Attachment 22

RESPONSE TO SCOPE OF SERVICES QUESTIONNAIRE

Instructions: **!!! IMPORTANT !!!**

A. **Responsiveness** –

- Generic responses or stock answers that do not address State-specific requirements will be deemed unresponsive.
- "Will discuss" and "will consider" are not appropriate answers.
- All questions are important to the State and therefore you may not answer that a topic is not applicable unless you specifically state why it is a service that does not apply for the plans or programs you are proposing.

B. **Respond to Each Question** –

- If a question is repeated in multiple sections and your answer is the same, do not refer to your answer in another section but copy it under each question.
- DO NOT LEAVE A RESPONSE BLANK! You must acknowledge that you feel the item does not apply and provide a reason why! Otherwise, we will need to ask you to reply in a follow-up question.

C. **Fees or Costs –** Fees or costs that are not included in your proposal and stated on the appropriate appendices (forms) will not be considered by the State. A fee only stated in a response to a question, whether or not we remind you to include a fee on the appropriate appendix or form, will not be considered! You must document ALL fees and costs in Attachment 31, Fee Quote.

D. **Numbering –** Please do not change the numbering of a question, even if there is an error in the sequence or a duplication.

1. Pharmacy Questionnaire - General

1. Please confirm each of the below listed State of Delaware Plan Design Details and provide any deviations within the "Notes" column. Each listed item is a feature of State of Delaware's current and proposed Plan Design/Benefit Design and it is imperative that PBM provides a full and accurate quote which aligns with each of the specific items listed in the table below. Additional details (as necessary) for each item are outlined within the "Additional Details" column.

Please note that State of Delaware will not accept any deviations from the table below.

a. Commercial

State of Delaware's Current and Proposed Plan Design	Response
Broad Retail Network	
Broad Retail 90 Network	
PBM's Standard Formulary with exclusions	
Pharmacy Benefit exclusions include: Non-Federal Legend Drugs (OTC) excepted where mandated by ACA, Investigational drugs, Prescription drugs that have OTC equivalents, Ostomy supplies, Blood Glucose Monitors not issued by the Health Plan Diabetes Care Management Program, Mifeprex, Cosmetic and hypopigmentation drugs, Dental fluoride products except where mandated by ACA, Allergy Sera and blood products, Erectile dysfunction agents, Hypoactive Sexual Desire Disorder (HSDD) Agents, Continuous Blood Glucose Monitoring Systems (e.g., monitor, transmitter, receiver, sensor), Insulin Pumps and Supplies, Peak Flow Meters and Nebulizers, Nutritional Supplements, Select Vitamins requiring a prescription, Periodontal Subgingival Implants, Medical Benefit Only Drugs (drugs designated to be covered under the health plan)	
Exclusive Specialty (including Biotek Remedys specialty pharmacy)	
Zero Specialty Grace Fill	
Prior Authorizations	
Step Therapies	
Quantity Limits	

a. EGWP

State of Delaware's Current and Proposed Plan Design	Response
Broad Retail Network	
Broad Retail 90 Network	
PBM's Standard Formulary with exclusions	
Pharmacy Benefit exclusions include: : Non-Federal Legend Drugs (OTC) excepted where mandated by ACA, Investigational drugs, Prescription drugs that have OTC equivalents, Ostomy supplies, Blood Glucose Monitors not issued by the Health Plan Diabetes Care Management Program, Mifeprex, Cosmetic and hypopigmentation drugs, Plan B One Step, Anti-Obesity Preparations, Weight Loss Medications, Dental fluoride products except where mandated by ACA, Allergy Sera and blood products, Erectile dysfunction agents, Hypoactive Sexual Desire Disorder (HSDD) Agents, Continuous Blood Glucose Monitoring Systems (e.g., monitor, transmitter, receiver, sensor), Insulin Pumps and Supplies, Peak Flow Meters and Nebulizers, Nutritional Supplements, Select Vitamins requiring a prescription, Periodontal Subgingival Implants, Medical Benefit Only Drugs (drugs designated to be covered under the health plan), Addyi	
Open Specialty	
Prior Authorizations	
Step Therapies	
Quantity Limits	

2. Attached is a description of the pharmacy benefit plan designs for State of Delaware, as well as the clinical programs in place today for Commercial and EGWP, Attachment #24 (Commercial Account Structure) and Attachment #25 (EGWP Account Structure) . Please provide your financial quote assuming no change in designs and clinical programs. Your offer should assume your most closely matched standard formulary and network to what State of Delaware currently has in place and all pharmacy lives provided in the data set. Additionally, please refer to, Attachment #24 (Commercial Account Structure) and Attachment #25 (EGWP Account Structure) that summarize the current account structure for Commercial and EGWP.

3. Confirm any "exceptions" that contradict or provide additional detail to questions and responses within this Questionnaire will not be accepted as part of your proposal. All details on your proposal must be included within your response to each applicable question as needed. Please review all Questionnaire responses, Financial Worksheets submission and any other documentation for accuracy and consistency across all responses. Caveat/Additional Clarification documents that conflict or provide additional information or language as compared to submitted Questionnaire and Financial Worksheets responses (outside of the specialty drug list) will not be accepted as a part of your proposal.

4. Review and sign the attached State of Delaware standard contractual documents.

5. Confirm that your organization agrees to assume full responsibility for accurately administering all of State of Delaware’s plans in accordance with the plan design and terms.

6. Confirm you commit to a maximum ten (10) business day turnaround for contract reviews during negotiations.

7. Acknowledge that State of Delaware reserves the right to withhold identifying the successful bidder until the contract is signed by both parties.

8. Confirm that State of Delaware has the sole decision making responsibility as it relates to benefit design and determining which medication categories are covered or excluded.

9. The effective date of the contract awarded under this RFP will be July 1, 2026. It is anticipated that the award will be made in late 2025/early 2026. Please confirm that if you are awarded the contract no later than December 31, 2025, you would be able to successfully implement Commercial pharmacy benefit management services for a May 2026 Open Enrollment period and a July 1, 2026, effective date, and EGWP pharmacy benefit management services for a January 1, 2027, effective date.

10. Assuming a contract award by December 31, 2025 and a Commercial effective date of July 1, 2026, as an exhibit provide a detailed implementation schedule and include steps required to implement the program, role played by the plan sponsor/vendor, testing of enrollment file feed(s), production and distribution of enrollment materials, contacts and personnel assigned to each step of the implementation process, establishment of online plan information, and online Open Enrollment in mid-May.

11. Please confirm that your organization will lead the implementation process taking direction from the State of Delaware. Describe what involvement would typically be expected from the SBO to support the implementation process.

12. Confirm that you will conduct a pre-implementation testing process to ensure accuracy of plan administration prior to the effective date and that you will share the results of the testing process with the State no later than 15 calendar days prior to effective date of the contract, contingent on plan benefit intent documents being completed and signed in a timely manner.

2. Contractual Provisions and Other Legal Requirements

1. Your organization agrees, upon termination of the relationship (regardless of which party terminates), to process run-out claims, at no cost, for a predetermined time of State of Delaware's choosing.

2. Your organization agrees, upon termination of the relationship (regardless of which party terminates), to provide transition files (open refill, prior authorization, claims history) at no additional cost for a period of at least one year.

3. Your organization agrees, upon implementation of the relationship, to accept transition files (open refill, prior authorization, claims history) at no additional cost.

4. Confirm the ability and flexibility to support State of Delaware with a strategy for direct contracting of select drugs with select manufacturers (e.g., direct negotiations with a pharmaceutical manufacturer for the pricing of one of their products, conducted by State of Delaware or its representative) at any time during the term of this agreement.

5. Confirm State of Delaware has the flexibility to focus on a specific therapy class or drug entity for contracting with Pharmaceutical Manufacturers, determining channel or site of care, etc.?

