicitation, the Contract, risk management provisions, and all attachments for defects, questionable, or objectionable material. Following review, vendors may have questions to clarify or interpret the RFP to submit the best proposal possible. To accommodate the questions and requests for clarifications, vendors shall submit any such question via email by the deadline reflected in **RFP Section 10.2**. All questions and requests for clarifications must be directed by email to:

Alicia Coleman, MDFA OI Procurement and Contracts Director
Email: InsuranceRFP@dfa.ms.gov

Vendors should enter "**RFP RFx Number 3120003010 - Questions**" as the subject for the email. Question submittals should include a reference to the applicable RFP section and be submitted in the format shown below:

	RFP Section, Page Number	Vendor Question/Request for Clarification
1.		

Official responses will be provided only for questions submitted as described above and only to clarify information already included in the RFP. The identity of the organization submitting the question(s) will not be revealed. All questions and answers will be published on the Mississippi Contract/Procurement Opportunity Search Portal website and the MDFA's website as an amendment to the RFP by the date and time reflected in **RFP Section 10.2**.

The MDFA will not be bound by any verbal or written information that is not contained within this RFP unless formally noticed and issued by the contact person as an RFP amendment. Vendors are cautioned that any statements made by MDFA personnel that materially change any portion of the proposal document shall not be relied upon unless subsequently ratified by a formal written amendment to the proposal document.

All vendor communications regarding this RFP must be directed to the Proposal Coordinator or Point of Contact, Alicia Coleman. At no time shall any vendor or its personnel contact, or attempt to contact, any MDFA staff regarding this RFP except the contact person as set forth and, in the manner, prescribed herein. Unauthorized contact regarding the RFP with other employees of the MDFA may result in the Vendor being disqualified. Further, the Vendor may be suspended, disbarred, or removed from consideration from future contract award(s) pursuant to Chapter 15 of the *PPRB OPSCR Rules and Regulations*.

No pre-proposal submission conference will be held for this RFP.

OI reserves the right to amend this RFP at any time. Should an amendment to the RFP be issued, it will be posted on the Mississippi Contract/Procurement Opportunity Search Portal website and the MDFA's website under the heading "Solicitations" in a manner that all vendors will be able to view. Furthermore, OI will send issued amendment(s) directly via email to all prospective vendors known to have received a copy of the RFP. Vendors must acknowledge receipt of any amendment to the solicitation by signing and returning the amendment with the proposal package, by identifying the amendment number and date in the space provided for this purpose on the RFP amendment, or by letter. The acknowledgment should be received by the MDFA by the time, date, and at the place specified for receipt of proposals. It is the Vendor's sole responsibility to monitor the websites for any updates or amendments to the RFP. Questions and Answer document(s), if any are issued/posted on the Mississippi Contract/Procurement Opportunity Search Portal website and the MDFA's website, must be treated the same as an RFP Amendment, meaning they will require acknowledgement.

The RFP is comprised of the base RFP document, any attachments, any amendments issued prior to the submission deadline, and any other documents released before contract award.

10.4 Corrections and Clarifications

OI reserves the right to request clarifications or corrections to proposals. Any proposal received which does not meet any of the requirements of this RFP, including clarification or correction requests, may be considered non-responsive and eliminated from further consideration.

10.5 Modification, Withdrawal, or Rejection of a Proposal

Modifications or additions to any portion of the procurement document may be cause for rejection of the Proposal. OI reserves the right to decide, on a case-by-case basis, whether to reject a proposal with modifications or additions as non-responsive. As a precondition to proposal acceptance, OI may request the Vendor to withdraw or modify those portions of the proposal deemed non-responsive that do not affect quality, quantity, price, or delivery of the service and the Agency determines such a change is not prejudicial to the interest of the Agency or fair competition. The RFP issued by OI is the official version and will supersede any conflicting RFP language subsequently submitted in proposals.

A vendor may withdraw a submitted proposal by submitting a written notification for its withdrawal to OI, signed by the Vendor, and emailed, or mailed to the addresses provided **within RFP Section 10.1** prior to the time and date set for proposal opening. OI shall not accept any amendments, revisions, or alterations to proposals after the due date unless requested by OI. Late proposals shall not be considered for award and the Vendor shall be notified as soon as practicable.

If the price bid/offered is substantially lower than those of other vendors, a mistake may have been made. A vendor may withdraw its proposal from consideration if certain conditions are met:

1. The proposal is submitted in good faith;
2. The price bid/offered is substantially lower than those of other vendors because of a mistake;
3. The mistake is a clerical error, not an error of judgment; and,
4. Objective evidence drawn from original work papers, documents, and other materials used in the preparation of the proposal demonstrates clearly that the mistake was an unintentional error in arithmetic or an unintentional omission of a quantity of labor or material.

To withdraw a proposal that includes a clerical error after proposal opening, the Vendor must give notice in writing to OI of claim of right to withdraw a proposal. Within two (2) business days after the proposal opening, the Vendor requesting withdrawal must provide to OI all original work papers, documents, and other materials used in the preparation of the bid/offer.

A vendor may also withdraw a bid/offer, prior to the time set for the opening of proposals, by simply making a request in writing to OI. No explanation is required.

No vendor who is permitted to withdraw a proposal shall, for compensation, supply any material or labor to or perform any subcontract or other work for the person to whom the Contract is awarded, or otherwise benefit from the Contract.

No partial withdrawals of a proposal are permitted after the time and date set for the proposal opening; only complete withdrawals are permitted.

A proposal that includes terms and conditions that do not conform to the terms and conditions in the RFP document is subject to rejection as non-responsive. Further, submission of a proposal that is not complete and/or signed is subject to rejection as non-responsive. OI reserves the right to permit the Vendor to withdraw nonconforming terms and conditions from its proposal prior to a determination by OI staff of non-responsiveness based on the submission of nonconforming terms and conditions.

Any proposal may be rejected in whole or in part when in the best interest of the Agency pursuant to Section 6.10 of the *PPRB OPSCR Rules and Regulations.*

10.6 Right to Consider Historical Information

OI reserves the right to consider historical information regarding the Vendor, whether gained from the Vendor's proposal, conferences with the Vendor, references, or any other source during the evaluation process. This may include, but is not limited to, information from any state or federal regulatory entity.

10.7 Right to Reject Proposals, Cancel and/or Issue Another RFP

OI specifically reserves the right to reject any or all proposals received in response to the RFP, cancel the RFP in its entirety, or issue another RFP pursuant to Section 6.10 of the *PPRB OPSCR Rules and Regulations*.

10.8 Cost of Proposal Preparation/Expenses Incurred in the Procurement Process

All costs incurred by the Vendor in preparing and delivering its proposal, making presentations, and any subsequent time and travel to meet with the Board regarding its proposal shall be borne exclusively by the

Vendor pursuant to Section 1.4.4 of the *PPRB OPSCR Rules and Regulations* as updated and replaced by PPRB.

10.9 Contract and Property Rights

Contract rights do not vest in any party until a contract is legally executed. The Agency is under no obligation to award a contract following issuance of this solicitation.

Property rights do not inure to any Vendor until such time as services have been provided under a legally executed contract. No party responding to this RFP has a legitimate claim of entitlement to be awarded a contract or to the provision of work thereunder. MDFA is under no obligation to award a contract and may terminate a legally executed contract at any time.

10.10 Registration with Mississippi Secretary of State

By submitting a proposal, the Vendor certifies that it is registered to do business in the State of Mississippi as prescribed by Mississippi law and the Mississippi Secretary of State or, if not already registered, that it will do so within seven (7) business days of being notified by the MDFA that it has been selected for contract award. Sole proprietors are not required to register with the Mississippi Secretary of State.

10.11 Vendor Investigations and Certifications

Before submitting a proposal, each vendor shall make all investigations and examinations necessary to ascertain all site conditions and requirements affecting the full performance of the Contract and to verify any representations made by the MDFA upon which the Vendor will rely. If the Vendor receives an award because of its proposal submission, failure to have made such investigations and examinations will in no way relieve the Vendor from its obligation to comply in every detail with all provisions and requirements of the Contract documents, nor will a plea of ignorance of such conditions and requirements be accepted as a basis for any claim whatsoever for additional compensation.

By submitting a proposal, the Vendor certifies the following:

1. That he/she has thoroughly read and understands the RFP and all attachments thereto;
2. That the company meets all requirements and acknowledges all certifications contained in the RFP and attachments thereto;
3. That it is not currently debarred from submitting proposals for contracts issued by any political subdivision or agency of the State of Mississippi and that it is not an agent of a person or entity that is currently debarred from submitting proposals for contracts issued by any political subdivision or agency of the State of Mississippi;
4. That the prices submitted in response to the solicitation have been arrived at independently and without, for the purpose of restricting competition, any consultation, communication, or agreement with any other vendor or competitor relating to those prices, the intention to submit a proposal, or the methods or factors used to calculate the prices bid/offered;
5. That such vendor has not retained any person or agency on a percentage, commission, or other contingent arrangement to secure this Contract. If the vendor cannot make such a representation, a full and complete explanation shall be submitted in writing; and,
6. That such vendor has not, is not, and will not offer, give, or agree to give any employee or former employee of MDFA a gratuity or offer of employment in connection with any approval, disapproval, recommendation, development, or any other action or decision related to the

solicitation and resulting contract. Further, that no employee or former employee of MDFA has or is soliciting, demanding, accepting, or agreeing to accept a gratuity or offer of employment for the reasons previously stated; any such action by an employee or former employee in the future, if any, will be rejected by Vendor. Further, that such vendor is in compliance with the Mississippi Ethics in Government laws, codified at Mississippi Code Annotated §§ 25-4-101 through 25-4-121, and has not solicited any employee or former employee to act in violation of said law.

The Vendor agrees that submission of a signed proposal, Administrative Cost and Network Proposal Section, and best and final offer (BAFO) (if requested), is certification that the Vendor will accept an award made to it because of the submission. Under no circumstances, shall the maximum time for proposal acceptance by the State extend beyond one (1) year from the date of opening.

10.12 State Approval

It is understood that the resulting contract may require approval by the PPRB. If required and if this contract is not approved, it is void and no payment shall be made hereunder. Every effort shall be made by OI to facilitate rapid approval and a start date consistent with the proposed schedule.

10.13 Proposal Evaluation and Basis for Award

All proposals received in response to this RFP by the stated deadline will receive a comprehensive, fair, and impartial evaluation. A formal scoring methodology comprised of three phases – compliance, analysis, and finalist, will be utilized with each proposal required to pass the previous phase to qualify for further evaluation in the next phase. MDFA will use an evaluation committee to review and evaluate the proposals using a 100-point scale as well as consensus scoring. Consensus scoring involves a solidarity or general agreement of opinion among evaluators, based on information and data contained in the RFP proposals. The evaluation of any proposal may be suspended and/or terminated at the OI's discretion at any point during the evaluation process at which time OI determines that said proposal and/or vendor fails to meet any of the mandatory requirements as stated in this RFP, the proposal is determined to contain fatal deficiencies to the extent that the likelihood of selection for contract negotiations is minimal, or OI receives reliable information that would make contracting with the Vendor impractical or otherwise not in the best interests of the Board and/or the State of Mississippi.

Compliance Phase - In this initial phase of the evaluation process, all proposals received are reviewed by the MDFA OI Procurement and Contracts Director and/or designee to determine if mandatory RFP requirements have been satisfied, meaning whether a proposal/vendor is responsive, responsible, and/or acceptable. Compliance requirements are not assigned a point percentage or score but are simply recorded as Pass or Fail.

- Every statement containing "must," "shall," "will," etc., is a mandatory requirement. Failure to respond leads to mandatory proposal disqualification. Such mandatory requirements are to be clear and (preferably) standing alone.

- Every statement containing "may," "can," "should," etc., is a desirable requirement. Vendors may ignore these if they wish. The only penalty for doing so is a possible loss of scoring points if the requirement has scoring points tied to it.

A Pass score is assigned to each factor for which the response to the question(s) defined is "Yes." If any factor receives a Fail score or for some reason cannot be evaluated, an explanation of the problem or concern and the corresponding question must be evaluated and made part of the record, to include any allowable waivers.

Proposals with errors that do not alter the substance of the proposal can be accepted, and the MDFA OI Procurement and Contracts Director may allow the Vendor to correct the problem prior to review if the irregularities are insignificant mistakes that can be waived or corrected without prejudice to other vendors. MDFA has the right to waive minor defects, variations, or informalities of a proposal from the exact requirements of the specifications. Minor informalities are matters of form rather than substance; are evident from the proposal; are insignificant mistakes which can be waived or corrected without prejudice to other offerors; and the effect of a correction on price, quantity, quality, delivery, or contractual conditions is negligible. MDFA may waive such informalities or allow the offeror to correct them depending on which the Agency determines is in its own best interest and does not prejudice the other offerors. If insufficient information is submitted by a vendor with the proposal for the MDFA to properly evaluate the proposal, the MDFA has the right to require such additional information as it may deem necessary after the time set for receipt of proposals, provided that the information requested does not change the price, quality, quantity, delivery, or performance time of the services being procured and such a request does not create an unfair advantage for any vendor. Discussions may be conducted with vendors who submit proposals determined to be reasonably susceptible of being selected for the award, but proposals may also be accepted without such discussions. If any component received a Fail score (a "No" response) on any item or contains an item which for some reason cannot be evaluated, it shall be deemed as non-responsive and/or non-responsible. Failure to comply with these RFP requirements may result in the proposal being eliminated from further consideration. All proposals which are determined to be responsive, responsible, and/or acceptable will continue to next phase.

Analysis Phase - In this phase of the evaluation process, the evaluation committee will utilize consensus scoring to determine numerical scores for each proposal. The evaluation factors are listed in order of their relative importance and weight:

1. **Cost (Weight/Value of 45%/Points)** – Cost is reviewed by the MDFA OI Procurement and Contracts Director and/or designee as it is objectively scored based on the competitiveness of the proposed fees, rates, price, or cost offered. The lowest cost proposed will receive a maximum of 45 points allocated to cost. The point allocations for cost on the other offers will be evaluated according to the following formula: Price of the lowest responsive and responsible offer divided by the price of the responsive and responsible offer being rated times the maximum 45 points allocated for cost equals the awarded points.

2. **Technical (Weight/Value of 35%/Points)** – Technical factors are scored by the evaluation committee and generally aid in determining the Vendor's technical ability to perform the service or provide the commodity. The evaluation committee will provide consensus scores of the quality and completeness of the Vendor's solutions and action plans for providing the services identified, demonstrating understanding, responsiveness, effectiveness, efficiency, and value to the Board in proposed approach.

3. **Management (Weight/Value of 15%/Points)** – Management factors are scored by the evaluation committee and generally aid in determining the Vendor's past performance of the service or provision of the commodity. The evaluation committee will provide consensus scores

of the personnel, equipment, and facilities to provide timely access to pharmacy benefit manager services for a plan of comparable size; the ability to technically implement and maintain the structure and resources for providing all services listed in this RFP, demonstrating where applicable the ability to perform the service reflected by technical training, education and general experience of staff and a documented record of past performance of providing services required in this RFP.