6. Please indicate if PBM receives compensation from manufacturers for providing the following programs/services to clients and their members and, if so, specify amounts or fee schedule for each program/ service:

Programs/Services	Bidder receives compensation from manufacturers (Yes/No)
Formulary compliance initiatives	
Clinical services	
Therapy management services	
Education services	
Inflation protection programs	
Medical benefit management services	
Cost containment programs	
Discount programs	
The sale of non-patient identifiable claim information	

7. Your organization will agree to disclose and pass through to State of Delaware all current sources of revenue attributable to their Rx Benefit including any monies or other payments from manufacturers or third parties. State of Delaware will not need to request this reporting and it will be provided, at a minimum, on a yearly basis.

8. Confirm you will remit to the client all rebates received from pharmaceutical companies on a quarterly basis within 90 days after the submitted quarter.

3. Audit

1. Your organization will allow State of Delaware the right to audit all aspects of the pharmacy program managed by the successful bidder including financial terms, the specialty program, service agreements, administration, guarantees and all transparent and pass through components up to three years after termination of the contract at no cost to State of Delaware. The review of all aspects of the pharmacy program may include but will not be limited to: paid claims, the claim processing system, benefit set up accuracy, rebate agreements including point-of-sale rebates, performance guarantees, pricing guarantees, retail networks, retail network contracts, mail order services, specialty networks, acquisition pricing, Medicare Part D reconciliations, transparency, pricing benchmarks (e.g., AWP source), onsite assessments, operational assessments, clinical assessments, clinical programs including clinical utilization management criteria/evaluation process, eligibility, accumulator coordination and any financial amounts processed between the organization and/or pharmaceutical manufacturer copay coupons and/or third parties administering copay coupon maximization programs and customer service call monitoring for both the commercial plan and EGWP plan, if applicable.

2. All documentation needed to complete the audit will be provided by your organization, including documentation related to previously identified errors which occurred during the audit time frame.

3. Audits will be conducted by a firm selected by State of Delaware.

4. PBM cannot charge State of Delaware or audit firm for plan set-up documentation or to pull claims or related data for audit.

5. Confirm that audit recovery overpayments will not be offset by any potential underpayments identified by the audit.

6. The successful bidder must agree to pass through to State of Delaware 100% recovery of retail pharmacy audit recoveries and overpayments.

7. The successful bidder must confirm that each contract year 5% of retail, mail and specialty pharmacies that submit at least 500 claims will be audited and will include claims paid under the State of Delaware plan. A report of State of Delaware's recoveries shall be provided at least annually and upon request by State of Delaware.

8. The successful bidder agrees to conduct a daily review of claims over $999 for accuracy.

9. The results of a daily review of claims over $999 will be provided to State of Delaware at a minimum on a quarterly basis.

10. The successful bidder must agree to have full liability for claim processing accuracy upon written confirmation of State of Delaware's intent for plan design and other program set up.

11. Confirm your organization agrees to provide a detailed explanation of any issues identified in an onsite or virtual rebate audit. Simply stating the claim was not eligible for rebates without furnishing additional explanation as to why the claims were ineligible for rebates, will not be acceptable.

12. Confirm your organization must agree to pass through to State of Delaware 100% of all error recoveries and overpayments, both plan and member, (even if recovery is not made), regardless if the error or overpayment was discovered through an internal audit, a State of Delaware audit, or through other means, and regardless of the point in time the error(s) is/are found.

13. Your organization will allow State of Delaware, or State of Delaware's consultant, the right to review the internal testing completed for State of Delaware's Commercial Plan and EGWP Plan for any plan design or clinical changes, including any significant design changes (e.g., change in formulary, new plan

option, significant plan design changes), if applicable, prior to the effective date of the plan on an annual basis.

14. Your organization will allow State of Delaware, or State of Delaware's consultant, the right to create and submit up to 200 test claims for State of Delaware's Commercial Plan and EGWP Plan as part of a pre or post implementation audit.

15. Please provide the number of claims that would be typically tested in advance of a new client's effective date, to ensure the plan is set up accurately. This is for internal PBM testing.

16. Confirm PBM will be responsible for reimbursing shortfalls regardless of whether a plan or member impact occurred due to coding errors made by the PBM.

17. Confirm your proposal assumes no additional charges for claims files or other necessary documents to State of Delaware for audits of any population, including, but not limited to, pre-implementation audit, annual claims audit and annual benefit audit, rebate audit, etc.

18. Confirm your proposal allows State of Delaware to conduct multiple ongoing audits of the pharmacy benefit for any population and will not charge State of Delaware for claims files or other necessary documentation in order to implement these audits.

19. Confirm for smaller scale, streamlined focus audits (for example, eligibility, accumulator coordination, customer service, implementation audits, etc.) the turnaround times will be shortened accordingly due to low or no claim samples for review.

20. Confirm your organization will not request a member to fund any processing errors, which resulted in a Plan overpayment, for any reason.

21. Please confirm PBM will honor rebates to the guarantees if the contract or amendment language is silent on any rebate classification within the client's claims experience. On any silent or unclear definitions, the guarantee that is most favorable to State of Delaware will apply.

22. Confirm any specialty copay assistance/coupon programs are fully transparent and auditable including verification of appropriate fees paid in alignment with the contract terms.

23. Confirm any point solution or clinical program administrative charges are fully transparent and auditable regardless of PBM owned or third party agreements.

24. Confirm that the audit sample claim size will be at least 500 claims per population per year. This sample claim size may increase should State of Delaware include any additional components to audit, such as any clinical or accumulator reviews.

25. Confirm PBM will provide written confirmation acknowledging PBM's approval of the audit timeline, within five days after the claims audit planning meeting.

26. Confirm that PBM will provide full claims file to auditors, upon request, of claims cost with and without the impact of POS rebates (if applicable).

27. Confirm PBM will provide complete responses to any audit follow-up questions pertaining to PBM's responses within 10 business days.

28. Confirm PBM will provide complete responses to all issues presented within the audit Executive Summary report which include:

i. System programming correction date or training measures in the case of manual errors
ii. Final financial impact of the error, including pre-audit and post-audit time period
iii. Date and method of payment for monies owed to State of Delaware and its members

29. Confirm that, in the event the audit Executive Summary report findings are not contested by PBM within the thirty (30) day time period following their presentation to State of Delaware (i.e., with clear documentation and all evidence to the contrary), PBM will assume full financial impact of all unaddressed findings.

30. Confirm that successful bidder will provide separate information upon request including ingredient cost, discounts and rebates per claim to allow for complete auditing of POS rebate plan design.

31. Confirm significant confirmed error recoveries will be paid prior to closure of all audit items, and will not be delayed to wait for all errors to be researched and resolved.

32. Confirm all reimbursements will be made no later than 30 calendar days after all parties have agreed to the final error and impact amounts.

33. Confirm the successful bidder will partner with State of Delaware’s auditor prior to audit programming to confirm the inclusion/exclusion rules for all financial guarantee measurement, including but not limited to: discounts, dispensing fees, rebates and admin fees.

34. The successful bidder agrees to share its own reconciliation report claim file used to measure its self-reported performance relative to the contract guarantees.

35. What root cause correction plan is in place to ensure errors discovered in audits are appropriately corrected, tested and do not occur again?

36. Confirm the successful bidder will allow for quarterly audits instead of annual audits for claims only.

37. Provide requirements for real time, ongoing audits of claim processing and the ability to provide real time data to an audit company by January 1, 2027.

4. PBM Performance Guarantees

Instructions: The State requires bidders to agree to place a percentage of fees per contract year at risk for performance guarantees. If you propose alternative guarantees, performance results, or definitions, please reflect in the comments specific to the performance guarantee. You are encouraged to provide additional amounts at risk; bidders that do so will be viewed favorably by the State. If your offer does not receive a clarifying question or any other response from the State, it does not infer acceptance. The State reserves the right to negotiate both financial and non-financial performance guarantees with the selected vendor.

Terms: The performance guarantees will be measured when stated, as applicable, and at the end of the project. Penalties will be assessed and paid within thirty (30) days.

Commercial Implementation Performance Guarantees

Implementation: While some implementation activities occur each year, such as reviewing plan design features and issuing employee communications, the bulk of the implementation activities will take place in Year 1. Since a successful program depends on a flawlessly executed implementation, a separate guarantee for implementation activities is required. An overall rating of satisfactory at the end of the implementation period is required. It will be based on ongoing feedback provided by the SBO on the status of the implementation and by September 1, 2026 for Commercial (March 1, 2027 for EGWP), the State will determine whether an overall rating of satisfactory was met. Penalty payments, if any, will be made by December 31, 2026 for Commercial (June 30, 2027 for EGWP).

1. **Non-Incumbent's Implementation:**
   a. Confirm your organization agrees to the terms of the implementation performance guarantees outlined in Attachment 15 – Performance Guarantees of this RFP.

   b. **Future Contract Development** - The PBM will prepare the first draft of the contract and will incorporate all of the Minimum Requirements from both Phases of this RFP. Any variance identified in the bid response accepted by the State for performance commitments in the first draft of the contract. The

vendor cannot propose changes that are not included in the terms of the RFP or their bid offering necessitating an excessive number of drafts. Confirm agreement to meet and propose the Fee at Risk ($ or % of Total Annual Fee At Risk).

c. **Implementation and Account Management** - Implementation manager and account executive /manager will participate in every implementation call and will be prepared to lead the calls, based on detailed agenda sent to the team in advance. Confirm agreement to meet and propose the Fee at Risk ($ or % of Total Annual Fee At Risk).

d. **Maintenance of Detailed Project Plan** - Project plan must delineate due dates, responsible parties and critical linkages between tasks, as appropriate. Project plan will be updated and distributed in advance of each implementation weekly call. Confirm agreement to meet and propose the Fee at Risk ($ or % of Total Annual Fee At Risk).

e. **Adherence to Key Deadlines** - All key dates will be met to the extent Vendor has control and/or has notified State of risks of failure in advance of due date. State and Vendor will agree at the beginning of implementation on which deadlines are critical to program success. Confirm agreement to meet and propose the Fee at Risk ($ or % of Total Annual Fee At Risk).

2. **Incumbent's Implementation**

a. Confirm your organization agrees to the terms of the implementation performance guarantees outlined in Section 2.4.1 of this RFP and on Attachment 15 – Performance Guarantees.

b. **Future Contract Development** - The PBM will prepare the first draft of the contract and will incorporate all of the minimum requirements from both Phases of this RFP. Any variance identified in the bid response accepted by the State for performance commitments in the first draft of the contract. The vendor cannot propose changes that are not included in the terms of the RFP or their bid offering necessitating an excessive number of drafts. Confirm agreement to meet and propose the Fee at Risk ($ or % of Total Annual Fee at Risk) on Attachment 15 - Performance Guarantees.

c. **Terms:** (CARRIER) will perform a review of its records to determine whether each standard was met for the time period of the quarter immediately preceding the 45th day of the month following the end of a quarter (for example, November 15 for the first quarter of the plan year - July 1 to June 30). Quarterly results will be averaged on an annual basis and penalty payments, if any, will be made annually within six (6) months of the end of the plan year.

3. **Commercial Ongoing Performance Guarantees**

Payment Accuracy and System Performance

a. **Financial Accuracy.** PBM will guarantee that at least 99.5% of Claim payments will be processed accurately according to Client's benefit Plan design and contractual guarantees. Measurement: Claims payments made without error relative to the total dollars paid. This is measured on a client specific basis.

b. **System Downtime.** Your organization will guarantee at least 99.5% access to its systems by all the retail pharmacies in PBM's network 24 hours a day, 7 days a week, 365 days a year, excluding systems downtime, telecommunications failure, or other circumstances outside the control of the PBM.

c. **Internet Availability Rate.** Your organization will guarantee that your website will be operational at least 98% of the time. Measurement: Percentage of hours that PBM's internet site is operational, excluding scheduled maintenance.

d. **Claims Enrollment Data.** Your organization will guarantee that all enrollment will be uploaded with 100% accuracy not to exceed (1) business day provided accurate and complete eligibility files are electronically transmitted by 10:00 am Eastern Time. If for any reason the eligibility file cannot be loaded properly or there are significant issues with the file, PBM will notify client within this one-day time period. This is measured on a client specific basis.

e. **Enrollment Data Error Reporting.** Your organization will guarantee that enrollment file error reporting on all enrollment file updates will be provided to the State of Delaware within two (2) business days.

f. **Invoicing Errors.** PBM will guarantee that all invoicing errors will be credited back to Client within 30 days of agreement on the amount due or PBM will pay a penalty of $1,000 per day beyond 30 days from the date of the agreement, up to the maximum amount at risk allocated for this standard. Invoicing Errors shall mean administrative or service fee errors.

g. **Plan Administration Accuracy:** PBM’s account team shall document requirements and secure Client sign off on all Plan change requests. PBM will accurately capture Client intent as mutually agreed upon in writing, implement all Plan design and/or other requested changes (e.g., clinical programs,

pricing, other programs, etc.) and conduct appropriate testing to confirm accuracy prior to the effective date of the change. PBM must provide Client at least five (5) Business Days prior to any PBM submission deadlines to review the PBM documents required to implement any program/Plan changes. Confirmation of the accurate Plan change set up will be provided by PBM to Client prior to the effective date of the change.

h. **Timely Data Feeds** PBM will guarantee 100% accurate and timely data feeds on a per file and on a "missed" Business Day basis (e.g., inaccurate, missed or late transmissions will be charged a penalty per file plus an additional penalty for each Business Day until such file is successfully delivered.) The definition of timely and accurate will be mutually agreed upon between PBM and Client.

4. Account Management

a. **Member Communication Mailing Errors.** PBM guarantees that 100% of ID cards and welcome booklets shall be accurate. Should an ID card or welcome booklet be sent in error or contain erroneous information regarding any aspect of the Plan's administration, PBM shall pay a penalty per erroneous document not to exceed $1000 per erroneous document up to the total annual penalty. This guarantee excludes errors made by Client only.

b. **Account Management Satisfaction.** Client may assess a penalty per Contract Year and each successive Contract Year, Client's benefits staff do not rate the account team's performance for such Contract Year an average of 3 or better on a scale of 1 to 5 (5 being the best based on a range of performance criteria agreed to between Client and PBM at the beginning of such Contract Year). All members of the account team will be reviewed as part of this guarantee measurement. Final measurement of Client's satisfaction with the account team will be subjective and will be based upon Attachment 17 to the RFP, Account Management Survey.

c. **Account Management Meetings.** PBM guarantees that your company will attend and actively participate at Statewide Benefits Office's request in Benefit Representative meetings, educational sessions and health fairs at no cost to the State.

d. **Account Management Issue Resolution:** PBM guarantees that if any issue cannot be resolved within two (2) Business Days, PBM will, within one (1) Business Day of receipt by the account manager, agree to a resolution timeline via electronic or verbal communication with the requestor. PBM account manager will maintain an issue log to track these items. "Issue" may be a complaint by a member, an adjudication error, or any other item that is being tracked on the issue log.