Finalist Phase - Upon completion of the Analysis Phase, the evaluation committee reviews and compares the numerical scores from among the vendors to determine finalists. The top scoring vendor, as well as all other vendors with scores within ten (10) points of the top scoring vendor, will be named as finalists and will be further evaluated. In the finalist phase of the evaluation process, the evaluation committee will seek to determine from among the finalists whose proposal is the most advantageous to the Board. This phase consists of the following components:

1. **Record of Past Performance of Similar Work (Experience and Qualifications)** – From among the finalists, client references will be contacted to verify a demonstration of an acceptable level of past performance for programs of a similar size and complexity to this program. **Weight/Value – This component of the evaluation is considered pass/fail.**

2. **Finalist Presentations and Site Visits (Weight/Value of 5%/Points)** – At the OI's discretion, all finalists may be required to make a presentation to the evaluation committee. If scheduled, individual finalist presentations shall be held either in Jackson, Mississippi, or virtually, to allow the evaluation committee the opportunity to conduct technical interviews of the finalists, and to confirm/clarify information provided in the submitted proposals or otherwise gathered during the evaluation process. Any substantial oral clarification shall be reduced to writing by the Vendor. The Board may also determine the need to conduct site visits as a component of the evaluation process. The Board will provide at least five (5) days advance notice to the impacted vendors. At the Board's discretion, site visits may be conducted for each finalist to allow the evaluation committee the opportunity to observe, confirm, and evaluate the Vendor's operations, systems, and respective resources as described in the response to the RFP. The Board may require access to the Vendor's claims data to confirm the accuracy of information provided in its proposal, and to evaluate the quality of service provided. Due to the constraints of the RFP timeline and the relative importance of presentations and site visits in the evaluation process, interested vendors are encouraged to be prepared to accommodate this schedule.

3. **Best and Final Offer (BAFO)** – At the OI's discretion, all finalists may be given the opportunity to provide a BAFO relative to their cost proposal. OI will notify finalists if a BAFO may be submitted and will establish a date and time for submission. Although a finalist is under no obligation to submit such an offer, any such BAFO should include any applicable revised financial exhibits and must be signed by an appropriate representative of your company. If a finalist chooses to not make a BAFO, the financial proposal included in your company's response to the RFP will be considered as the BAFO. NOTE: Unsolicited BAFO, including but not limited to such offers submitted by non-finalists, will not be accepted. **Weight/Value – The numerical scores for the Cost factor from the Analysis Phase will be adjusted for any BAFO received from a finalist.**

Upon completion of the evaluation of proposals, the evaluation committee will determine the top scoring proposal and provide a recommendation to the Board. The Board will decide as to the proposal deemed

most advantageous to the Board and will authorize the issuance of (an) intent to award the contract(s) to the selected vendor(s) and authorize contract negotiations with selected vendor(s). After such authorization by the Board, all participating vendors will be notified in writing of the contract award(s) and will be afforded the opportunity to participate in a post-award debriefing.

The MDFA intends to award one contract to provide the services described within this RFP to a responsible and responsive vendor whose proposal is determined in writing to be the most advantageous to the State taking into consideration the price and the evaluation factors set forth in this RFP. No other factors or criteria shall be used in the evaluation. Award for this procurement will be posted on the Mississippi Contract/Procurement Opportunity Search Portal website and the agency website at https://www.dfa.ms.gov/bids-and-rfps-notices. All responding vendors will be notified via email of the award.

OI reserves the right to further clarify and/or negotiate with selected vendor(s) evaluated best following completion of the evaluation of proposals but prior to contract execution if deemed necessary. OI reserves the right to further clarify and/or negotiate with selected vendor(s) on any matter submitted to facilitate arriving at contract(s). OI also reserves the right to move to the next best vendor if negotiations do not lead to executed contract(s) with the best vendor(s).

10.14 Post-Award Vendor Debriefing

A vendor, successful or unsuccessful, may request a post-award vendor debriefing, in writing, by email (InsuranceRFP@dfa.ms.gov). Vendors should enter "**RFP RFx Number 3120003010 – Debriefings**" as the subject for the email. The written request must be received by Alicia Coleman, MDFA OI Procurement and Contracts Director, within three (3) business days of notification of contract award(s). A post-award vendor debriefing is a meeting and not a hearing; therefore, legal representation is not required. A debriefing typically occurs within three (3) business days of receipt of the request. If a vendor prefers to have legal representation present, the Vendor must notify Alicia Coleman, MDFA OI Procurement and Contracts Director, in writing and identify its attorney by name, address, and telephone number. The MDFA will schedule and/or suspend and reschedule the meeting at a time when a Representative of the Office of the Mississippi Attorney General can be present.

For additional information regarding Post-Award Vendor Debriefing, please refer to Section 6.9.2, Debriefings, of the *PPRB OPSCR Rules and Regulations* as updated and replaced by PPRB.

10.15 Request for Reconsideration of the Terms of the Solicitation or the Intent to Award

Any actual or prospective vendor who is aggrieved in connection with this solicitation or the outcome of this RFP may file a request for reconsideration with Alicia Coleman, MDFA OI Procurement and Contracts Director, and the MDFA Director of OPSCR. It shall be the sole responsibility of the requesting vendor to ensure the request is timely received by all required parties. Failure to timely request reconsideration in compliance shall result in waiver of any claim a vendor may have.

If requesting reconsideration of the terms of the solicitation, the request shall be submitted within three (3) business days following the date of public notice as defined in *PPRB OPSCR Rules & Regulations* Section 6.5.1. The request shall contain the requesting vendor's name, a single contact person, all contact information for the contact person, the RFx number of the solicitation, the date the RFP was issued, and an explanation of the specific basis for the request, including the identification of which of these rules and

regulations the requesting offeror believes were violated by the solicitation, as written. The request may not be based on anything other than the solicitation document and the Rules and Regulations of the Office of Personal Service Contract in effect at the time of the issuance of this RFP.

If requesting reconsideration of the intent to award, the request shall be submitted within seven (7) calendar days of the Notice of Intent to Award and posting of the Agency Procurement File, in writing after such aggrieved person or entity knows or should have known of the facts giving rise thereto. The request shall contain the requesting vendor's name, a single contact person, all contact information for the contact person, the RFx number of the solicitation, the date the RFP was issued, the date the Notice of Intent to Award was issued, and an explanation of the specific basis for the request, including the identification of which of these rules and regulations and/or the terms of the RFP the requesting vendor believes were violated by the Agency during the evaluation process, explain the factual basis for the alleged violation(s), and specify how the alleged violation(s) affected the outcome of the procurement. The request shall not be based on anything other than the Agency Procurement File, these rules and regulations, and the terms of the RFP or RFQ. If the requesting vendor believes the Agency Procurement File posted on the Agency website is incomplete (i.e., does not contain a document or documents required by these rules and regulations), the requesting vendor shall so state in the request and shall specify what it believes to be missing. Should the requesting vendor believe the trade secrets and/or confidential commercial or financial information which were redacted from the Agency Procurement File posted on the Agency website contain issues related to its request, the requesting vendor shall state those concerns in the request – even if speculative – in a manner which is specific enough for the Agency to provide a response.

All requests must be in writing, dated, signed by the Vendor or an individual authorized to sign contracts on behalf of the requesting vendor. Exhibits shall not be included with the request. The request shall not be supplemented. Reference to documents outside of or facts not supported by the Agency Procurement File or the RFP shall not be considered by the Agency when responding to the request.

10.16 Required Contract Terms and Conditions

A draft contract has been included as Appendix A to this RFP for your review and comment. Any contract entered into with the MDFA pursuant to this RFP shall have the clauses in blue font as these are required pursuant to the PPRB OPSCR Rules and Regulations as updated and replaced by PPRB. These required clauses are mandatory. While edits may be limited, reasonable requests may be considered. MDFA discourages exceptions from the draft contract content, regardless of content being required or not. Such exceptions may cause a proposal to be rejected as non-responsive. Proposals which condition the proposal based upon the State accepting other terms and conditions not found in the RFP, or which take exception to the State's terms and conditions, may be found non-responsive, and no further consideration of the proposal will be given.

10.17 Agency Website

This RFP, any amendment thereto, such as Questions and Answer document(s) and Summary of Pre-Proposal Submission Conference, Tour, or Site Visit, if any were issued, the Notice of Intent To Award, and the Evaluation Report will be posted on the agency website at https://www.dfa.ms.gov/bids-and-rfps-notices and on the Mississippi Contract/Procurement Opportunity Search Portal website at https://www.ms.gov/dfa/contract_bid_search.

10.18 Attachments

The attachments to this RFP are made a part of this RFP as if copied herein in words and figures.

Appendix A

Draft Pharmacy Benefit Manager Services Contract

Pharmacy Benefit Manager Services Contract

This Pharmacy Benefit Manager Services Contract (Contract) is made by and between the Mississippi State and School Employees Health Insurance Management Board (Board), acting administratively through the Mississippi Department of Finance and Administration (MDFA), and [Insert] (Contractor), effective January 1, 2026, under which the Contractor agrees to provide pharmacy benefit management services to the Mississippi State and School Employees' Life and Health Insurance Plan (Plan), subject to the following terms and conditions:

1. Definitions

A. "**Aggregator**" means the company that helps manage the complex world of formulary and rebate management for pharmacy benefit managers (PBMs), health plans, and employer groups. These aggregators are often PBM owned or affiliated.

B. "**Allowable Charge**" means the lesser of the amount payable under the terms of the pharmacy's contract with the PBM for a covered drug or the cash price inclusive of all applicable customer discounts which a cash paying customer of the pharmacy pays for a covered drug.

C. "**AWP**" means the "average wholesale price" for a standard package size of a prescription drug from the most current pricing information provided to PBM by Medi-Span Prescription Pricing Guide, or following approval by the Board, any other nationally available reporting service of pharmaceutical prices as utilized by PBM as a pricing source for prescription drug pricing. The AWP used is based on the date sensitive 11-digit national drug code (NDC) of the actual package size dispensed as set forth by Medi-Span on the date the claim is dispensed.

D. "**Brand Name Drug**" means drug that has a trade name and is protected by a patent. A brand name drug may only be produced and sold by the pharmaceutical company holding the patent or a pharmaceutical company that has been licensed and authorized by the patent holder to produce and sell the drug. Medi-Span Multi-Source Indicator will be used for calculating aggregate financial guarantees. For prescription drug claims processed where the underlying prescription drug product is identified having a multi-source indicator code identifier of "M", "N", or "O" on the date dispensed, the claim should be considered a Brand claim unless otherwise noted as an exclusion. Claims processed where the multi-source indicator is a "Y" on the date dispensed will be considered as Generic claims.

E. "**Compound Drug**" shall mean a formulation containing one or more "Drug Products", which is extemporaneously weighed or measured then prepared by a pharmacy in accordance with a physician's prescription order. A compound drug prescription meets the following criteria: two or more solid, semi-solid or liquid ingredients, at least one of which is a covered drug that is not commercially available. Compound drug claims will only be covered for drugs for which the compounded product is not commercially available.

F. "**Copayment**" means that portion for a covered prescription which, under the terms of the Plan, is required to be paid by the participant directly to the pharmacy. The Employee will pay the lower of:

a. the copayment, coinsurance or deductible;
b. the acquisition cost, plus dispensing fee; or
c. the pharmacy's usual and customary charge for the drug product, MAC (maximum allowable cost) or retail cash price.

G. "**Covered Service**" means a prescription drug provided under the terms of this contract for which payment may be requested under terms of the Plan.

H. "**Employee**" means an eligible person who has satisfied the specifications of the Plan's Plan Document's eligibility guidelines and has enrolled for coverage under the Plan. Unless otherwise, "Employee" refers to an active employee, a retired employee or a COBRA participant.

I. "**Formulary**" means the PBM's Performance Drug List (PDL), which is a list of pharmaceutical products and supplies, quantity limits, prior authorization guidelines, and clinical guidelines detailing coverage of such products, created and maintained by the PBM, as amended from time to time, which: (a) has been approved by PBM's pharmacy and therapeutics committee; (b) reflects the PBM's recommendations as to which pharmaceutical products should be given favorable consideration by plans and their participants; (c) includes all standard clinical programs, including but not limited to prescribing guidelines such as prior authorization, step therapy, and quantity level limits, if elected by the Board; and (d) includes any custom request by the Board for addition or deletion of drugs at the sole discretion of the Board.

J. "**Generic Drug**" means a drug that is therapeutically equivalent (identical in strength, concentration, and dosage form) to a Brand Name Drug and that generally is made available when patent protection expires on the Brand Name Drug. The Board's expectation is that Medi-Span Multi-Source Indicator will be used for calculating aggregate financial guarantees. For prescription drug claims processed where the underlying prescription drug product is identified having a multi-source indicator code identifier of "M", "N", or "O" on the date dispensed, the claim should be considered a Brand claim unless otherwise noted as an exclusion. Claims processed where the multi-source indicator is a "Y" on the date dispensed will be considered as Generic claims.

K. "**Group Purchasing Organization**" or "**GPO**" is an entity that is created to leverage the purchasing power of a group of businesses to obtain discounts from vendors based on the collective buying power of the members. PBM-lead GPOs are organizations formed by PBMs with one or more members, whose primary purpose is to aggregate purchasing volume to negotiate discounts with biopharmaceutical manufacturers.

L. "**Health Insurance Portability and Accountability Act**" or "**HIPAA**" shall refer to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

M. "**Health and Wellness Management Vendor**" means the vendor that provides health and wellness management services to the Plan including, but not limited to, incentive management and wellness promotion management services and at the discretion of the Board may include disease management, maternity management, weight management, tobacco cessation, and a clinical improvement promotion program that includes four wellness coaches strategically located in Mississippi and an online portal, mobile app, and digital coaching.

N. "**Limited Distribution Drugs**" means specialty drugs which are distributed to either one (1) or a very limited number of pharmacies, distributors or wholesalers.

O. "**Maximum Allowable Cost**" or "**MAC**" means the unit price that has been established by the PBM for a multi-source generic drug (i.e., a generic drug with more than two sources) included on the MAC drug list applicable to the Board, which list may be amended from time to time by the PBM

in maintaining its generic pricing program. A copy of such MAC drug list shall be provided to the Board prior to execution of this contract and thereafter upon the Board's reasonable request.

P. "**Network Pharmacy**" means a retail pharmacy, home delivery pharmacy, specialty pharmacy or other facility that is duly licensed to operate as a pharmacy and is owned or operated by the PBM (or an affiliate) or has entered into a Network Pharmacy Agreement.

Q. "**Paid Claims**" means all transactions made on eligible participants that result in a payment to pharmacies or participants from the Plan or the Plan participant copayments. (Does not include reversals, rejected claims and adjustments.) Each unique prescription that results in payment shall be calculated separately as a paid claim.

R. "**Participant**" means an individual eligible to receive prescription drug services for which payment may be sought under the terms of the Plan.

S. "**Participating Provider**" means a pharmacy or pharmacist which has entered into a contract with the PBM to provide prescription drug services under this contract. All pharmacists employed by a Participating Provider are subject to all requirements imposed on Participating Providers under this Contract.

T. "**Pharmacy Benefit Manager**" or "**PBM**" means the entity that administers the prescription drug portion of the Plan. The PBM is expected to provide pharmacy claims processing, mail order pharmacy services, and other services, such as rebate administration, development and management of pharmacy networks, formulary management, drug utilization review programs, generic drug substitution, and disease management programs.

U. "**Plan**" means the self-insured Mississippi State and School Employees' Health Insurance Plan as defined in Mississippi Code Annotated § 25-15-1 et. seq.

V. "**Plan Document**" means the document that states the benefits and eligibility terms of the Plan. The Plan Document is published and maintained by the Board. All benefits under the Plan are subject to the Plan Document. The 2024 Plan Document is available on the Plan's website at https://knowyourbenefits.dfa.ms.gov/publications/.

W. "**Rebate**" means any compensation or remuneration of any kind received or recovered by the PBM, or any of its affiliates from a pharmaceutical manufacturer attributable to the purchase or utilization of covered drugs by eligible persons, including, but not limited to, incentive rebates categorized as mail order purchase discounts; credits; rebates, regardless of how categorized; market share incentives; promotional allowances; commissions; educational grants; market share of utilization; drug pull-through programs; implementation allowances; clinical detailing; rebate submission fees; and administrative or management fees. Rebates also include any fees that PBM, or any of its affiliates, receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access.

X. "**Specialty Drug**" means pharmaceutical products that are typically expensive and require special handling and monitoring such as patient training, care coordination, adherence monitoring. They can be administered orally or through injection, infusion, inhalation, or other non-oral methods. Many are biologically developed (biologics) and can be used to treat chronic, life threatening, and rare conditions.

Y. "**Specialty Pharmacy**" means a contracted pharmacy providing Specialty Drugs, including any specialty pharmacies owned by the PBM.

Z. "**Third Party Claims Administrator**" means the organization under contract to the Board responsible for processing all medical claims, other than claims for prescription drug services, received from participants.

AA. "**Usual and Customary**" or "**U&C**" means the amount a Network Provider would charge to a cash paying customer for same strength, quantity, and dosage form of a covered drug, as of the date the prescription is filled.

BB. "**Utilization Management Vendor**" means the vendor that provides utilization management services to the Plan including, but not limited to, hospital management services (hospital admission, pre-admission and post-discharge outreach, and case management), continued stay management, discharge planning, retrospective review, review of high-cost diagnostic procedures, and medical necessity review for specified medical services.

2. Responsibilities of the PBM

This section contains information on services and procedures the PBM must provide, or adhere to, in servicing the Board's account, either directly or through identified subcontractors. The applicable *Plan Document* provides specific details of the Plan and is located on the Plan's website at https://knowyourbenefits.dfa.ms.gov/publications/.

The PBM agrees to perform all services required in this Contract in accordance with customary and reasonable industry standards as well as in strict conformance to all laws, statutes, and ordinances and the applicable rules, regulations, methods and procedures of all government boards, bureaus, offices, and other agents whether currently in place, updated and replaced, or newly created. The PBM shall be responsible for the complete performance of all work; for the methods, means, and equipment used; and for furnishing all materials, tools, apparatus, and property of every description used in connection therewith. No statement within this Contract shall negate compliance with any applicable governing regulation. The absence of detail specifications or the omission of detail description shall be recognized as meaning that only the best commercial practices are to prevail and that only first quality materials and workmanship are to be used.

The PBM shall provide the following services:

A. Account Management

1) Hire and maintain sufficient staff to meet the needs of the Board and the Plan's participants.

2) Comply with staffing minimum requirements provided in **Section 3.2 through 3.3** of the *Mississippi State and School Employees Health Insurance Management Board's Request for Proposals for Pharmacy Benefit Manager Services, dated October 15, 2024*.

3) Maintain an adequate customer service staff to respond to inquiries from participants, providers, and MDFA staff regarding the services provided by the PBM through a toll-free telephone line. The service shall be available 24 hours, 7 days a week, other than scheduled maintenance times,

to participants and providers. Currently, the Board's pharmacy customer service center averages 4,300 calls per quarter.

4) Provide competent and proficient account management staff to promptly address and respond to any staffing concerns with MDFA.

5) Cooperate with the Board and with all other contractors of the Board with respect to the ongoing coordination and delivery of health care services, and in any transition of responsibilities.

6) Provide consultative services regarding pharmacy benefit design including, but not limited to, formularies, allowable charges, generic drug incentives, implementation of programs which control utilization and optimize health, utilization review services, and evaluation of drug use and cost data.

7) Participate in activities with the PBM and/or MDFA staff in responding to participant or provider inquiries or complaints relating to pharmacy benefit services.

8) Conduct at least one (1) customer satisfaction survey within the third quarter of the initial contract period and one (1) annually thereafter. The contents of the satisfaction survey must be agreed upon by the Board and the PBM.

9) Participate, at its own expense, in health/benefit fairs to educate participants throughout the State.

10) All services directly related to this contract must be provided from an office located within the United States.

B. Pharmacy Benefit Manager Services

The PBM's duties and responsibilities shall include, but are not limited to, the following:

1) Comply with mutually agreed service performance guarantees. Refer to **RFP Section 4, Performance Standards**, and **Exhibit B, Performance Standards and Discount Guarantees,** of the proposed contract.

2) Pharmacy Network Service:

a. The PBM is responsible for the delivery of quality prescription drug services to participants through discount arrangements or other financial contracts with participating pharmacies. The PBM must maintain a pharmacy re-credentialing process at least every three years or as otherwise required by URAC or CMS.
b. The PBM is required to maintain a separate credentialing process for specialty and compound pharmacies. The PBM is required to provide an open credentialing process for specialty network without unnecessary restrictions such as limited application period, licensed in at 50 states, etc.
c. The PBM is required to provide on-line access to a directory of participating pharmacies, including their names, addresses and telephone numbers. Participating pharmacy information must be regularly maintained and updated.

d. The PBM agrees to notify MDFA staff at least 60 days in advance regarding termination of a current pharmacy chain or independent pharmacy. PBM agrees to also notify impacted participants within 15 days of termination.
e. The PBM must include independent pharmacies in the proposed retail network and all guarantees proposed are inclusive of independent pharmacies.

3) Communication Materials/Forms:

The PBM, at its own cost, is responsible for designing, printing, and distributing brochures, preferred drug lists, and forms, cobranded, and with the Board's approval, as necessary and required to establish and administer pharmacy services and programs. Communication materials/forms will be mailed to participants, employer units, and the Board.

4) Identification Cards:

The PBM, at its own cost, must provide routine distribution of ID cards, including printing, mailing, and postage. The PBM, at its own cost, will provide ID cards directly to the participant's home address for (1) the initial enrollment of the Plan, (2) future new enrollees, (3) participants who change coverage category (e.g. single to family), and (4) replacement of lost cards. Participants with single coverage should receive one (1) ID card; participants with dependent coverage should receive at least two (2) ID cards. The information to be printed on each ID card will include, at a minimum, the participant's name and identification number, Plan name, the PBM name and toll-free customer service telephone number.

5) Claims Processing Services:

a. The PBM's claims processing services must include, at a minimum, verification of eligibility, review of claims in accordance with the Plan benefits, receipt, processing, adjustment, and authorization of claim payments and provision of claim forms.
b. The PBM must maintain, at a minimum, the following information for all claims: participant name, participant identification number, patient name or other specific identifier, claim number, pharmacy number, pharmacy name, service date, mail/retail indicator, formulary flag, specialty indicator, ingredient cost, dispensing fee, sales tax amount, plan paid amount, copayment amount, NDC, and drug name.
c. The PBM must be able to accommodate multiple plan designs such as the Plan's current Base Coverage and Select Coverage as described in the 2024 Plan Document (https://knowyourbenefits.dfa.ms.gov/publications/), and must be able to process claims with a deductible that is integrated with the medical plan deductible (i.e. Base Coverage).
d. The PBM must adjudicate all claims according to "lowest of" logic such that participants and the Plan pay the lowest cost of the contracted price or the pharmacy's usual and customary amount (including the pharmacy's sale price, if any). PBM will not be allowed to adjudicate claims based on 'zero balance logic" or on a minimum copayment amount, and retail pharmacies will not be allowed to collect a minimum payment.
e. Any pharmaceutical provider tax is to be paid by the PBM.

6) Federal Reporting:

As required by Federal law, the PBM, after discussions and negotiations with the Board, will prepare and file reports required by the Federal Government.

7) Coordination of Benefits:

The PBM is responsible for providing coordination of benefits (COB) services. The Third-Party Medical Claims Administrator (TPA) provides information regarding a participant's COB status to the PBM. The PBM must reject primary payment for participants for whom the Plan is secondary and must provide for secondary payment of prescription drug claims submitted, either electronically or by submission of a hard copy claim form to be obtained from the PBM. Benefits for secondary claims, are based upon the allowable charge, less the amount paid by the primary carrier, less the applicable copayment for that prescription drug. Any additional cost for this service must be included in the financial proposal.

8) Quality Control:

The PBM is responsible for quality control processes to regularly evaluate the performance and accuracy of the claims processing systems and the claims processing staff. Findings of quality control evaluations will be provided to the Board quarterly.

9) Appeal Resolution:

The PBM must provide an appeal process for claims partially or fully denied for payment upon the request of a participant or provider in accordance with guidelines outlined in the Plan Document at no extra cost to the Board. All appeal processing (e.g. first, second, and third/IRO level appeals) is to be provided by the PBM at no additional cost.

10) Prior Authorization Program:

The PBM must provide prior authorization services to promote cost management while ensuring that participants can access needed prescription drugs. The prior authorization program must use evidence-based guidelines and the latest clinical literature and outcomes data, as well as FDA guidelines. The PBM will advise the MDFA regarding those drugs for which the Plan may benefit by requiring prior authorization for coverage. The PBM's staff, under the supervision of clinical pharmacists, will review participant prescriptions for those drugs requiring prior authorization and/or medical necessity review in accordance with criteria, definitions and procedures developed by the PBM. The Board shall require prior authorization on drugs at its discretion.

11) Management Reporting:

The PBM must provide management reports, with content and in a format approved by the Board, at no additional charge. These reports will be provided, at the Board's request, in a hard copy and/or electronic format. The PBM must provide assigned MDFA staff access to web-based reporting tools for management and other reports. The PBM shall have the capability of providing ad hoc reports at the Board's request.

12) Drug Utilization Review (DUR):

The PBM is required to provide a concurrent, prospective and retrospective DUR system to assist pharmacy providers in screening certain drug categories for clinically important potential drug

therapy problems at the time the prescription is dispensed to the participant. The DUR program must provide an evaluation of drug therapy before each prescription is filled by means of an online, real-time, electronic point-of-sale claims management system. Evaluation must include, at a minimum, monitoring for therapeutic appropriateness, over-utilization and under-utilization, appropriate use of generic products, and screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug interactions, incorrect drug dosage or duration of drug treatment, physician profiling, and clinical abuse/misuse and, as necessary, introduce remedial strategies in order to improve the quality of care of the participant.

13) Step Therapy:

The PBM is required to provide a step therapy program designed to optimize rational drug therapy while controlling costs by defining how and when a particular drug or drug class should be used based on a patient's drug history.

14) Dosage Optimization:

The PBM is required to provide a dose optimization program designed to slow the rising cost of prescription drugs and help increase patient compliance with drug therapies. As part of the dose optimization program, the PBM must work with the participant, the health-care provider and pharmacist to replace multiple doses of lower strength drugs with a single dose of higher-strength drugs where appropriate.

15) Medication Adherence Program:

The PBM is required to provide a comprehensive pharmacy care program to improve medication adherence for participants with chronic conditions. As part of the medication adherence program, the PBM will provide telephonic coaching that will involve calls to participants from a health educator who is specially trained in chronic conditions. The calls will involve coaching participants on behavioral reinforcement strategies that will help them to continue taking their medications on schedule; calls will also include specially tailored education for the chronic condition. Doctors will receive written educational information on the rates of medication adherence, implications of non-adherence, and methods for improving adherence. Doctors will also receive alerts on participants who are not filling their medication prescriptions.

16) Quantity Limits:

The PBM is required to provide a limitation program for drugs which are indicated only for a specific therapeutic period or are limited to certain amounts. If, based on on-line adjudication, the quantity of a covered drug is not approved by the PBM, the prescribing physician must be allowed to contact the PBM for prior approval of additional quantities based on documentation of medical necessity.

17) Early Refill:

The PBM is required to process requests from participants, pharmacists, and providers for early refills or advance supplies of a medication due to vacations, dosage changes, or for lost or destroyed medication according to allowance per plan design.

18) Website:

The PBM will develop and maintain a searchable public website that is accessible to participants and providers. The website contains at a minimum:

a. A current provider directory
b. Ability to conduct a zip-code based pharmacy proximity search
c. Claim forms (Participant submitted paper claim forms) for both primary and secondary coverage
d. On-line mail order refill capabilities
e. Mail order forms
f. Formulary or preferred drug list
g. Total Drug Cost (participant and Plan payment) as well as alternative drug price check functionality
h. Research drug interactions, side effects, and risks of drugs
i. Determine the availability of generic substitutions
j. Health/wellness information

19) Field and Desk Audits:

The PBM shall conduct regular pharmacy field and desk audit services and the PBM must provide quarterly reports of audit activities and findings. Any errors will be addressed and corrected in a timely manner by the PBM. Any amounts recovered due to a field or desk audit will be 100% refunded to the Board no more than 45 days of the finding. The PBM is required to notify the Board of any provider termination resulting from an audit along with the reason for termination.