5. **Member Services**
   a. **Mail Order Dispensing Accuracy Rate.** PBM guarantees that 99.99% of prescriptions will be dispensed with the correct drug and strength. Measurement: Number of accurately ordered mail order pharmacy prescriptions divided by number of all mail order pharmacy prescriptions dispensed during the year. Measured based on PBM's book of business. Performance standards for PBM's Mail Service Pharmacy assume a minimum of 1,000 Mail Service Pharmacy prescriptions submitted annually.

   b. **Mail Turnaround - Prescriptions Not Requiring Intervention.** PBM guarantees that 95% of prescriptions dispensed within an average of two (2) business days and 100% within an average of three (3) business days. Performance standards for PBM's Mail Service Pharmacy assume a minimum of 1,000 Mail Service Pharmacy prescriptions submitted annually.

   c. **Mail Turnaround - Prescriptions Requiring Intervention.** PBM guarantees that 95% of prescriptions dispensed within an average of four (4) business days and 100% within an average of five (5) business days. Performance standards for PBM's Mail Service Pharmacy assume a minimum of 1,000 Mail Service Pharmacy prescriptions submitted annually.

   d. **Phone Average Speed of Answer.** PBM guarantees that 100% of member calls shall be answered within an average of 30 seconds (excluding IVR).

   e. **Phone Abandonment Rate.** PBM guarantees that 100% of Member calls shall be answered with an abandonment rate of 3% of less; excluding IVR and excluding calls abandoned by the member in the first thirty (30) seconds.

   f. **Written Inquiry Answer Time.** PBM guarantees that 95% of e-mail or letter inquiries responded to within five (5) business days - 100% within ten (10) business days.

   g. **Direct Member Reimbursement Response Rate.** PBM guarantees that 100% of manually submitted claims will be processed within 14 calendar days.

   h. **Member Satisfaction Survey.** The PBM agrees to conduct a Member Satisfaction Survey for each contract year. The Satisfaction Rate will be 90%

or greater. A yearly penalty may be assessed against the PBM for failure to meet this standard. “Member Satisfaction Rate” means (i) the number of Eligible Persons responding to PBM annual standard Patient Satisfaction Survey as being satisfied with the overall performance under the Integrated Program divided by (ii) the number of Eligible Persons responding to such annual Patient Satisfaction Survey. For the Performance standard to be applicable the response rate must be statistically significant. Measured annually from the State of Delaware's participants based on the average of quarterly surveys conducted by phone.

i. **State Approval of Member Communications.** PBM guarantees that 100% of all member communications will be approved by the State of Delaware - exceptions for drug recalls, urgent patient safety communications, and standard documents of an operational nature.

j. **Issue Resolution: State Staff Involvement / Escalation.** PBM guarantees that PBM will resolve 98% of Member issues within two (2) Business Days for any case that required the involvement of Client’s staff due to incorrect or incomplete information being provided by PBM. If not resolved within 72 hours, a penalty will be applied of $5,000 per case, up to the annual maximum amount at risk allocated by Client. The penalty is based on per case below 98% target.

k. **First Call Resolution.** PBM will resolve at least 95% of issues at the first point of contact. First call resolution is the number of inquiries completely resolved at the time of initial contact divided by the total inquiries.

6. Reports

a. **Ad-hoc Reports.** PBM guarantees that a minimum of 98% of *ad hoc* reports will be accurate and delivered to the State of Delaware within seven (7) business days of the request. *Ad hoc* reports are defined as reports that are not part of PBM's standard reporting package. This is measured on a client specific basis.

b. **Standard Reports.** PBM guarantees that a minimum of 100% of standard reports will be accurate and delivered to Client by the target date specified in Attachment #16 to the RFP, Master Report List – Commercial. During the term of the Agreement, Client and PBM can change the reporting requirements by mutual written agreement.

7. Audits

a. **Provide Data Extract Requested.** PBM guarantees to provide a claims file in standard format within 30 days of request date or 10 days of the executed confidentiality agreement (whichever occurs later).

b. **Provide Complete Response to Data Request.** PBM guarantees to provide a complete response to Claims data request within thirty (30) Business Days of request.

c. **Providing Initial Response to Audit Findings.** PBM guarantees to provide an initial response to audit findings within 45 business days of receipt of findings.

d. **Pharmacy Audit Resolution.** PBM guarantees that within six (6) months of identification and notification to PBM by Client or its designee except if a pharmacy grievance or litigation is pending, PBM will resolve all processing errors.

e.

8. Open Enrollment

a. **Open Enrollment Readiness:** PBM will guarantee to provide the State of Delaware open enrollment readiness support each contract year, provided the State of Delaware has submitted final requirements at least three months prior to open enrollment. Such support shall include training PBM customer service on the changes, implementing plan design changes, accurate set up of open enrollment website, including pricing, plan design, network and formulary look up, and any additional the State of Delaware-specific culture changes as reasonably requested by the State of Delaware and providing accurate member communications (printed materials) (as requested by the State of Delaware). PBM will perform testing of customer service calls to measure accuracy of responses. PBM will perform testing of the open enrollment website to measure accuracy of plan design and functionality of the website. All test results will be documented, reviewed and sent to the State of Delaware prior to open enrollment.

b. This support will be set up and functioning accurately by the State of Delaware's first day of open enrollment. Open enrollment is conducted in May for the Commercial plan. This is measured on a client specific basis.

9. Other Guarantees

a. **Innovative Guarantees.** Please outline any unique and innovative guarantees that you are offering as part of your proposal, or are willing to provide to the State of Delaware. For example, PBM guarantees the customer care representatives will provide accurate information to all members. This may also include guarantees such as integration, improved outcomes, trend, etc. Please outline the guarantee, amount at risk and measurement. If needed, this guarantee outline can be included in your pricing supplement documentation.

10. **Contract Amendment Turnaround Time and Accuracy Performance Guarantees**
    a. **Contract Amendment Turnaround Time and Accuracy:** PBM agrees to provide initial and subsequent drafts of the contract amendments within ten (10) Business Days following receipt of formal requests/comments from the consultant or the State of Delaware relating to the contract amendment. PBM also agrees that the contract amendment drafts will accurately reflect agreed upon changes. Measurement will be on a per draft and on a "missed" business day basis (e.g., inaccurate, missed or late drafts will be charged a penalty per draft plus an additional penalty for each business day until such draft is successfully delivered.)

EGWP Performance Guarantees

EGWP Implementation Performance Guarantees

<u>Implementation:</u> While some implementation activities occur each year, such as reviewing plan design features and issuing employee communications, the bulk of the implementation activities will take place in Year 1. Since a successful program depends on a flawlessly executed implementation, a separate guarantee for implementation activities is required. An overall rating of satisfactory at the end of the implementation period is required. It will be based on ongoing feedback provided by the SBO on the status of the implementation and by September 1, 2026 for Commercial (March 1, 2027 for EGWP), the State will determine whether an overall rating of satisfactory was met. Penalty payments, if any, will be made by December 31, 2026 for Commercial (June 30, 2027 for EGWP).

11. **Non-Incumbent's Implementation:**
    f. Confirm your organization agrees to the terms of the implementation performance guarantees outlined in Attachment 15 – Performance Guarantees of this RFP.

    g. **<u>Future Contract Development</u>** - The PBM will prepare the first draft of the contract and will incorporate all of the Minimum Requirements from both Phases of this RFP. Any variance identified in the bid response accepted by the State for performance commitments in the first draft of the contract. The vendor cannot propose changes that are not included in the terms of the RFP or their bid offering necessitating an excessive number of drafts. Confirm agreement to meet and propose the Fee at Risk ($ or % of Total Annual Fee At Risk).

    h. **<u>Implementation and Account Management</u>** - Implementation manager and account executive /manager will participate in every implementation call and will be prepared to lead the calls, based on detailed agenda sent to the team

in advance. Confirm agreement to meet and propose the Fee at Risk ($ or % of Total Annual Fee At Risk).

i. **Maintenance of Detailed Project Plan** - Project plan must delineate due dates, responsible parties and critical linkages between tasks, as appropriate. Project plan will be updated and distributed in advance of each implementation weekly call. Confirm agreement to meet and propose the Fee at Risk ($ or % of Total Annual Fee At Risk).

j. **Adherence to Key Deadlines** - All key dates will be met to the extent Vendor has control and/or has notified State of risks of failure in advance of due date. State and Vendor will agree at the beginning of implementation on which deadlines are critical to program success. Confirm agreement to meet and propose the Fee at Risk ($ or % of Total Annual Fee At Risk).

12. Incumbent's Implementation

d. Confirm your organization agrees to the terms of the implementation performance guarantees outlined in Section 2.4.1 of this RFP and on Attachment 15 – Performance Guarantees.

e. **Future Contract Development** - The PBM will prepare the first draft of the contract and will incorporate all of the minimum requirements from both Phases of this RFP. Any variance identified in the bid response accepted by the State for performance commitments in the first draft of the contract. The vendor cannot propose changes that are not included in the terms of the RFP or their bid offering necessitating an excessive number of drafts. Confirm agreement to meet and propose the Fee at Risk ($ or % of Total Annual Fee at Risk) on Attachment 15 - Performance Guarantees.

f. **Terms:** (CARRIER) will perform a review of its records to determine whether each standard was met for the time period of the quarter immediately preceding the 45th day of the month following the end of a quarter (for example, November 15 for the first quarter of the plan year - July 1 to June 30). Quarterly results will be averaged on an annual basis and penalty payments, if any, will be made annually within six (6) months of the end of the plan year

EGWP Ongoing Administration

a. Payment Accuracy & System Performance

1. **EGWP Financial Accuracy.** PBM will guarantee that at least 99.5% of Claim payments will be processed accurately according to The State's benefit Plan design and contractual guarantees. Measurement: Claims payments made without error relative to the total dollars paid.

2. **EGWP System Downtime.** Your organization will guarantee at least 99.5% access to its systems by all the retail pharmacies in PBM's network 24 hours a day, 7 days a week, 365 days a year, excluding systems downtime, telecommunications failure, or other circumstances outside the control of the PBM.

3. **EGWP Internet Availability Rate.** Your organization will guarantee that your website will be operational at least 98% of the time. Measurement: Percentage of hours that PBM's internet site is operational, excluding scheduled maintenance.

4. **EGWP Claims Enrollment Data.** Your organization will guarantee that all enrollment will be uploaded with 100% accuracy not to exceed (1) business day provided accurate and complete eligibility files are electronically transmitted by 10:00 am Eastern. If for any reason the eligibility file cannot be loaded properly or there are significant issues with the file, PBM will notify client within this one-day time period. This is measured on a client specific basis.

5. **EGWP Enrollment Data Error Reporting.** Your organization will guarantee that enrollment file error reporting on all enrollment file updates will be provided to State of Delaware within two (2) business days.

6. **EGWP Invoicing Errors.** PBM will guarantee that all invoicing errors will be credited back to The State within 30 days of agreement on the amount due or PBM will pay a penalty of $1,000 per day beyond 30 days from the date of the agreement, up to the maximum amount at risk allocated for this standard. Invoicing Errors shall mean administrative or service fee errors

7. **EGWP Plan Administration Accuracy:** PBM's account team shall document requirements and secure The State sign off on all Plan change requests. PBM will accurately capture The State intent as mutually agreed upon in writing, implement all Plan design and/or other requested changes (e.g., clinical programs, pricing, other programs, etc.) and conduct appropriate testing to confirm accuracy prior to the effective date of the change. PBM must provide The State at least five (5) Business Days prior to any PBM submission deadlines to review the PBM documents required to implement any program/Plan changes. Confirmation of the accurate Plan change set up will be provided by PBM to The State prior to the effective date of the change.

8. **EGWP Timely Data Feeds.** PBM will guarantee 100% accurate and timely data feeds on a per file and on a "missed" Business Day basis (e.g., inaccurate, missed or late transmissions will be charged a penalty per file plus an additional penalty for each Business Day until such file is successfully delivered.) The definition of timely and accurate will be mutually agreed upon between PBM and The State.

a. Account Management

1. **EGWP Member Communication Mailing Errors.** PBM guarantees that 100% of ID cards and welcome booklets shall be accurate. Should an ID card or welcome booklet be sent in error or contain erroneous information regarding any aspect of the Plan's administration, PBM shall pay a penalty per erroneous document not to exceed $1000 per erroneous document up to the total annual penalty. This guarantee excludes errors made by The State only.

2. **EGWP PBM Account Team's Performance.** The State of Delaware may assess a penalty per Contract Year and each successive Contract Year, the State of Delaware's benefits staff do not rate the account team's performance for such Contract Year an average of 3 or better on a scale of 1 to 5 (5 being the best based on a range of performance criteria agreed to between the State of Delaware and the PBM at the beginning of such Contract Year). All members of the State of Delaware's account team will be reviewed as part of this guarantee measurement. Final measurement of client's satisfaction with their account team will be subjective and will be based upon Attachment 17, Account Management Survey.

3. **EGWP Meeting Attendance.** PBM guarantees that your company will attend (in person if required) and actively participate at Statewide Benefits Office's request in Benefit Representative meetings, educational sessions and health fairs at no cost to the State.

4. **EGWP Account Management Issue Resolution.** PBM guarantees that if any issue cannot be resolved within two (2) Business Days, PBM will, within one (1) Business Day of receipt by the account manager, agree to a resolution timeline via electronic or verbal communication with the requestor. PBM account manager will maintain an issue log to track these items. "Issue" may be a complaint by a member, an adjudication error, or any other item that is being tracked on the issue log.

b. Member Services

1. **EGWP Mail Order Dispensing Accuracy Rate.** PBM guarantees that 99.99% of prescriptions will be dispensed with the correct drug and strength. Measurement: Number of accurately ordered mail order pharmacy prescriptions divided by number of all mail order pharmacy prescriptions dispensed during the year. Measured based on PBM's book of business. Performance standards for PBM's Mail Service Pharmacy assume a minimum of 1,000 Mail Service Pharmacy prescriptions submitted annually.

2. **EGWP Mail Turnaround - Prescriptions Not Requiring Intervention.** PBM guarantees that 95% of prescriptions dispensed within an average of two (2) business days and 100% within an average of three (3) business days. Performance standards for PBM's Mail Service Pharmacy assume a minimum of 1,000 Mail Service Pharmacy prescriptions submitted annually.

3. **EGWP Mail Turnaround - Prescriptions Requiring Intervention.** PBM guarantees that 95% of prescriptions dispensed within an average of four (4) business days and 100% within an average of five (5) business days. Performance standards for PBM's Mail Service Pharmacy assume a minimum of 1,000 Mail Service Pharmacy prescriptions submitted annually.

4. **EGWP Phone Average Speed of Answer.** PBM guarantees that 100% of member calls shall be answered within an average of 30 seconds (excluding IVR).

5. **EGWP Phone Abandonment Rate.** PBM guarantees that 100% of Member calls shall be answered with an abandonment rate of 3% of less; excluding IVR and excluding calls abandoned by the member in the first thirty (30) seconds.

6. **EGWP Written Inquiry Answer Time.** PBM guarantees that 95% of e-mail or letter inquiries responded to within five (5) business days - 100% within ten (10) business days.

7. **EGWP Direct Member Reimbursement Response Rate.** PBM guarantees that 100% of manually submitted claims will be processed within 14 calendar days.

8. **EGWP Member Satisfaction Survey.** The PBM agrees to conduct a Member Satisfaction Survey for each contract year. The Satisfaction Rate will be 90% or greater. A yearly penalty may be assessed against the PBM for failure to meet this standard. “Member Satisfaction Rate” means (i) the number of Eligible Persons responding to PBM annual standard Patient Satisfaction Survey as

being satisfied with the overall performance under the Integrated Program divided by (ii) the number of Eligible Persons responding to such annual Patient Satisfaction Survey. For the Performance standard to be applicable the response rate must be statistically significant. Measured annually from the State of Delaware's participants based on the average of quarterly surveys conducted by phone.