20) Specialty Medication and Supplies:

a. The PBM is required to provide an open Specialty Network for prescription fulfillment and distribution of specialty medications and supplies, pharmaceutical care management services, customer service, utilization and clinical management, integrated reporting, and claims processing. The specialty medication program must include, at a minimum, patient profiling focusing on the appropriateness of specialty medication therapy and care, and the prevention of drug interactions. The program must also include patient education materials, patient monitoring, adherence programs, and compliance programs. Programs such as drug utilization review, drug limitation (step therapy, quantity and supply limits) and prior authorization services must be extended to the specialty medication program. Channel distribution (retail, specialty, mail pharmacy) must be optimized for plan and participant savings.
b. The Specialty Network must open and comply with the State's "any willing provider" statutory requirements (Section 83.9.6 subs 3(b)). Note: An exclusive central fill distribution channel is not acceptable.
c. Specialty medications must be deliverable to the participant's residence or the participant's physician's office. The PBM must provide to participants a toll-free telephone access to a registered nurse, pharmacist, or patient care coordinator (as appropriate) twenty-four (24) hours per day, seven (7) days per week.
d. The Specialty Pharmacies must be properly licensed, certified or credentialed to operate in the applicable states where dispensing specialty operations reside.

e. The Specialty Pharmacies must collect copayments for specialty mail order services with no balance billing of unpaid copayments allowed.
f. The PBM must provide an overall specialty discount guarantee for those drugs dispensed through the exclusive specialty drug program in addition to a claim by claim, the greater of will apply.
g. The PBM agrees during the life of the contract no new therapeutic classes will be added to the specialty drug list without written consent of the State.
h. The PBM will adjudicate all specialty claims at the lesser of: (a) the contracted discount plus dispensing fee or (b) MAC plus dispensing fee.
i. The PBM will guarantee Retail/Specialty unit cost equalization meaning that Specialty unit costs for medications dispensed at non-retail specialty pharmacies prior to participant cost sharing, and dispensing fees will be no greater than the unit cost for the same NDC-11 at Retail.
j. The PBM will produce a date-sensitive comparison report showing unit costs charged to the State at a GCN-level and reimburse the State on a dollar-for-dollar basis for all instances where Specialty unit costs exceed retail unit's costs. Report and reconciliation will be provided on a quarterly basis, without a request being made by the State.
k. The Board may add or remove a drug from the specialty list at its sole discretion.

21) Mail Order Services:

a. The PBM must make available a mail order prescription drug program to process and dispense covered prescription drugs. Programs such as drug utilization review, drug limitation, and prior authorization services must be applied to mail order services and must be consistent with the retail channel.
b. The PBM's mail order service must provide to participants toll free telephone access to a pharmacist and customer service representative twenty-four (24) hours per day, seven (7) days per week.
c. The PBM will guarantee that discounts provided on mail order claims should meet or exceed those of retail.
d. In no event shall the cost of mail order medications (Plan or participant cost) be more than retail. Mail order is expected to save the Plan and will be monitored accordingly.

22) Individual Utilization Tracking Report:

The PBM must be capable of providing an annual on-line utilization tracking report to each participant utilizing the prescription drug program. The purpose of the annual utilization tracking report is not only to provide the participant with a complete list of prescription drugs processed through the prescription drug program, but to educate the participant regarding potential savings based on therapeutic and generic substitutions, dosage optimization, etc. At a minimum, the utilization tracking report should include:

a. Name and Address of PBM
b. Toll Free Number for PBM
c. Participant's Name and Address
d. Participant's Identification Number
e. Patient's Name
f. Provider Name
g. Claim Date of Service
h. Type of Service

i. Total Charges
j. Discount Amount
k. Allowed Amount
l. Excluded Charges
m. Amount Applied to Deductible
n. Copayment or Coinsurance Amount
o. Total Patient Responsibility
p. Total Payment Made and To Whom

23) Rebates:

a. The Board shall be entitled to receive the greater of: (1) the guaranteed minimum per claim rebate amount, or (2) 100% of all rebates, as defined by this RFP, paid by pharmaceutical manufacturers or intermediaries or other similar sources attributable to the Board's utilization that the PBM receives from any and all pharmaceutical manufacturers or intermediaries or other similar sources. These sources may include, but will not be limited to, market share incentives; promotional allowances; commissions; educational grants; Inflation protection; implementation allowances; clinical detailing; or rebate submission fees. The intermediary will pay the PBM 100% of the rebates it receives that are directly attributable to prescription drug claims paid by the Board, allowing the PBM to pay the Board 100% of the rebates collected, regardless of who collected them (the PBM or the intermediary). The Board shall have full unrestricted audit rights to ensure compliance by the PBM and its intermediary with transparency and rebate submission requirements. The PBM must ensure that, to the extent that the Plan's prescription drug purchases are included, any agreement the PBM now has, or subsequently enters into with an intermediary for rebate collection, contain sufficient language to provide the Board free and direct audit access to the financial records, claims data, remittance data, contracts (e.g. pharmacy network, pharmaceutical manufacturer, etc.), reports and other information required by the Board to verify that the Transparency requirement is being met by the PBM and the intermediary. Any fees or cost associated with rebates administration should be included in the PBM's bundled administration fee.
b. The PBM will offer price or inflation protection guarantees.
c. The PBM must pass through price protection received from manufacturers through rebates to the Plan and shall be reported to the Plan quarterly.
d. The PBM will provide an NDC level report on earned rebate dollars and all ancillary fees paid by pharmaceutical manufacturers for medications dispensed for the Plan in addition to the monthly and annual reconciliation reports.
e. The PBM must provide rebate reporting by therapeutic category and by manufacturer on a quarterly basis and down to the NDC level.
f. The PBM will charge one overall administrative fee for all pharmacy services which shall include, but not be limited to, fees for rebate management, retail management, formulary management, and network management.
g. Manufacturer coupons or copay card programs cannot be used or included in the calculation of any rebate guarantees. Savings generated by coupon or copay shall not be used in calculating rebate guarantees. However, in the event a participant utilizes a copay or discount card in addition to their Plan benefits, any savings earned are to be passed back to the Board at 100% of the total value of the rebate or manufacturer reimbursement payments.

24) Transparency:

a. The Board requires absolute transparency and full pass through of all revenue, whether rebates or not, by the PBM and from the aggregator and/or GPO that the PBM contracts with. All revenue, no matter the form or what it is called or where it comes from, must pass through the Plan.
b. The Board must have a transparent financial pricing arrangement from the PBM. "Transparency" refers to financial arrangements which represent a direct and complete pass-through of all elements of financial payments. The Board must receive the full and complete amount of any discounts received by the PBM from any and all retail pharmacies. The PBM will not retain a differential (i.e. spread) between the amount reimbursed to the PBM by the Board for each transaction and the payments made to the retail pharmacies by the PBM.
c. The Board will not apply the above standard to mail order or specialty pharmaceutical transactions when owned by the PBM. For these mail order or specialty pharmaceuticals, the Board will accept the best possible discount arrangements from the PBM as it relates to discounts from AWP. Rebates generated through mail order and/or specialty pharmaceuticals will be subject to the transparency requirement described herein.
d. The only compensation the PBM will receive, attributable to the Plan's utilization shall be from or on behalf of the Board, for the services described in this proposal or any subsequent contract, shall be the PBM's quoted administrative fees listed in the PBM's proposal or agreed upon in writing through subsequent discussion with the Board.
e. The PBM agrees to disclose details of all programs and services generating financial remuneration from outside entities.

25) Full Disclosure and Independent Review:

The Board must have access to all of the PBM, aggregator, and/or GPO's financial records including the Maximum Allowable Cost (MAC) list used to adjudicate the Plan's claims, claims data, remittance data, contracts (e.g. pharmacy network, pharmaceutical manufacturer, etc.), reports and other information required by the Board to verify that the transparency requirement is being met by the PBM, aggregator, and/or GPO during the period covered by the contractual term. Full disclosure as used herein would include, but not be limited to, auditing the following types of financial arrangements:

a. Any amount paid for the Plan by the PBM, aggregator, and/or GPO to retail pharmacies under contract with the PBM, aggregator, and/or GPO's retail network is subject to audit even though the PBM, aggregator, and/or GPO may deem said contracts proprietary and confidential;
b. Rebates or any other monies or fees, which include administrative fees, paid to the PBM, aggregator, and/or GPO by pharmaceutical manufacturers are subject to review for audit purposes;
c. Any amount paid for the Plan by the PBM, aggregator, and/or GPO to a mail order or specialty pharmacy, when not owned by the PBM, aggregator, and/or GPO, will be subject to audit, whether or not the contract is considered proprietary and confidential by the PBM, aggregator, and/or GPO;
d. Discounts negotiated directly by the PBM, aggregator, and/or GPO with manufacturers shall be subject to audit; and
e. Aggregate rebate collecting, reporting, and contractual arrangements.

The Board, at its discretion, may use the services of an independent reviewer to perform reviews/audits of the PBM, aggregator, and/or GPO's records on behalf of the Board. The Board

and its independent reviewer will comply with all applicable confidentiality laws and will not reveal any confidential information acquired as a result of the review/audit. The Board has the right to review/audit records for the entire term of the agreement without limitation up to two times per calendar year. Any claims information, documents, etc. which the PBM, aggregator, and/or GPO may deem as containing "trade secrets" will not preclude an examination of such items through the audit process. The PBM, aggregator, and/or GPO will provide the Board assistance in the audit reviews by providing access to records, copies of claims data, access to reasonable support staff, etc. at no cost to the Board. The PBM, aggregator, and/or GPO will cooperate with the independent reviewer and agree to respond to any inquiries by the independent reviewer within the agreed upon schedule. The PBM, aggregator, and/or GPO will, within 60 days of final report being issued by Auditor, complete the final reconciliation and submit any and all reimbursement to the Plan. The PBM, aggregator, and/or GPO will not restrict the size of the claims sample reviewed by the independent reviewer which may include a review of 100% of all claims for the period under review. The Board will bear the cost of any fees charged by its independent reviewer.

26) Market Checks:

The Board may perform, or have performed on its behalf, following the twelfth (12th) month of the effective date services being provided and annually thereafter, a market check or an assessment of market conditions, pharmaceutical pricing, dispensing fees, and any other matters, services, or price drivers pertaining to this contract to determine if the terms of the contract are competitive with the then current market conditions. The market check will be allowed annually for the life of the contract.

If the Board or its designee provides the PBM with a written report conducted by a third party audit firm that takes into account, in the aggregate, the general plan design, formulary, clinical and trend programs utilized by the Board, participating network, utilization, and demographics for generally comparable plans that indicate a 1% or greater savings, the PBM will have the opportunity to respond, within thirty (30) days of receipt of the third party auditor market assessment, with a proposed amendment to the contract for new pricing terms that are mutually agreed upon and implemented no later than sixty (60) days after the third party audit firm report is completed and provided to the PBM. If the parties cannot come to agreement on the new terms, the Board reserves the right to terminate the contract with 120 days advance notice without penalty.

27) Formulary Management:

a. The PBM must administer all the provisions outlined in the 2024 Plan Document (https://knowyourbenefits.dfa.ms.gov/publications/).
b. The PBM must adhere to, develop and administer an evidence and value-based formulary program including ongoing pharmacy and therapeutics committee review and maintenance.
c. The PBM must provide a customizable formulary which provides access to clinically effective medications at the lowest net cost.
d. The PBM agrees that drugs will not be excluded from coverage unless required by FDA or the plan sponsor. The Board reserves the right to add or exclude medications from the formulary.
e. The PBM must provide plan design, clinical and utilization management program and formulary modeling service at no charge.

28) Manufacturer Coupons/Patient Assistance Programs:

a. The PBM agrees to have programs in place to counter the use of manufacturer's coupons/patient assistance programs that promote the dispensing of higher cost brand name drugs when a lower cost generic or alternative is available.
b. The PBM will administer a variable copayment plan design to leverage available specialty drug manufacturer patient assistance programs and is compatible with HDHP.
c. The PBM's variable copayment plan design, if selected, will be in place for the life of the contract.

29) Data Transfers and File Maintenance Requirements:

a. The PBM will receive updated eligibility information from the Board's TPA based on the current specifications. It is the PBM's responsibility to coordinate the data transfer with the Board's TPA to ensure an efficient and accurate process. The PBM is also responsible for the electronic transfer of prescription drug claim information to the Board's TPA for purposes of coinsurance maximum, out-of-pocket limit, and deductible accumulation.
b. The PBM is responsible for the electronic transfer of prescription drug claim information to the Board's health management vendor.
c. The PBM is responsible for the electronic transfer of prescription drug claim information to the Board's decision support services vendor.
d. The PBM is responsible for the electronic transfer of prescription drug claim information to the Board's Utilization Management Vendor.
e. The Board may request up to five (5) additional data transfers during the life of the Contract at no additional cost.

C. Data Management

1) Provide to Board staff read-only access to its claims processing and eligibility system, which must include, at a minimum, review of participant claims history and participant eligibility information.

2) Provide to Board staff read-only access to its participant website with a dummy login prior to the go-live date.

D. Claims and Performance Reviews

The Board, at its own expense, contracts with an independent third-party vendor to conduct claims and performance reviews of the PBM, aggregator, and/or GPO. In addition, the operations of the PBM, aggregator, and/or GPO relative to the Plan are included in annual audits conducted by the State Auditor's Office or its designee. The PBM, aggregator, and/or GPO agrees that upon at least two (2) business days' notice by the Board to the PBM, aggregator, and/or GPO, the Board has the right to audit all records maintained by the PBM, aggregator, and/or GPO relative to the PBM, aggregator, and/or GPO's performance. The Board maintains the right to perform financial, performance and other special audits on records maintained by the PBM, aggregator, and/or GPO during regular business hours. The PBM, aggregator, and/or GPO will make available all records, as defined by the selected auditor, for review at no cost to the Board. This does not preclude the auditing of other services or additional claims. Any errors detected via the audit will be addressed

and corrected in a timely manner by the PBM, aggregator, and/or GPO. Any claim processing error will be adjusted to the proper account and savings from errors will be reimburse to the Plan at 100%.

The PBM must provide the Board with a current annual SOC or similar audit report.

E. Standard/Ad Hoc Reporting

The PBM must furnish standard reports in a form and content approved by the Board. These reports will be provided, at the Board's request, in electronic media format, as well as hard copy if so requested by the Board. The PBM shall provide web-based reporting tools that allow the Board to view, print, and download reports to spreadsheet software. All reports must include report parameters and definitions. Report parameters/definitions must be revised as appropriate when revisions to the report scope occur.

Additionally, the PBM will provide ad hoc reports at the Board's request. The PBM shall provide the Board, for the Board's approval, the time and cost for the development of ad hoc reports prior to the development of the report.

All other reports are to be performed and provided as stated in **Exhibit C, PBM Services Contractor Reports**.

F. Cooperation with Other Board Vendors

The TPA will cooperate as required with the Board's other contracted vendors and will work with other vendors to facilitate the provision of the on-going coordination and delivery of services, and in any transfer of responsibility.

3. Responsibilities of the Board, Administrator of the Plan

A. The Board reserves the exclusive right to amend, reduce, or eliminate any part of the Plan or change any benefits at any time. To the extent that such amendment, reduction, elimination, or change materially affects the services provided by the PBM under this Contract, the Board shall notify the PBM of such change via a letter of authorization in a timely manner and in advance of such change to the extent possible.

B. In case of conflict between this Contract and the applicable *Plan Document*, the *Plan Document* shall prevail.

C. The Board or its designee shall provide educational material to all Participants explaining conditions of coverage, cost sharing, benefit design, and financial incentives encouraging compliance with the Plan's Pharmacy Benefit Management program.