9. **EGWP State Approval of Member Communications.** PBM guarantees that 100% of all member communications will be approved by the State of Delaware - exceptions for drug recalls, urgent patient safety communications, and standard documents of an operational nature.

10. **Issue Resolution: State Staff Involvement / Escalation.** PBM guarantees that PBM will resolve 98% of Member issues within two (2) Business Days for any case that required the involvement of The State's staff due to incorrect or incomplete information being provided by PBM. If not resolved within 72 hours, a penalty will be applied of $5,000 per case, up to the annual maximum amount at risk allocated by The State. The penalty is based on per case below 98% target.

11. **First Call Resolution.** PBM will resolve at least 95% of issues at the first point of contact. First call resolution is the number of inquiries completely resolved at the time of initial contact divided by the total inquiries.

c. Reports

1. **EGWP Ad-hoc Reports.** PBM guarantees that a minimum of 98% of *ad hoc* reports will be accurate and delivered to The State within seven (7) Business Days of the request or by a mutually agreed upon date. *Ad hoc* reports are defined as reports that are not part of PBM 's standard reporting package.

2. **EGWP Standard Reports.** PBM guarantees that a minimum of 100% of standard reports will be accurate and delivered to the State of Delaware by the target date specified in Attachment 16 , Master Report List - EGWP. If you are the selected bidder, you agree that during the term of the Agreement, the State of Delaware and PBM can change the reporting requirements by mutual written agreement. This is measured on a client specific basis.

d. Audits

1. **EGWP Provide Data Extract Requested.** PBM guarantees to provide a claims file in standard format within 30 days of request date or 10 days of the executed confidentiality agreement (whichever occurs later).

2. **EGWP Provide Complete Response to Data Request.** PBM guarantees to provide a complete response to claims date request within thirty (30) days of request.

3. **EGWP Providing Initial Response to Audit Findings.** PBM guarantees to provide an initial response to audit findings within 45 business days of receipt of findings.

4. **EGWP Pharmacy Audit Resolution.** PBM guarantees that within six (6) months of identification and notification to PBM by the State of Delaware or its designee, except if a pharmacy grievance or litigation is pending, PBM will resolve all processing errors.

e. PDP Standards

1. **PDP Member Appeal Resolution Time.** PBM guarantees 97% of standard appeals within seven (7) business days; 97% of expedited appeals within 72 hours.

2. **PDP Initial Coverage Determination Time.** PBM guarantees 97% of standard determinations within 72 hours; 97% of determinations in 24 hours.

3. **PDP Prescription Drug Event (PDE) Submission Time.** PBM guarantees 99% of prescription claims to be reported within ninety (90)days of date of service.

4. **PDP Member Explanation of Benefit Mailing.** PBM guarantees 98% of PDP Member Explanation of Benefit Mailings will be sent by the end of month subsequent to the reporting month.

5. **PDP Reporting.** PBM guarantees that at no cost to the State of Delaware, PBM will prepare and provide reports set forth in Attachment 16, Master Report List - EGWP. During the term of the Agreement, the State of Delaware and PBM may change the reporting requirements by mutual written agreement. The reports set forth in the Attachment #16, Master Report List - EGWP will be available within the time periods set forth in Attachment 16 , Master Report List , or as soon as reasonably possible. This Standard is measured and calculated on a Client-specific basis. PBM will make every effort to provide the reports in Attachment 16, Master Report List, within the target time frames. However, in those instances in which PBM must rely on a third party in order to provide the reports, PBM reserves the right to work with the State of Delaware to identify a mutually agreeable delivery date if the third party has delays in providing the necessary data for the report.

f. Open Enrollment

1. **EGWP Open Enrollment Readiness:** PBM will guarantee to provide the State of Delaware open enrollment readiness support each contract year, provided the State of Delaware has submitted final requirements at least three months prior to open enrollment. Such support shall include training PBM customer service on the changes, implementing plan design changes, accurate set up of open enrollment website, including pricing, plan design, network and formulary look up, and any additional the State of Delaware-specific culture changes as reasonably requested by the State of Delaware and providing accurate member communications (printed materials) (as requested by the State of Delaware). PBM will perform testing of customer service calls to measure accuracy of responses. PBM will perform testing of the open enrollment website to measure accuracy of plan design and functionality of the website. All test results will be documented, reviewed and sent to the State of Delaware prior to open enrollment. This support will be set up and functioning accurately by the State of Delaware's first day of open enrollment. Open enrollment is conducted in March for the EGWP plan. This is measured on a client specific basis.

g. Other Guarantees

1. **EGWP Innovative Guarantees.** Please outline any unique and innovative guarantees that you are offering as part of your proposal, or are willing to provide to the State of Delaware. For example, PBM guarantees the customer care representatives will provide accurate information to all members. This may also include guarantees such as integration, improved outcomes, trend, etc. Please outline the guarantee, amount at risk and measurement. If needed, this guarantee outline can be included in your pricing supplement documentation.

h. Contract Turnaround Time and Accuracy Performance Guarantees

1. **EGWP Contract Turnaround Time and Accuracy:** PBM agrees to provide initial and subsequent drafts of the contract or contract amendments within ten (10) Business Days following receipt of formal requests/comments from consultant or the State of Delaware relating to the contract or contract amendment. PBM also agrees that contract or contract amendment drafts will accurately reflect agreed upon changes. Measurement will be on a per draft and on a “missed” business day basis (e.g., inaccurate, missed or late drafts will be charged a penalty per draft plus an additional penalty for each business day until such draft is successfully delivered.)

6. Pharmacy Strategy

1. Provide two examples of innovative strategies through the PBM, implemented by clients in peer industries to State of Delaware in the last 1 to 2 years. Please include innovative strategies focused on mental health, specialty drugs and/or weight management.

2. How is your organization currently using artificial intelligence and machine learning to analyze data to improve delivery of care? If you are not using AI today, please outline your roadmap for incorporating into your future programs or service delivery.

3. Confirm if PBM has partnerships with any third party vendors (i.e. digital formulary, point solutions, etc.).If yes, please complete the table below:

Vendor	Condition Addressed	PBM discounted fee and/or ROI guarantee	Advantages to PBM relationship versus direct	PBM Reporting provided to client	PBM wraparound service offered

4. What programs or initiatives are you doing to address social determinants of health?

5. What programs or initiatives are you launching that incorporate digital therapeutics? Please indicate if those programs are in-house or a partnership with an outside vendor. Include details about targeted conditions and offerings.

6. How is your organization planning on managing psychedelics?

7. PBM Company Profile and History

1. Do you have a parent organization? If yes, please provide the full legal name.

2. Do you fully own and operate each of the following:

	Yes/No	If No, Explain and provide subcontractor(s)	If No, can the subcontractor and its associated contracts/arrangements be directly audited by State of Delaware. If a subcontractor(s) is involved, note in your response to this question and complete Appendix 6, *Subcontractor Information Form*, included herein for each subcontractor. The company OSD classification information is for self-identification only. Each vendor is required to submit the forms for their subcontractors.
a. Mail order pharmacies			
b. Specialty pharmacies			
c. Rebate contracting and administration			

d. Retail pharmacy network contracting and administration			
e. Clinical program administration			
f. Customer service centers			
g. 340b Administration Capabilities			
h. Communications			
i. Other (please explain any other subcontracting relationships)			

3. Please provide the following general information on your clients and volume for the prior year and current year to date.