D. The Board shall have final authority on any appeal, application, and interpretation of the Plan's benefits or eligibility policies.

E. The Board shall not disseminate, sell, or license any proprietary information belonging to the PBM to others without the PBM's prior written approval, unless the information is subject to the Public Records Law of the State of Mississippi, or is required to be released by law.

4. Contract Term

A. The effective date of this Contract is January 1, 2026. The term of the Contract will be for five (5) years.

B. This Contract may be terminated by either party, with or without cause, upon at least ninety (90) days prior written notice of intent to terminate provided to the other party. However, the PBM agrees to adjudicate and process all claims with service dates prior to the termination date of the contract that are received by the PBM for one (1) year after the termination date with claim payments funded by the Board in accordance with the terms and conditions of this terminated contract.

C. All records and information provided by the Board or through its third-party vendors to the PBM are the sole property of the Board and shall be returned to the Board within thirty (30) days of the termination date of this Contract if so required by the Board. The PBM shall be entitled to retain and utilize data that have been captured, computed, or stored in the PBM's databases to the extent that such data cannot be identified or linked to the Board, Plan, or an individual Participant with the restrictions described in Item 16, of this Contract to apply.

D. Upon termination of this Contract, the PBM shall reasonably cooperate with the Board and the new PBM vendor during the transition of the Plan to the new PBM vendor. Upon request of the Board, the PBM shall provide all information maintained by the PBM in relation to the Plan in a time frame specified by the Board. Information provided shall be in a format designated by the Board and shall include, but not be limited to, where applicable, file layouts and legends. The PBM shall provide such explanation of the information provided in order to facilitate a smooth transition.

5. Consideration

The Board agrees to compensate the PBM for services approved by the Board and performed by the PBM under the terms of this Contract in an amount not to exceed [Insert Amount], as follows:

A. The fees illustrated in *Exhibit A, Fee Schedule for Pharmacy Benefit Manager Services*, of this Contract shall constitute the entire compensation due to the PBM for services and all of the PBM's obligations hereunder regardless of the difficulty, materials, or equipment required. Said fees include, but are not limited to, all applicable taxes, fees, general office expense, travel, overhead, profit, and all other direct and indirect costs, incurred or to be incurred, by the PBM, including various service fees that are typically passed through the claims wire. No additional compensation shall be provided by the Board for any expense, cost, or fee not specifically authorized by this Contract, or by written authorization from the Board. Said fees are firm for the duration of this Contract and are not subject to escalation for any reason, unless this Contract is duly amended.

B. In accordance with State law and applicable Contract conditions, the Board shall compensate the PBM such fees after the appropriate services have been rendered. The Board shall not provide any prepayments or initial deposits in advance of services being rendered. Fees for services provided by the PBM shall be billable to the Board in arrears on a monthly basis. Only those services agreed to under this Contract shall be considered for reimbursement or compensation by the Board. Payment for any and all services provided by the PBM to the Board and/or the Plan shall be made only after said services have been duly performed and properly invoiced.

C. The PBM shall submit all invoices, in a form acceptable to the OI (provided that such acceptance will not be unreasonably withheld) with all the necessary supporting documentation, prior to any payment to the PBM of any administrative fees. Administrative fees shall be invoiced on a monthly basis, in sufficient detail and format as determined by the OI. Such invoices shall include, at a minimum, a description of the service(s) provided, the quantity or number of units billed, the compensation rate, the time period in which services were provided, total compensation requested for each individual service being billed, and total administrative fees requested for the period being invoiced. In the event of termination of this Contract for any reason, PBM shall be paid for services rendered and allowable up to the effective date of termination. Upon the effective date of termination of this Contract, the PBM's obligation to provide any further services under this Contract shall cease. The PBM shall, however, remain liable for any obligations arising hereunder prior to the effective date of such termination. No additional compensation will be provided by the MDFA for any expense, cost, or fee not specifically authorized by this Contract, or by written authorization from the MDFA.

D. The payment of an invoice by the Board shall not prejudice the Board's right to object or question any invoice or matter in relation thereto. Such payment by the Board shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any costs invoiced therein. PBM's invoice or payment shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Board, on the basis of audits, not to constitute allowable costs. Any payment shall be reduced for overpayment, or increased for underpayment on subsequent invoices. For any amounts which are or shall become due and payable to the Board and/or the Plan by the PBM, including but not limited to any liquidated damages resulting from the PBM's failure to satisfy any performance standards described in *Exhibit B, Performance Standards*, the Board reserves the right to (1) deduct from amounts which are or shall become due and payable to the PBM under Contract between the parties any amounts which are or shall become due and payable to the Board by the Contractor; or (2) request and receive payment directly from the PBM within fifteen (15) days of such request, at the Board's sole discretion.

E. Compensation to the PBM for travel expenses for quarterly meetings and annual onsite trainings are included in the bundled per script fee. In the event the Board requests and authorizes the PBM for the performance of any of the services covered under this Contract for which travel expenses are not already included, compensation to the PBM for travel, meals and/or lodging must be approved in advance and shall be allowed subject to the following criteria:

1. In order to be compensable, travel expenses must be reasonable and necessary for the fulfillment of the project and contractual obligations;
2. Air travel reimbursement will be limited to "Coach" or "Tourist" class rates, and must be supported by a copy of an original invoice;
3. Meals and lodging expenses will be reimbursed in the amount of actual costs, subject to the maximum per diem as defined in the Federal Register. A copy of all meal and hotel receipts must be provided;
4. Taxi fares, reasonable rental car expenses, and airport parking expenses will be reimbursed in the amount of actual costs, and must be supported by a copy of an original receipt/invoice;
5. Personal automobile mileage and related costs are not compensable expenses;
6. Time spent in "travel status" is not compensable.

6. E-Payment and Paymode

The PBMA agrees to accept all payments in United States currency via the State of Mississippi's electronic payment and remittance vehicle. The MDFA agrees to make payment in accordance with Mississippi law on "Timely Payments for Purchases by Public Bodies", which generally provides for payment of undisputed amounts by the agency within forty-five (45) days of receipt of the invoice. Mississippi Code Annotated § 31-7-301, *et seq*. Payments by state agencies using the State's accounting system shall be made and remittance information provided electronically as directed by the State. These payments shall be deposited into the bank account of the PBM's choice. The MDFA may, at its sole discretion, require the PBM to submit invoices and supporting documentation electronically at any time during the term of this Contract. The PBM understands and agrees that the MDFA is exempt from the payment of taxes. All payments shall be in United States currency.

7. Availability of Funds

It is expressly understood and agreed that the obligation of the Board to proceed under this Contract is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of state and/or federal funds. If the funds anticipated for the continuing time fulfillment of the Contract are, at any time, not forthcoming or insufficient, either through the failure of the federal government to provide funds or of the State of Mississippi to appropriate funds or the discontinuance or material alteration of the program under which funds were provided or if funds are not otherwise available to the MDFA, the Board shall have the right upon ten (10) working days written notice to the PBM, to terminate this Contract without damage, penalty, cost or expense to the Board of any kind whatsoever. The effective date of termination shall be as specified in the notice of termination.

8. Record Retention and Access to Records

The PBM agrees that the Board or any of its duly authorized representatives at any time during the term of this Contract shall have unimpeded, prompt access to and the right to audit and examine any pertinent books, documents, papers, and records of the PBM related to the PBM's charges and performance under this Contract. The Board agrees to provide the PBM with reasonable advance notice for any standard audits or reviews, with the expectation that such reviews shall be made during normal business hours of the PBM. The parties shall cooperate to schedule and conduct such audit or inspection to prevent disruption to PBM's performance of the services hereunder and for PBM's other customers. All records related to this Contract shall be retained by the PBM for a period of six (6) years after final payment under this Contract and all pending matters are closed unless the Board authorizes their earlier disposition. However, if any litigation, claim, negotiation, audit or other action arising out of or related in any way to this Contract has been started before the expiration of the six (6) year period, the records shall be retained for one (1) year after all issues arising out of the action are finally resolved or until the end of the six (6) year period, whichever is later. The PBM agrees to refund to the MDFA any overpayment disclosed by any such audit arising out of or related in any way to this Contract.

9. Right to Audit

PBM shall maintain such financial records and other records as may be prescribed by MDFA or by applicable federal and state laws, rules, and regulations. PBM shall retain these records for a period of three years after final payment, or until they are audited by MDFA, whichever event occurs first. These records shall be made available for inspection during regular business hours and with reasonable advance notice during the term of the Contract and the subsequent three-year period for examination, transcription, and audit by the Mississippi Office of the State Auditor, its designees, or other authorized bodies.

10. Right to Inspect

MDFA, the Mississippi Office of the State Auditor, or any other auditing agency prior-approved by MDFA, or their authorized representative shall, at all reasonable times, have the right to enter onto the PBM's premises, or such other places where duties under this Contract are being performed, to inspect, monitor, or otherwise evaluate (including periodic systems testing) the work being performed. The PBM shall provide access to all facilities and assistance for MDFA and Mississippi Office of the State Auditor's representatives. All inspections and evaluations shall be performed in such a manner as to not delay work. Refusal by the PBM to allow access to all documents, papers, letters or other materials, shall constitute a breach of Contract. All audits performed by persons other than MDFA staff shall be coordinated through MDFA and its staff.

11. Applicable Law

The Contract shall be governed by and construed in accordance with the laws of the State of Mississippi (State), excluding its conflicts of laws provisions, and any litigation with respect thereto shall be brought in the courts of the State. The PBM shall comply with applicable federal, state, and local laws and regulations.

12. Severability

If any part of this Contract is declared to be invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision of the Contract, and to this end the provisions hereof are severable. In such event, the parties shall amend the Contract as necessary to reflect the original intent of the parties and to bring any invalid or unenforceable provisions in compliance with applicable law.

13. Anti-Assignment/Subcontracting

PBM acknowledges that it was selected by the Board to perform the services required hereunder based, in part, upon PBM's special skills and expertise. PBM shall not assign, subcontract, or otherwise transfer this Contract, in whole or in part, without the prior written consent of the Board, which the Board may, in its sole discretion, approve or deny without reason. Any attempted assignment or transfer of its obligations without such consent shall be null and void. No such approval by the Board of any subcontract shall be deemed in any way to provide for the incurrence of any obligation of the Board in addition to the total fixed price agreed upon in this Contract. Subcontracts shall be subject to the terms and conditions of this Contract and to any conditions of approval that the State may deem necessary. Subject to the foregoing, this Contract shall be binding upon the respective successors and assigns of the parties.

14. Compliance with Laws

The PBM understands that the State is an equal opportunity employer and therefore maintains a policy which prohibits unlawful discrimination based on race, color, creed, sex, age, national origin, physical handicap, disability, genetic information, or any other consideration made unlawful by federal, state, or local laws. All such discrimination is unlawful and the PBM agrees during the term of the Contract that the PBM shall strictly adhere to this policy in its employment practices and provision of services. The PBM shall comply with, and all activities under this Contract shall be subject to, all applicable federal, State of Mississippi, and local laws and regulations, as now existing and as may be amended or modified.

15. Information Designated by Contractor as Confidential

"Confidential Information" shall mean: (a) those materials, documents, data, and other information which the PBM has designated in writing as proprietary and confidential; and (b) all data and information which the PBM acquires as a result of its contact with and efforts on behalf of the Board and any other information designated in writing as confidential by the Board. Each party to this agreement agrees to the following:

A. To protect all confidential information provided by one party to the other to the extent allowed under State and/or federal law; and,

B. To treat all such confidential information as confidential to the extent that confidential treatment is allowed under State and/or federal law; and,

C. Any disclosure of those materials, documents, data, and other information which PBM has designated in writing as proprietary and confidential shall be subject to the provisions of Mississippi Code Annotated §§ 25-61-9 and 79-23-1. As provided in the Contract, the personal or professional services to be provided, the price to be paid, and the term of the Contract shall not be deemed to be a trade secret, or confidential commercial or financial information.

Any liability resulting from the wrongful disclosure of confidential information on the part of the PBM or its subcontractor shall rest with PBM. Disclosure of any confidential information by the PBM or its subcontractor without the express written approval of the Board shall result in the immediate termination of the Contract.

16. Disclosure of Confidential Information Required by Law

In the event that either party to this Contract receives notice that a third-party requests divulgence of confidential or otherwise protected information and/or has served upon it a subpoena or other validly issued administrative or judicial process ordering divulgence of confidential or otherwise protected information that party shall promptly inform the other party and thereafter respond in conformity with such subpoena to the extent mandated by law. This section shall survive the termination or completion of this Contract. The parties agree that this section is subject to and superseded by Mississippi Code Annotated § 25-61-1 *et seq*.

17. Confidentiality

Notwithstanding any provision to the contrary contained herein, it is recognized that MDFA is a public agency of the State of Mississippi and is subject to the Mississippi Public Records Act. Mississippi Code Annotated § 25-61-1 *et seq*. If a public records request is made for any information provided to MDFA pursuant to the Contract and designated by the PBM in writing as trade secrets or other proprietary confidential information, MDFA shall follow the provisions of Mississippi Code Annotated §§ 25-61-9 and 79-23-1 before disclosing such information. The MDFA shall not be liable to the PBM for disclosure of information required by court order or required by law.

18. Transparency

This Contract, including any accompanying exhibits, attachments, and appendices, is subject to the "Mississippi Public Records Act of 1983," and its exceptions. See Mississippi Code Annotated §§ 25-61-1 *et seq*. and 79-23-1. In addition, this Contract is subject to the provisions of the Mississippi

Accountability and Transparency Act of 2008. Mississippi Code Annotated § 27-104-151 *et seq*. Unless exempted from disclosure due to a court-issued protective order, a copy of this executed Contract is required to be posted to the Mississippi Department of Finance and Administration's independent agency contract website for public access at http://www.transparency.mississippi.gov. Information identified by PBM as trade secrets, or other proprietary information, including confidential vendor information or any other information which is required confidential by state or federal law or outside the applicable freedom of information statutes, shall be redacted.

19. E-Verification

If applicable, the PBM represents and warrants that it shall ensure its compliance with the *Mississippi Employment Protection Act of 2008*, and shall register and participate in the status verification system for all newly hired employees. Mississippi Code Annotated § 71-11-1 *et seq.* The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. The PBM agrees to maintain records of such compliance. Upon request of the State and after approval of the Social Security Administration or Department of Homeland Security when required, the PBM agrees to provide a copy of each such verification. The PBM further represents and warrants that any person assigned to perform services hereafter meets the employment eligibility requirements of all immigration laws. The breach of this clause may subject the PBM to the following:

A. termination of this Contract and exclusion pursuant to Chapter 15 of the *Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations*; or

B. the loss of any license, permit, certification, or other document granted to the PBM by an agency, department, or governmental entity for the right to do business in Mississippi; or

C. both.

In the event of such cancellation/termination, the PBM would also be liable for any additional costs incurred by the State due to Contract cancellation or loss of license or permit to do business in the State.

20. Independent Contractor Status

The PBM shall perform all services as an Independent Contractor and shall at no time act as an agent for the Board or MDFA. Nothing contained herein shall be deemed or construed by the Board or MDFA, the PBM, or any third party as creating the relationship of principal and agent, master and servant, partners, joint ventures, employer and employee, or any similar such relationship between the Board or MDFA and the PBM. Neither the method of computation of fees or other charges, nor any other provision contained herein, nor any acts of the Board or MDFA or the PBM hereunder creates, or shall be deemed to create a relationship other than the independent relationship of Board or MDFA and Contractor. The PBM's personnel shall not be deemed in any way, directly or indirectly, expressly or by implication, to be employees of the Board or MDFA. No act performed or representation made, whether oral or written, by the PBM with respect to third parties shall be binding on the Board or MDFA. Neither the PBM nor its employees shall, under any circumstances, be considered servants, agents, or employees of the Board or MDFA; and the Board or MDFA shall at no time be legally responsible for any negligence or other wrongdoing by the PBM, its servants, agents, or employees. The Board or MDFA shall not withhold from

the Contract payments to the PBM any federal or state unemployment taxes, federal or state income taxes, Social Security tax, or any other amounts for benefits to the PBM. Further, the Board or MDFA shall not provide to the PBM any insurance coverage or other benefits, including Worker's Compensation, normally provided by MDFA for its employees.

21. Force Majeure

Each party shall be excused from performance for any period and to the extent that it is prevented from performing any obligation or service, in whole or in part, as a result of causes beyond the reasonable control and without the fault or negligence of such party and/or its subcontractors. Such acts shall include without limitation acts of God, strikes, lockouts, riots, acts of war, epidemics, governmental regulations superimposed after the fact, fire, earthquakes, floods, or other natural disasters ("force majeure events"). When such a cause arises, the PBM shall notify MDFA immediately in writing of the cause of its inability to perform, how it affects its performance, and the anticipated duration of the inability to perform. Delays in delivery or in meeting completion dates due to force majeure events shall automatically extend such dates for a period equal to the duration of the delay caused by such events, unless MDFA determines it to be in its best interest to terminate the Contract.

22. Authority to Contract

PBM warrants: (a) that it is a validly organized business with valid authority to enter into this Contract; (b) that it is qualified to do business and in good standing in the State of Mississippi; (c) that entry into and performance under this Contract is not restricted or prohibited by any loan, security, financing, contractual, or other contract of any kind; and, (d) notwithstanding any other provision of this Contract to the contrary, that there are no existing legal proceedings or prospective legal proceedings, either voluntary or otherwise, which may adversely affect its ability to perform its obligations under this Contract.

23. Debarment and Suspension

The PBM certifies to the best of its knowledge and belief, that it: (i) Is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transaction by any federal department or agency or any political subdivision or agency of the State of Mississippi; (ii) Has not, within a three-year period preceding this proposal, been convicted of or had a civil judgment rendered against it for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; (iii) Has not, within a three-year period preceding this proposal, been convicted of or had a civil judgment rendered against it for a violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (iv) Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of these offenses enumerated in paragraphs two (ii) and three (iii) of this certification; and, (v) Has not, within a three-year period preceding this proposal, had one or more public transactions (federal, state, or local) terminated for cause or default.

24. Modification or Renegotiation

This Contract may be modified, altered or changed only by written agreement signed by the parties hereto and approved by the Board and PPRB, if required. The parties agree to renegotiate the Contract if federal, State and/or the MDFA revisions of any applicable laws or regulations make changes in this Contract necessary.

25. Procurement Regulations

The Contract shall be governed by the applicable provisions of the *Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations*, a copy of which is available on MDFA's website (https://www.dfa.ms.gov). Any Contractor doing business with a state agency is deemed to be on notice of all requirements therein.

26. Representation Regarding Contingent Fees

The PBM represents that it has not retained a person to solicit or secure a Board contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee.

27. Representation Regarding Gratuities

The PBM represents that it has not, is not, and will not offer, give, or agree to give any employee or former employee of MDFA a gratuity or offer of employment in connection with any approval, disapproval, recommendation, development, or any other action or decision related to the solicitation and resulting contract. PBM further represents that no employee or former employee of MDFA has or is soliciting, demanding, accepting, or agreeing to accept a gratuity or offer of employment for the reasons previously stated; any such action by an employee or former employee in the future, if any, will be rejected by PBM. PBM further represents that it is in compliance with the Mississippi Ethics in Government laws, codified at Mississippi Code Annotated §§ 25-4-101 through 25-4-121, and has not solicited any employee or former employee to act in violation of said law.

28. Termination for Convenience

The Board may, when the interests of the Board so require, terminate this Contract in whole or in part, for the convenience of the Board. The Board shall give written notification of the termination to the PBM specifying the part of the Contract terminated and when the termination becomes effective. The PBM shall incur no further obligations in connection with the terminated work and on the date set in the notice of termination, the PBM shall stop work to the extent specified. The PBM shall also terminate outstanding orders and subcontracts as they relate to the terminated work. The PBM shall settle the liabilities and claims arising out of the termination of subcontractors and orders connected with the terminated work. The Board may direct the PBM to assign the PBM's right, title, and interest under terminated orders or subcontracts to the Board. The PBM shall still complete the work not terminated by the notice of termination and may incur obligations as are necessary to do so.

29. Termination for Default

If the Board gives the PBM a notice that the personal or professional services are being provided in a manner that is deficient, the PBM shall have 30 days to cure the deficiency. If the PBM fails to cure the deficiency, the Board may terminate the Contract for default and the PBM will be liable for the additional cost to the Board to procure the personal and professional services from another source. Termination under this paragraph could result in the PBM being excluded from future contract awards pursuant to Chapter 15 of the *Mississippi Public Procurement Review Board Office of Personal Service Contract Review Rules and Regulations*. Any termination wrongly labelled termination for default shall be deemed a termination for convenience.

30. Termination for Bankruptcy

This Contract may be terminated in whole or in part by the Board upon written notice to the PBM, if the PBM should become the subject of bankruptcy or receivership proceedings, whether voluntary or involuntary, or upon the execution by PBM of an assignment for the benefit of its creditors. In the event of such termination, PBM shall be entitled to recover just and equitable compensation for satisfactory work performed under this Contract, but in no case shall said compensation exceed the total Contract price.

31. Stop Work Order

The Board may, by written order to the PBM at any time, required the PBM to stop all or any part of the work called for by this Contract. This order shall be for a period of time specified by the Board. Upon receipt of such an order, the PBM shall forthwith comply with its terms and take all reasonable steps to minimize any further cost to the Board. Upon expiration of the stop work order, the PBM shall resume providing the services which were subject to the stop work order, unless the Board has terminated that part of the Contract or terminated the Contract in its entirety. The Board is not liable for payment for services which were not rendered due to the stop work order.

32. Oral Statements

No oral statement of any person shall modify or otherwise affect the terms, conditions, or specifications stated in this Contract. All modifications to the Contract shall be made in writing by the Board and agreed to by the PBM, and approved by the PPRB, if required.

33. Ownership of Documents and Work Papers

The Board shall own all documents, files, reports, work papers and working documentation, electronic or otherwise, created in connection with the project which is the subject of this Contract, except for the PBM's internal administrative and quality assurance files and internal project correspondence, Confidential Business Information and Creations, proprietary rights, trademarks and trade names. The PBM shall deliver such documents and work papers to the Board upon termination or completion of the Contract if so requested by the Board. The foregoing notwithstanding, the PBM shall be entitled to retain a set of such work papers for its files. The PBM shall be entitled to use such work papers only after receiving written permission from the Board and subject to any copyright protections.

34. Trade Secrets, Commercial and Financial Information

It is expressly understood that Mississippi law requires that the provisions of this Contract which contain the commodities purchased or the personal or professional services provided, the price to be paid, and the term of the Contract shall not be deemed to be a trade secret or confidential commercial or financial information and shall be available for examination, copying, or reproduction.

35. Third Party Action Notification

The PBM shall give the MDFA prompt notice in writing of any action or suit filed, and prompt notice of any claim made against the PBM by any entity that may result in litigation related in any way to this Contract.

36. Indemnification

To the fullest extent allowed by law, the PBM shall indemnify, defend, save and hold harmless, protect, and exonerate the State of Mississippi, its Commissioners, Board Members, officers, employees, agents, and representatives from and against all claims, demands, liabilities, suits, actions, damages, losses, and costs of every kind and nature whatsoever, including, without limitation, court costs, investigative fees and expenses, and attorneys' fees, arising out of or caused by PBM and/or its partners, principals, agents, employees, and/or subcontractors in the performance of or failure to perform this Contract. In the State's sole discretion, upon approval of the Office of the Mississippi Attorney General, the PBM may be allowed to control the defense of any such claim, suit, etc. In the event the PBM defends said claim, suit, etc., the PBM shall use legal counsel acceptable to the Office of the Mississippi Attorney General. The PBM shall be solely responsible for all costs and/or expenses associated with such defense, and the State shall be entitled to participate in said defense. The PBM shall not settle any claim, suit, etc., without the concurrence of the Office of the Mississippi Attorney General, which shall not be unreasonably withhold.

37. Insurance, Bonds, or Other Sureties

The PBM shall maintain, throughout the term of this Contract, at its own expense,

A. **Implementation Bond or Escrow Account** in an amount no less than One Million Dollars ($1,000,000.00) naming the Board as exclusive beneficiary, to guarantee timely and complete establishment of the Contract and related services. Such bond or escrow account must be obtained or established within thirty (30) days of contract award. The bond shall be a corporate surety bond issued by a surety company authorized to do business in the State of Mississippi; while an escrow account is subject to approval by agency legal counsel. Any failure of the PBM to perform timely and complete establishment of such services shall result in damages recoverable by the Board against the implementation bond or escrow account. This requirement will not apply if the incumbent PBM Vendor with services established under the current contract is selected through this procurement process to enter negotiations for the new contract. Upon the agreement by the Board that the PBM has complied with its implementation responsibilities, the implementation bond shall be released.

B. **Employee Dishonesty or Fidelity Bond with third party liability** coverage in an amount no less than One Million Dollars ($1,000,000) with the Board named as exclusive beneficiary for the duration of this Contract; Pursuant to such bond, any losses incurred by the Board due to theft or dishonesty of a PBM employee shall be fully reparable to the Board. The PBM shall be responsible for procuring any such recovery and reimbursing the Board accordingly.

C. **Professional liability insurance** coverage in an amount no less than One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annual aggregate that covers any damages caused by an error, omission or any negligent acts related to the services to be provided under this Contract;

D. **Cyber liability insurance** coverage in an amount no less than Two Million Dollars ($2,000,000.00) that covers security and privacy liability, incident response expenses, business interruption, business interruption waiting period, data recovery, regulatory proceedings, and cyber extortion; and

E. **Workers' compensation** coverage as required by the State of Mississippi.

All insurances policies shall list the Board as Certificate Holder on the policy and shall be issued by insurance companies authorized to do business under the laws of the State of Mississippi, meaning insurance carriers must be licensed or hold a Certificate of Authority from the Mississippi Insurance Department. PBM shall not commence work under this Contract until it obtains all insurances required under this provision and furnishes certificate(s) or other form(s) showing proof of current coverage to the MDFA. After work commences, the PBM shall maintain in force all required insurance until the Contract is terminated or expires. PBM shall submit renewal certificates as appropriate during the term of the Contract. PBM shall ensure that should any of the above-described policies be cancelled before the expiration date thereof, or if there is a material change, potential exhaustion of aggregate limits or intent not to renew insurance coverage(s), that written notice will be delivered to the MDFA. There shall be no cancellation, material change, potential exhaustion of aggregate limits or non-renewal of insurance coverage(s) to MDFA. Any failure to comply with the reporting provisions of this clause shall constitute a material breach of Contract and shall be grounds for immediate termination of this Contract by MDFA.

38. No Limitation of Liability

Nothing in this Contract shall be interpreted as excluding or limiting any liability of the PBM for harm arising out of the PBM's or its subcontractors' performance under this Contract.

39. Property Rights

Property rights do not inure to the PBM until such time as services have been provided under a legally executed contract. PBM has no legitimate claim of entitlement to the provision of work hereunder and acknowledges that the Board may terminate this Contract at any time for its own convenience.

40. Attorneys' Fees and Expenses

In the event PBM defaults on any obligations under this Contract, PBM shall pay to MDFA all costs and expenses, without limitation, incurred by MDFA in enforcing this Contract or reasonable related to enforcing this Contract. This includes but is not limited to investigative fees, court costs, and attorneys' fees. Under no circumstances shall MDFA be obligated to pay attorneys' fees or legal costs to the PBM.

41. Approval

It is understood that if this Contract requires approval by the Mississippi State and School Employees Health Insurance Management Board (Board), the Public Procurement Review Board (PPRB) and/or the MDFA Office of Personal Service Contract Review (OPSCR) and if this Contract is not approved by the Board, PPRB and/or OPSCR, it is void and no payment shall be made hereunder.

42. Change in Scope of Work

The Board may order changes in the work consisting of additions, deletions, or other revisions within the general scope of the Contract. No services may be changed, requiring changes to the amount of compensation to the PBM or other adjustments to the Contract, unless such changes or adjustments have been made by written amendment to the Contract signed by the Board and the PBM. If the PBM believes that any particular work is not within the scope of the project, is a material change, or shall otherwise require more compensation to the PBM, the PBM shall immediately notify the Board in writing of this belief. If the Board believes that the particular work is within the scope of the Contract as written, the

PBM shall be ordered to and shall continue the work as changed and at the cost stated for the work within the scope.

43. Disputes

Any dispute concerning the Contract which is not disposed of by agreement shall be decided by the Chair of the Board who shall reduce such decision to writing and mail or otherwise furnish a copy thereof to the PBM. The decision of the Chair of the Board shall be final and conclusive. Nothing in this paragraph shall be construed to relieve the PBM of full and diligent performance of the Contract.

44. Standards of Care/Remedies

The PBM shall exercise reasonable care and due diligence consistent with standards in the industry in the performance of its obligations under this Contract.

45. Contractor Personnel

The Board shall, throughout the life of the Contract, have the right of reasonable rejection and approval of staff or subcontractors assigned to the work by the PBM. If the Board reasonably rejects staff or subcontractors, the PBM shall provide replacement staff or subcontractors satisfactory to the Board in a timely manner and at no additional cost to the Board. The day-to-day supervision and control of the PBM's employees and subcontractors is the sole responsibility of the PBM.

46. Recovery of Money

Whenever, under the Contract, any sum of money shall be recoverable from or payable by the PBM to the MDFA, the same amount may be deducted from any sum due to the PBM under the Contract or under any other contract between the PBM and the MDFA. The rights of the MDFA are in addition and without prejudice to any other right the MDFA may have to claim the amount of any loss or damage suffered by the MDFA on account of the acts or omissions of the PBM.