	Prior Year	Current Year to Date
a. Number of employed clients		
b. Number of clients in State of Delaware's peer industry (public sector)?		
c. Number of PBM covered members at retail and mail.		
d. Number of mail order pharmacies		
e. Percent capacity at which the mail order service centers are functioning (5% must be entered as 5.00)		
f. Number of annual prescriptions filled through your mail order facility		
g. Number of specialty mail order pharmacies		
h. Number of years doing business as a PBM		
i. Annual company revenue attributable to the PBM business		
j. Company Credit Ratings		
k. Net Promoter Score		

4. Does your organization (including any parent or sister organizations) have any relationships (financial investment, or other financial relationship) with any third party consultancies, actuarial firms, or other firm that provides marketplace advice, analysis, or information? If so, please describe.

5. Do you, on behalf of the clients in your book of business, file, collect and redistribute any class action lawsuit settlements at no charge?

6. During the current year or any of the preceding six calendar years, is there or was there any significant litigation or any government action against your company, or has any such litigation or government action been proposed or threatened in writing? If yes, please provide all details within the space provided for this question.

7. Have you had any “security incidents” relating to PHI in the last 24 months? Security incidents refer to attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in information systems such as hardware, software, information, data, applications, communications, and people. If yes, how long did it take for you to notify impacted participants and their employer or health plan and was any credit monitoring offered to the impacted participants, their employer, or health plan after the incident?

8. Confirm that your organization has not experienced a significant data/security breach involving other personally-identifiable information within the last five years. Briefly explain any breach.

9. Please provide details of any warning letters/citations from the FDA or any other regulatory body within the last 5 years.

8. PBM Account Management and Implementation

1. Please provide the following information for the Implementation Manager, Account Manager (the day to day contact), Account Executive, Clinical pharmacist, and Financial Analyst that will be servicing this client:
    a. Name
    b. Location
    c. Description of qualifications and experience
    d. Years of service at the company
    e. Number of other clients responsible for, including State of Delaware

2. State of Delaware requires that there be a day-to-day client service team that State of Delaware can contact for escalated member issues outside of the account team. Please confirm.

3. Describe your quality assurance procedures and how you guarantee accuracy.

4. State of Delaware has the right to review, meet with and approve changes to the account team assigned by PBM to service State of Delaware. PBM agrees not to change the assigned account team without prior consent from State of Delaware. PBM will provide a transition plan for any changes to the account team and will provide at least 30 days notice to State of Delaware of the proposed change.

The State of Delaware reserves the right to request changes to the assigned account team at the State's discretion.

5. Confirm your organization can facilitate warm transfers of members to other resources, that is, live transfer from PBM customer service representative to another live representative. Such transfer can include third party vendors like the medical vendor, wellness vendors, etc. as reasonably requested by State of Delaware.

6. Upload, as an attachment, a copy of your implementation timeline assuming State of Delaware's effective date.

7. State of Delaware requires that a designated implementation manager and support team (not part of the regular account management team) be assigned to lead and coordinate the implementation activities with State of Delaware. Please confirm you agree to this requirement. The implementation manager shall not be managing more than 3 implementations at the same time.

8. In the table below, list the medical carrier(s) with whom you have the capability to support the integration of pharmacy claims data with a consumer-driven health plan, for the frequencies noted. Please also indicate whether or not you are integrated with the listed medical carrier(s) to administer the following: shared deductible, out-of-pocket maximum, lifetime maximum, bi-directional data transfers.

Data Integration Method	Current Vendor Connections	Comments
a. Real-time sharing of information by two parties		
b. Multiple times per day, but not real-time		
c. Daily (e.g., overnight batch process)		
d. Other, specify		

9. Are you able to coordinate with other health plan vendors to issue a single ID card at no additional cost? If so, with which vendors have you successfully integrated?

10. When eligibility data is coming from the medical vendor, please describe the member ID transfer process.

11. Are you able to administer a real-time integrated fertility coverage maximum (annual or lifetime) with the medical vendor?

9. PBM Member Service

1. Confirm that State of Delaware will have designated member service representatives during their open enrollment periods. If not, what provisions will be in place to ensure a smooth transition? Describe the other support you will provide, including, access to an open enrollment web site and/or a link on State of Delaware's web site.

2. Provide the following information for the primary member service center office being proposed for State of Delaware. This information should be provided as an average and be related to normal business hours for the most recently available 12-month period. Include any available SLAs/performance guarantees offered for the applicable metrics.

	Member Service Center
a. Location	
b. Hours of operation (including timezone)	
c. Answering time to a live person (# of seconds)	
d. Length of call (# of minutes)	
e. Abandonment rate	
f. # Calls received per day	
g. % First-time calls successfully resolved	
h. % Calls referred for management resolution	
i. What % of your call center associates are certified pharmacy technicians?	
j. What is your call center turnover rate excluding employees during their first 90 days working for your organization?	
k. What percentage of the call center conversations are recorded?	

3. Describe the number of individuals and composition (role and years of experience) of the member service team members, including supervisors. What are the team's hours of availability? What are the backup resources?

4. Describe the percent of member service staff with healthcare credentials/certification, defining the frequency by type of credentials/certification.

5. Describe hiring criteria for member service staff and the internal training process once hired.

6. Describe ongoing training provided or required for member service staff. Describe how PBM account team ensures that member service staff are notified of unique plan requirements.

7. What type of specialized client specific training would take place for member service representatives when a plan design change is implemented?

8. Confirm that PBM may allow for State of Delaware to provide culture training, if needed/desired.
9. What online and mobile device capabilities are available to PBM members? Provide the URL, app name, and temporary login ID. Are these services available and functional to members via a mobile-enabled website and/or a smartphone application? For Smartphone Application, please specify if this functionality is native to the application or mobile web interface.

	Website	Mobile App	Fee	Comments
a. URL/Mobile App Name and temporary login ID				
b. Interactive health management tools				
c. Health information				
d. Submit inquiries to customer services				
e. Mail Service order status check				
f. Medication profile				
g. Pricing: Retail				
h. Pricing: Mail				
i. Pricing: Specialty				
j. Alternative drugs within a therapeutic class				
k. Pharmacy locator				
l. EOB				
m. Specialty Drug services				
n. Summary Cost Statement (e.g., FSA)				
o. Drug pricing information at different retailers within the Rx network				
p. Drug pricing information at the same retailers within the Rx network (e.g., different locations of the same chain)				
q. Pricing information for the cost of injectable products				
r. Two way text messaging capabilities				
s. Email messaging capabilities				
t. Print temporary ID card online				
u. Single Sign-on (SSO)				
v. Refill medications				
w. Video conferencing (e.g., injection training, teleconference, etc.)				

x. Scanning capabilities				

10. Confirm all customer service calls will be recorded, including those for vendors you leverage for programs (I.e. specialty copay card programs) and both telephone recordings and call logs will be kept accessible to clients. Recordings and call logs will be furnished upon request within ten (10) days. Confirm ability for clients to request call reviews with the Account team.

11. How long are recorded customer service calls maintained and accessible to clients?

12. Provide samples of PBM reporting available on member engagement including any issue resolution/feedback, survey responses, or email, web or chat transcripts. Specify whether reporting is available at the client level for each type of member interaction including phone, website, email and chat.

13. Confirm that there are no additional fees associated with participation in onsite open enrollment / health fair employee meetings required by clients as part of the implementation process and on an ongoing basis. Also confirm that there is no minimum enrollment requirement for this service.

14. Please describe the following processes to ensure superior member customer service, including standard timelines:

Item/Name:	Average Turnaround Time	Comments
New Prior Authorization Approval		
Prior Authorization expiration notification		
Renewal of Prior Authorization		
Appeal of a denied claim, prior authorization, or approval of a medication for a tier change (e.g., waive brand penalty)		
Primary Appeal		
Secondary (Tertiary) Appeal		
Member requesting escalation for customer service or fill issue		
Member calling standard #, but has both routine questions and questions on specialty		

15. Please briefly describe your Business Continuity Plan and testing approach for member and provider phone calls, member website, and claims processing.