47. Failure to Enforce

Failure by the Board at any time to enforce the provisions of the Contract shall not be construed as a waiver of any such provisions. Such failure to enforce shall not affect the validity of the Contract or any part thereof or the right of the Board to enforce any provision at any time in accordance with its terms.

48. Business Associate Statement

In the paragraphs that follow under this section, the term "BA Statement" shall refer to this section of the Contract, the term "Business Associate" shall refer to the PBM, and the term "Covered Entity" shall refer to the Plan. The purpose of this BA Statement is to satisfy certain standards and requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA) and regulations promulgated thereunder by the U.S. Department of Health and Human Services (HHS) (the HIPAA Regulations) and other applicable laws, including the American Recovery and Reinvestment Act (ARRA) of 2009, as applicable. The Covered Entity wishes to disclose certain information (Information) to Business Associate pursuant to the terms of the Contract, some of which may constitute Protected Health Information (PHI). The Covered Entity desires and directs Business Associate to share PHI with other

Business Associates of the Covered Entity. In consideration of mutual promises below and exchange of information pursuant to this BA Statement, the parties agree as follows:

A. Definitions

Terms used, but not otherwise defined, in this BA Statement shall have the same meaning as those terms in the Standards for Privacy of Individually Identifiable Information (the Privacy Rule) and the Security Standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In the event of an inconsistency between the provisions of this BA Statement and mandatory provisions of the Privacy Rule and or the Security Standards, as amended, the Privacy Rule and/or the Security Standards shall control. Where provisions of this BA Statement are different than those mandated in the Privacy Rule and/or the Security Standards, but are nonetheless permitted by the Privacy Rule and/or the Security Standards, the provisions of this BA Statement shall control.

1. Breach. Breach shall be as defined in HITECH and the HIPAA regulations at 45 CFR §164.402.
2. Business Associate. Business Associate shall have the meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 CFR § 160.103.
3. Covered Entity. Covered Entity shall have the same meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 CFR § 160.103.
4. Designated Record Set. Designated Record Set shall have the same meaning given to such term under 45 CFR § 164.501 and shall mean a group of records maintained by or for the Covered Entity that is the payment, enrollment, claims adjudication and case or health management record systems maintained by or for the Covered Entity, or used, in whole or in part, by or for the Covered Entity, to make decisions about Individuals.
5. Electronic Media. Electronic Media has the same meaning as the term “electronic media” in 45 CFR § 160.103, which is:
    a. Electronic storage material on which data is or may be recorded electronically, including for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or
    b. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet (wide-open), extranet (using internet technology to link a business with information accessible only to collaborating parties), or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media if the information being exchanged did not exist in electronic form immediately before the transmission.
6. Electronic Protected Health Care Information or (EPHI). EPHI has the same meaning as the term ‘electronic protected health care information’ in 45 CFR § 160.103, and is defined as that PHI that is transmitted by or maintained in electronic media.
7. Individual. Individual shall have the same meaning as the term “individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
8. Privacy Rule. Privacy Rule shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, subparts A and E.
9. Protected Health Information or (PHI). PHI shall have the same meaning as the term “protected health information" in 45 CFR § 164.103, limited to the information created, maintained, transmitted or received by Business Associate from or on behalf of Covered Entity.

10. Required By Law. Required By Law shall have the same meaning as the defined term "required by law" in 45 CFR § 164.103.
11. Security Incident has the meaning in 45 CFR § 164.304, which is: the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
12. Security Standards shall mean the Security Standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) codified at 45 CFR Parts 160 and 164, subpart C (Security Rule).
13. Unsecured PHI as defined in HIPAA and the HIPAA regulations at 45 CFR § 164.402, means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in guidance issued under 13402(h)(2) of Public Law 111-5 on HHS website.

B. Obligations and Activities of Business Associate

1. Compliance with Applicable Laws. Business Associate shall fully comply with the standards and requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (ARRA) and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the HIPAA Regulations) and other applicable laws as of the date(s) the requirements under these laws become effective for Business Associates. This compliance shall include all requirements noted in Section 13404(a), (b) and (c) of the HITECH Act.
2. Business Associate directly subject to certain HIPAA provisions. Under HITECH, Business Associate acknowledges that it is directly subject to certain HIPAA provisions including, but not limited to, Sections 13401, 13404, 13405 of HITECH.
3. Use and Disclosure of Protected Health Information. Business Associate may use and/or disclose the Covered Entity's PHI received by Business Associate pursuant to this BA Statement, the Contract, or as required by law, or as permitted under 45 CFR §164.512, subject to the provisions set forth in this BA Statement. Business Associate may use PHI in its possession for its proper management and administration or to fulfill any of its legal responsibilities. The Covered Entity specifically requests that Business Associate disclose PHI to other Business Associates of the Covered Entity for Health Care Operations of the Covered Entity. The Covered Entity shall provide a list of the affected Business Associates and shall request specific disclosures in written format. If any affected Business Associate is no longer under a BA Statement with the Covered Entity, the Covered Entity shall promptly inform Business Associate of such change.
4. Safeguards Against Misuse of Information. Business Associate shall use appropriate safeguards to prevent the use or disclosure of the Covered Entity's PHI in any manner other than as required by this BA Statement or as required by law. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities.
5. Reporting of Disclosures. Business Associate shall report to the Covered Entity any use or disclosure of the Covered Entity's PHI in violation of this BA Statement or as required by law of which the Business Associate is aware, including Breaches of Unsecured PHI as required by 45 CFR §164.410, and agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of the Covered Entity's PHI by Business Associate in violation of this BA Statement.
6. Business Associate's Agents. Business Associate shall ensure that any agents, including subcontractors, to whom it provides PHI received from (or created or received by Business

Associate on behalf of) the Covered Entity agree to be bound to by restrictions and conditions on the use or disclosure of PHI that are no less protective that those that apply to Business Associate with respect to such PHI. Business Associate represents that in the event of a disclosure of PHI to any third party, the information disclosed shall be in a limited data set if practicable and in all other cases the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

7. Nondisclosure. Business Associate shall not use or further disclose the Covered Entity's PHI otherwise than as permitted or required by this BA Statement, the Contract, or as required by law.
8. Availability of Information to the Covered Entity and Provision of Access and Accountings. Business Associate shall make available to the Covered Entity such Protected Health Information maintained by the Business Associate in a Designated Record Set as the Covered Entity may require to fulfill the Covered Entity's obligations to provide access to, or provide a copy of, such Designated Record Set as necessary to satisfy the Covered Entity's obligations under 45 CFR § 164.524. Business Associate shall also maintain and make available the information required to provide an accounting of disclosures of Protected Health Information to Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR § 164.528.
9. Amendment of PHI. Business Associate shall make the Covered Entity's PHI available to the Covered Entity as the Covered Entity may require to fulfill the Covered Entity's obligations to amend PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR § 164.526 and Business Associate shall, as directed by the Covered Entity, incorporate any amendments to the Covered Entity's PHI into copies of such PHI maintained by Business Associate. Business Associate agrees to make any amendment(s) to Protected Health Information that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of the Covered Entity or an Individual, and in the time and manner designated by the Covered Entity. [45 CFR § 164.504(e)(2)(F)]
10. Internal Practices. Business Associate agrees to make its internal practices, policies, procedures, books, and records relating to the use and disclosure of PHI received from the Covered Entity (or received by Business Associate on behalf of the Covered Entity) available to the Secretary of the U.S. Department of Health and Human Services for inspection and copying for purposes of determining the Covered Entity's compliance with HIPAA and the HIPAA Regulations.
11. Notification of Breach. During the term of this BA Statement, Business Associate shall notify the Covered Entity following discovery and without unreasonable delay (but in no case later than 60 days) any Breach of Unsecured PHI. Business Associate shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.
12. Safeguard of EPHI. The Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.
13. Subcontractors. The Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI agrees to implement reasonable and appropriate safeguards to protect it.
14. Notification. The Business Associate shall report to the Covered Entity through the Mississippi Department of Finance and Administration, Office of Insurance any Breach of Unsecured PHI of which it becomes aware, without unreasonable delay, in the following time and manner:
    a. any actual, successful Security Incident shall be reported to the Covered Entity in writing, without unreasonable delay; and

b. any attempted, unsuccessful Security Incident, of which Business Associate becomes aware, shall be reported to the Covered Entity in writing, on a reasonable basis, at the written request of the Covered Entity. If the Security Rule is amended to remove the requirement to report unsuccessful attempts at unauthorized access, this subsection (ii) shall no longer apply as of the effective date of the amendment of the Security Rule.

15. Business Associate shall maintain and provide to the Covered Entity without unreasonable delay and in no case later than 60 days of discovery of a Breach of Unsecured PHI, (as these terms are defined in the HIPAA Regulations), the appropriate information to allow the Covered Entity to adhere to Breach notification.
16. The information provided to the Covered Entity shall include, at a minimum and to the extent possible, the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been accessed, acquired, used, or disclosed during the Breach, and the Business Associate shall provide the Covered Entity with any other available information that the Covered Entity is required to include in its notification to the Individual following discovery of a Breach and without unreasonable delay or promptly thereafter as information becomes available, including:
    a. A brief description of what happened, including the date of the breach, if known, and the date of the discovery of the breach.
    b. A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code).
    c. The steps individuals should take to protect themselves from potential harm resulting from the breach.
    d. A brief description of what the Business Associate involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches.
17. Minimum Necessary. Business Associate shall limit its uses and disclosures of, and requests for, PHI (a) when practical, to the information making up a Limited Data Set; and (b) in all other cases subject to the requirements of 45 CFR § 164.502(b), to the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.
18. Marketing. Business Associate shall not sell PHI or use or disclose PHI for purposes of marketing, as defined and proscribed in the Regulations.
19. Data Aggregation. Business Associate may use PHI in its possession to provide data aggregation services relating to the health care operations of the Covered Entity, as provided for in 45 CFR §164.501.
20. De-identification of PHI. Business Associate may de-identify any and all PHI, provided that the de-identification conforms to the requirements of 45 CFR § 164.514(b), and further provided that Business Associate maintains the documentation required by 45 CFR § 164.514(b), which may be in the form of a written assurance from Business Associate. Pursuant to 45 CFR § 164.502(d), de-identified information does not constitute PHI and is not subject to the terms of the BA Statement.

C. Obligations of the Covered Entity

1. Covered Entity's Representatives. The Covered Entity shall designate, in writing to Business Associate, individuals to be regarded as the Covered Entity's representatives, so that in reliance upon such designation Business Associate is authorized to make disclosures of PHI to such individuals or to their designee(s).
2. Restrictions on Use or Disclosure of PHI. If the Covered Entity agrees to restrictions on use or disclosure, as provided for in 45 CFR § 164.522 and the HITECH Act, of PHI received or created

by Business Associate regarding an Individual, the Covered Entity agrees to pay Business Associate the actual costs incurred by Business Associate in accommodating such voluntary restrictions.

3. Limitation on Requests. The Covered Entity shall not request or require that Business Associate make any use or alteration of PHI that would violate HIPAA or HIPAA Regulations if done by the Covered Entity.

D. Audits, Inspection, and Enforcement

Upon reasonable notice, upon a reasonable determination by the Covered Entity that Business Associate has breached this BA Statement; the Covered Entity may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this BA Statement. Business Associate shall promptly remedy any violation of any term of this BA Statement and shall certify the same to the Covered Entity in writing. The fact that the Covered Entity inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this BA Statement, nor does the Covered Entity's (i) failure to detect or (ii) detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of the Covered Entity's enforcement rights under this BA Statement. Business Associate shall fully cooperate with the U.S. Department of Health and Human Services, as the primary enforcer of the HIPAA, who shall conduct periodic compliance audits to ensure that both Business Associate and the Covered Entity are compliant.

E. Termination

1. Material Breach. A breach by Business Associate of any provision of this BA Statement, as determined by the Covered Entity, shall constitute a material breach of the BA Statement and shall provide grounds for immediate termination of the BA Statement and the Contract by the Board pursuant to Section E.2. of this BA Statement. [45 CFR § 164.504(e)(3)]
2. Reasonable Steps to Cure Breach. If either Party knows of a pattern of activity or practice of the other that constitutes a material breach or violation of that Party's obligations under the provisions of this BA Statement or another arrangement and does not terminate this BA Statement pursuant to Section E.1., then that Party shall take reasonable steps to cure such breach or end such violation, as applicable. If the Party's efforts to cure such breach or end such violation are unsuccessful, that Party shall either (i) terminate this BA Statement if feasible; or (ii) if termination of this BA Statement is not feasible, the non-breaching Party shall report the other Party's breach or violation to the Secretary of the Department of Health and Human Services. [45 CFR § 164.504(e)(1)(ii)]
3. Judicial or Administrative Proceedings. Either party may terminate this BA Statement, effective immediately, if (i) the other party is named as a defendant in a criminal proceeding for a violation of HIPAA or (ii) a finding or stipulation that the other party has violated any standard or requirement of HIPAA or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.
4. Effect of Termination. Upon termination of this BA Statement and the Contract for any reason, Business Associate shall return or destroy PHI received from the Covered Entity (or created or received by Business Associate on behalf of the Covered Entity) that Business Associate still maintains in any form, and shall retain no copies of such PHI except for one copy that Business Associate shall use solely for archival purposes and to defend its work product, provided that documents and data remain confidential and subject to this BA Statement, or if return or

destruction is not feasible, it shall continue to extend the protections of this BA Statement to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. [45 CFR § 164.504(e)(2)(I)]

F. Disclaimer

The Covered Entity makes no warranty or representation that compliance by Business Associate with this BA Statement, HIPAA or the HIPAA Regulations shall be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or shall be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

G. Amendment

Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this BA Statement and the Contract may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that the Covered Entity shall receive satisfactory written assurance from Business Associate that Business Associate shall adequately safeguard all PHI that it receives or creates pursuant to this BA Statement. Upon the Covered Entity's request, Business Associate agrees to promptly enter into negotiations with the Covered Entity concerning the terms of an amendment to this BA Statement and the Contract embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA Regulations or other applicable laws. The Covered Entity may terminate this BA Statement upon 90 days written notice in the event (i) Business Associate does not promptly enter into negotiations to amend this BA Statement and the Contract when requested by the Covered Entity pursuant to this Section; or (ii) Business Associate does not enter into an amendment to this BA Statement and the Contract providing assurances regarding the safeguarding of PHI that the Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA Regulations.

H. Assistance in Litigation or Administrative Proceedings

Business Associate shall make itself, and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this BA Statement, available to the Covered Entity to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Covered Entity, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

I. No Third Party Beneficiaries

Nothing expressed or implied in this BA Statement is intended to confer, nor shall anything herein confer, upon any person other than the Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

J. Effect on Contract

Except as specifically required to implement the purposes of this BA Statement, or to the extent inconsistent with this BA Statement, all other terms of the Contract shall remain in force and effect.

K. Electronic Health Records (EHR)

If electronic health records are used or maintained with respect to PHI, individuals shall have the right to obtain a copy of such information in "electronic format".

L. No Remuneration for PHI

Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI, unless it first obtains a valid authorization from the individual whose PHI is being disclosed.

M. Interpretation

This BA Statement shall be interpreted as broadly as necessary to implement and comply with HIPAA, HIPAA Regulations and applicable state laws. The parties agree that any ambiguity in this BA Statement shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Regulations.

49. Notices

All notices required or permitted to be given under this Contract shall be in writing and personally delivered or sent by certified United States mail, postage prepaid, return receipt requested, to the party to whom the notice should be given at the address set forth below. Notice shall be deemed given when actually received or when refused. The parties agree to promptly notify each other in writing of any change of address.

If to the Board/MDFA:
Executive Director
Mississippi Department of Finance and Administration
501 N. West St., Suite 1301 Woolfolk Building
Post Office Box 267
Jackson, Mississippi 39205-0267

With a copy of any notice to:
State Insurance Administrator
Mississippi Department of Finance and Administration
Office of Insurance
501 N. West St., Suite 1201-C Woolfolk Building
Post Office Box 24208
Jackson, Mississippi 39225-4208

If to the PBM:
[Name, Title]
[Contractor Name]
[Address]
[City, State, Zip]

50. Incorporation of Documents

This Contract consists of and precedence is hereby established by the order of the following documents incorporated herein:

A. This Contract signed by the parties including ***Exhibit A, Fee Schedule for Pharmacy Benefit Manager Services; Exhibit B, Performance Standards;*** and ***Exhibit C, PBM Services Contractor Reports***;

B. The ***PBM Contractor's Response to the Mississippi State and School Employees Health Insurance Management Board's Request for Proposals for Pharmacy Benefit Manager Services, Dated December 12, 2024,*** and includes any applicable requested and submitted Best and Final Offer, and attached hereto as ***Exhibit C*** and incorporated fully herein by reference; and

C. The ***Mississippi State and School Employees Health Insurance Management Board's Request for Proposals for Pharmacy Benefit Manager Services, dated October 15, 2024***, attached hereto as ***Exhibit D*** and incorporated fully herein by reference. This RFP includes any amendment thereto, such as Questions and Answer document(s), if any were issued, as well as any Best and Final Offer request.

The Remainder of this Page is Left Blank Intentionally

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be executed on the date shown below:

[Contractor Name]	**State and School Employees Health Insurance Management Board**
By: _____	By: _____
Name: _____	Name: Liz Welch
Title: _____	Title: Chairman of the Board
Date: _____	Date: _____

Exhibit A - Fee Schedule for Third Party Administration Services

The fees listed in Exhibit A – Fee Schedule shall constitute the entire compensation due to the PBM for services and all of the PBM's obligations hereunder regardless of the difficulty, materials, or equipment required. The fees include, but are not limited to, all applicable taxes, fees, general office expense, travel, overhead, profit, and all other direct and indirect costs, incurred or to be incurred, by the PBM. The fees listed in this Fee Schedule are guaranteed and firm for the duration of this Contract and are not subject to escalation for any reason, unless this Contract is duly amended. No additional compensation shall be provided by the Board for any expense, cost, or fee not specifically authorized by this Contract, or by written authorization from the Board. The Board will not pay any upfront fees prior to the January 1, 2026 Contract effective date.

[Insert Fee Schedule Proposed]

Exhibit B - Performance Standards

The PBM agrees to the following minimum performance standards and the assessment of liquidated damages for failure to meet these standards. At the Board's discretion, an audit of the accuracy of the PBM's results will be performed via a randomly selected, statistically verifiable sample of claims by a qualified, independent third party. The results of the audit, after appropriate review and comment by the PBM, will be the final determinant of performance standard compliance. When sampling methods are used to estimate performance for the universe of claims, audit samples will be large enough to ensure a confidence interval whose deviation is no greater than plus or minus three (3) percent and whose confidence level is at least ninety-five percent (95%). The Board will consider the point estimate for the sample as the PBM's performance level in calculating liquidated damages. The PBM will be provided the opportunity to review and discuss the audit results before the application of liquidated damages. The Board reserves the right to reduce or waive any fees at risk if, in the Board's sole discretion, failure to meet a performance standard was due to extraordinary circumstances.

All payments made on behalf of the Board for approved services, shall be in accordance with rules, regulations, and restrictions of the Board and the laws of the State of Mississippi. The PBM shall identify claims that have been incorrectly processed and initiate appropriate action to correct processing outcomes. The PBM shall notify the OI in writing immediately upon discovery of any systems problem that has caused multiple overpayments, duplicate payments or incorrect payments, irrespective of cause, prior to initiating recovery or corrective action. The PBM shall notify OI by letter of any system errors that result in a potential overpayment or other incorrect payment and describe in detail the plan and deadlines for corrective action.

Performance Standard	**Description of Standard**	**Fees at risk**
Pharmacy Network Access	95% of all participants within 5 miles of at least 1 participating pharmacy Measurement Period: Annually Notify MDFA staff at least 60 days in advance regarding termination of a current pharmacy chain or independent pharmacy as well as notify impacted participants within 15 days of said termination	$25,000 Annually $25,000 Annually
Network Pharmacy POS Compliance	99% of time internal on-line system available Measurement Period: Quarterly	$20,000 Quarterly
Retail Paper Claims Processing Time	95% of prescriptions reimbursed or responded to within 15 business days of receipt Measurement Period: Quarterly	$20,000 Quarterly

Performance Standard	Description of Standard	Fees at risk
Retail Claims Financial and Processing Accuracy	99.5% of all claims paid with NO errors (i.e. correct drug, correct form, correct strength, correct patient, correct AWP, correct copayment, or correct deductible). Retail claims adjudication accuracy is the total number of retail claims paid correctly divided by the total number of retail claims paid. The PBM will maintain an internal audit process to quarterly self-report the results. Measurement Period: Quarterly	$20,000 Quarterly
Mail Order Claims Processing Time	95% of prescriptions requiring NO intervention to be shipped within 2 business days (as measured from date order received at the PBM to date order shipped) Measurement Period: Quarterly 95% of prescriptions requiring administrative or clinical intervention to be shipped within 5 business days (as measured from date order received at the PBM to date order shipped) Measurement Period: Quarterly	$20,000 Quarterly $20,000 Quarterly
Mail Order Claims Financial and Processing Accuracy	99.5% of all claims paid with NO errors (i.e. correct drug, correct form, correct strength, correct patient, correct AWP, correct copayment, or correct deductible). Mail order claims adjudication accuracy is the total number of mail order claims paid correctly divided by the total number of mail order claims paid. Measurement Period: Quarterly	$25,000 Quarterly

Performance Standard	Description of Standard	Fees at risk
Rebate Remittance Time	100% of all rebate dollars remitted to the Board within 60 days of the rebates being received by PBM. The Board must receive the greater of: (1) the guaranteed minimum per claim rebate amount, or (2) 100% of all rebates, as defined by this RFP, paid by pharmaceutical manufacturers or intermediaries or other similar sources attributable to the Board's utilization that the PBM receives from any and all pharmaceutical manufacturers or intermediaries or other similar sources. These sources may include, but will not be limited to, market share incentives; promotional allowances; commissions; educational grants; inflation protection; implementation allowances; clinical detailing; or rebate submission fees. The intermediary will pay the PBM 100% of the rebates it receives that are directly attributable to prescription drug claims paid by the Board, allowing the PBM to pay the Board 100% of the rebates collected, regardless of who collected them (the PBM or the intermediary). Measurement Period: Quarterly	$20,000 Quarterly
Customer Service	90% of calls answered by a live customer service representative within 30 seconds during open hours <5% of calls abandoned 99% of written inquiries responded to within 10 business days Measurement Period: Quarterly	$5,000 Quarterly $5,000 Quarterly $5,000 Quarterly

Performance Standard	Description of Standard	Fees at risk
Account Service	Subjective satisfaction of Board with the contractual and administrative relationship based on mutually agreed satisfaction survey. Measurement Period: Annually	$40,000 Annually
	Conduct at least one (1) customer satisfaction survey within the third quarter of the initial contract period and one (1) annually thereafter. The contents of the satisfaction survey must be agreed upon by the Board and the PBM. Measurement Period: Annually	$25,000 Annually
ID Card Distribution	95% of ID cards mailed within 15 days of receipt of eligibility data (for monthly changes) or request for replacement card Measurement Period: Quarterly	$10,000 Quarterly
	Average time to mail ID cards for ongoing eligibility (from the clean eligibility information provided) is ≤ 5 business days Measurement Period: Quarterly	$5,000 Quarterly
Reporting Requirements	Quarterly reports provided to Board ≤ 30 calendar days after the end of the quarter	$10,000 Quarterly
	Quarterly report quality control evaluation findings to the Board ≤ 30 calendar days after the end of the quarter	$10,000 Quarterly
	Quarterly report the audit activities and findings of the pharmacy field and desk audit services	$10,000 Quarterly
	Quarterly report all pass through price protection received from manufacturers through rebates to the Plan by therapeutic category and by manufacturer and down to the NDC level Measurement Period: Quarterly	$10,000 Quarterly
	Monthly and annual report of all reconciliations Measurement Period: Monthly and Annually	$1,000 per day delayed

Performance Standard	Description of Standard	Fees at risk
Written and Telephone Inquiry Response Rate	98% response within 5 business days + 100% within 7 business days Measurement Period: Quarterly	$10,000 per each 1% below standard Quarterly
Data Transfers	99% of error transactions from the data transfer sent to the PBM will be corrected and returned to the PBM via data transfer within two (2) business days of receipt of the error report. 100% will be corrected and returned with fifteen (15) business days. Measurement Period: Quarterly	$10,000 Quarterly $10,000 Quarterly
Field & Desk Audit	100% refund of any amounts recovered due to a field or desk audit to the Board no more than 45 days Measurement Period: Annually	$1,000 per each day of delay
Annual Independent Audit	Finalize the audit schedule with the Independent Auditor/MDFA during the month of December each year and meet the agreed to deadlines. Measurement Period: Annually	$1,000 per each day of delay
Annual Independent Audit Reconciliation	Within 60 days of final report being issued by the Independent Auditor, the PBM, aggregator, and/or GPO will complete the final reconciliation and remit any and all reimbursement to the Plan. Measurement Period: Annually	$50,000 + $1,000 per day after deadline

Measurement of Performance

The Board will use the PBM's internal reports to measure the PBM's performance relative to the standards included in this Exhibit. The PBM's internal reports and/or data (including detail claims data) supporting the PBM's internal reports may be reviewed/audited by the Board, or at the Board's discretion, by an independent reviewer. The report and determination of the independent reviewer shall be final, binding and conclusive as to an administrative review on the PBM and the Board; provided, however, that before a final report and determination is issued, the Board and the PBM shall each have a reasonable opportunity to review the non-proprietary supporting documentation and proposed report of the independent reviewer and to provide any comments to the independent reviewer. As described in section **BB. Full Disclosure and Independent Review**, the Board requires full cooperation from the PBM with the Board's independent reviewer to ultimately determine if the performance standards related to the annual independent review are satisfied.

Payment of Liquidated Damages

In the event the Board determines that the PBM has not met a given Performance Standard, under which liquidated damages are payable to the Board for failure to comply, the PBM shall remit the applicable at-risk fees for failing to meet the corresponding Performance Standard to the Board within forty-five (45) days after the end of the measurement period.

Measurement Period

Quarterly and Annual Measurement Periods are measured based on the calendar year.

Exhibit C - PBM Services Contractor Reports

PBM will provide reporting which will reflect transactional (monthly) elements as well as the overall success of the program (quarterly and annual) elements. All reports must include report parameters and definitions. The report list and frequency will be as follows:

Deliverable	Ongoing Frequency	Description
Quality Control Evaluation Report	Quarterly	
Pharmacy Field and Desk Audit Services Report	Quarterly	Report of the audit activities and findings of the pharmacy field and desk audit services
Manufacturers Rebate Report	Quarterly	Report all pass-through price protection received from manufacturers through rebates to the Plan by therapeutic category and by manufacturer and down to the NDC level
Reconciliation Report	Monthly and Annually	
Manufacturers Rebate and Paid Ancillary Fee Report	Monthly and Annually	Monthly and annual NDC level report on earned rebate dollars and all ancillary fees paid by pharmaceutical manufacturers for medications dispensed for the Plan
SOC or similar audit report	Annually	
Standard/Ad Hoc Reporting	Per Board request	Detailed report will be provided at the Board's request in a hard copy and/or electronic media format. The Vendor shall provide web-based reporting tools that allow the Board to view, print and download reports to spreadsheet software.

Exhibit D - The PBM Contractor's Response to the Mississippi State and School Employees Health Insurance Management Board's Request for Proposals for Pharmacy Benefit Manager Services, Dated December 12, 2024

Exhibit E - Mississippi State and School Employees Health Insurance Management Board's Request for Proposals for Pharmacy Benefit Manager Services, dated October 15, 2024

Appendix B

Pharmacy Benefit Manager Services Vendor Reports

The selected vendor will provide reporting which will reflect transactional (monthly) elements as well as the overall success of the program (quarterly and semi-annual) elements. Reports and frequency may be modified upon mutual agreement. The report list and frequency will be as follows:

Deliverable	Ongoing Frequency	Description
Quality Control Evaluation Report	Quarterly	
Pharmacy Field and Desk Audit Services Report	Quarterly	Report of the audit activities and findings of the pharmacy field and desk audit services
Manufacturers Rebate Report	Quarterly	Report all pass-through price protection received from manufacturers through rebates to the Plan by therapeutic category and by manufacturer and down to the NDC level
Reconciliation Report	Monthly and Annually	
Manufacturers Rebate and Paid Ancillary Fee Report	Monthly and Annually	Monthly and annual NDC level report on earned rebate dollars and all ancillary fees paid by pharmaceutical manufacturers for medications dispensed for the Plan
SOC or similar audit report	Annually	
Standard/Ad Hoc Reporting	Per Board request	Detailed report will be provided at the Board's request in a hard copy and/or electronic media format. The Vendor shall provide web-based reporting tools that allow the Board to view, print and download reports to spreadsheet software.

Appendix C

Specialty Drug List and Guaranteed Discounts

Appendix D

Top 50 Pharmacies Utilized by Participants

Appendix E

Financial Requirements

Appendix F

Financial Offer

Appendix G

Specialty Pharmacy Offer

Appendix H

Claims and Trend Assumptions

Appendix I

Exclusions

Appendix J

Mfc. Coupon Programs

Appendix K

Administrative Ancillary Fees

Appendix L

Formulary Disruption Results