16. Confirm member support phone line and client-specific open enrollment website will be set up with member benefit information programmed ahead of State of Delaware's pre-open enrollment (if applicable) as well as their open enrollment in May for the Commercial plan and March for the EGWP plan. This includes the ability to price individual prescriptions, determine drug coverage, formulary status, alternatives and pharmacy locator.

17. Do your member/customer services representatives have on-line access to mail, retail, specialty, paper, clinical program communications and DUR information on a single system?

18. Describe your ability to accommodate ex-patriate (global benefits) members transitioning to the US Benefits.

19. Is any component of member services subcontracted to a vendor (i.e. customer service rep who is not a PBM employee)?

10. PBM Communication

1. Confirm that your organization would allow State of Delaware the opportunity to review and edit any communications before being released to members.

2. Confirm that you are willing to customize all communication materials and that State of Delaware will have final sign-off on the documents and messaging on the website at no additional cost to the State.

3. Confirm that no communications will be delivered to State of Delaware employees without prior notification to and approval by State of Delaware.

4. Confirm that customized communications and postage will be provided to State of Delaware at no additional cost.

5. Describe your ability to support electronic communications to and from State of Delaware's members. Will email addresses and phone numbers provided by State of Delaware via eligibility files be stored and referenced? Please briefly outline any plans or key initiatives for future enhancements.

6. Please confirm that your organization will use claims data from the incumbent to create targeted, consolidated member communications prior to go-live for any members that will be disrupted due to formulary or clinical edit (PA, Step, QL) change.

7. Do you send targeted member letters, digital or telephonic messages (e.g., email/text) that identify areas of savings opportunities? Include which programs targeted letters are sent for, as applicable.

	Comments
a. Targeted mailings/digital messages	
b. Frequency	
c. Savings threshold	
d. Additional fees	
e. Ability to opt out	
f. Telephonic messages	
g. Frequency	
h. Savings threshold	
i. Additional fees	
j. Ability to opt out	

8. Does your website or e-prescribing platform:

Provider Function	Your current capabilities
a. Have the capability to allow physicians to submit and complete prior authorization requests on-line	
b. Have the capability to allow physicians to submit initial prescription	
c. Have the capability to allow physicians to submit refill prescriptions	
d. Promote a formulary with preferred alternatives and expected copay to the physician's	
e. Promote both expected copay and total drug cost	
f. Promote lower cost alternatives	
g. Show lower cost generics for higher cost generics	
h. Show lower cost alternatives to members that may be available outside of the plan coverage.	
i. Promote alternatives less preferred by the plan, but at a lower cost to the member after incorporating manufacturer assistance/coupon value applicable	
j. Include the value of the rebate when showing physicians the total cost of the drug	
k. Show the physician an alternative that would be a higher cost to the member even though the net cost (value of the rebate) is lower for the plan	
l. Have the capability to allow physicians to notify of quantity limit restrictions	

m. Have the capability to allow physicians to alert for drug utilization review issues	
n. Other	

9. Describe your approach and any member, patient or prescriber outreach that occurs for each of the following entities when the manufacturer or the FDA issues a Class I Recall, Class II Recall, Class III Recall, Market Withdrawal, and Medical Device Safety Alert:

	Class I Recall	Class II Recall	Class III Recall	Market Withdrawal	Medical Device Safety Alert
Mail Pharmacy					
Specialty Pharmacy					
PBM Services					

10. Confirm that there will be no cost to the client or member for any outreach (telephonic, mail, email, text, etc.) that occurs as a result of a Recall Notice, Market Withdrawal or Medical Device Safety Alert.

11. As a condition of participation, does PBM require your participating retail network pharmacy(s) to issue Recall Notice, Market Withdrawal or Medical Device Safety Alerts to their patients? If yes, is notification required for Class I, Class II, Class III, Market Withdrawal and Medical Device Safety Alerts?

12. Regarding PBM's website or e-prescribing platform's capabilities, confirm whether these functionalities can be turned on or off by State of Delaware at any time for no additional charge.
13. 10.13 Indicate what is required by PBM in order to send pre-eligibility communications for formulary, prior authorization, specialty and preventive drug list comparisons prior to implementation start date.

14. Confirm your organization will send transition letters or other communications related to the formulary, preventive drug list, and utilization management disruption based on received vendor transition files.

15. Indicate earliest date PBM can send member communications for formulary and other transition areas.

16. Confirm you have the ability to display the amount the member's out of pocket cost has been reduced due to point of sale rebates and/or copay cards or

discounts on the member portal (website), mobile app, and receipt/invoice from home delivery, if the State of Delaware were to decide to implement this model.

17. Confirm your organization agrees to provide communications to members regarding UM or network changes. Confirm that the communications will go out at a minimum of 60 days in advance of the change.

11. PBM Plan Administration

1. Confirm your capability to administer the following benefit types. Describe the percentage of National Employers in your book of business that have implemented these types of approaches. Are there added costs for custom benefits? If so, please specify.
    a. Reference Based Pricing
    b. Value Based Design
    c. Custom Utilization Management Programs
    d. Custom Preventive Drug Lists (ACA)
    e. Custom Preventive Drug Lists (non-ACA for HDHP), if the State of Delaware were to implement this plan design
    f. Custom Maintenance Drug Lists for mandatory mail order programs
    g. Rebates adjudicated at the point of sale
    h. Member cost share based on engagement with an external vendor(s)

2. Confirm PBM is willing to provide a review and make recommendations on pharmacy plan design in Summary Plan Description (SPD) and Summary of Benefit Coverage (SBC) documents.

3. Please provide a copy of your standard preventive drug list(s) for HDHPs (not the ACA preventive drug list) in Excel format. Include the NDC, Drug Name, Therapeutic Category, and Condition Treated. Confirm the number of preventive drug lists that the PBM maintains.

4. Please confirm that you will accept full liability for all the medications that are placed on your standard preventive drug list should State of Delaware be audited or be questioned for violations against a qualified HDHP.

5. Please conduct a Preventive Drug List (ACA and non-ACA) Impact Analysis for all Preventive Drug Categories and populate the summary table in the following format. Please provide the summary and the detailed analysis at drug level in Excel format. Provide clear footnotes on how the analysis was calculated.

6. Confirm that your organization will provide State of Delaware with a disruption analysis of the maintenance drug list as compared to State of Delaware's current maintenance drug list.

7. Confirm that your organization will provide general communications regarding your maintenance drug list along with targeted communications to any members that will be disrupted due to changes in the maintenance drug list at no cost to State of Delaware.

8. Confirm the ability and flexibility to support State of Delaware with a strategy for contracting with a vendor that can compare member out-of-pocket costs through the plan versus discount card programs.

9. Explain how you address the use of manufacture couponing at each channel (mail, retail, and specialty), and how do you structure your offering to ensure clients are not negatively impacted by the use of couponing.

10. Confirm that you are proactively identifying members who may be eligible for manufacturer patient assistance programs (leveraging the Medicare Reform Act of 1993).

11. Confirm PBM also offers any needs-based patient assistance alongside traditional patient assistance programs. Provide BOB use of needs-based patient assistance programs.

12. Do you have a program that will vary copay/benefit designs based on manufacturer assistance programs? If so, please describe all options available to commercial clients including limitations (e.g., HDHP, non-HDHP), client considerations, and fees. . If a subcontractor(s) is involved, note in your response to this question and complete Appendix 6, *Subcontractor Information Form*, included herein for each subcontractor. The company OSD classification information is for self-identification only. Each vendor is required to submit the forms for all of their subcontractors.

13. If you do not have this program, please confirm that you will allow clients to contract with an external vendor that provides this support without impacting any financial guarantees.

14. Please verify that you have the ability to administer rebates adjudicated at the point of sale if the State were to consider this type of arrangement. Please describe your process, and outline any costs associated with administering the program.

15. Please verify that utilizing point of sale rebates is optional.

16. Confirm whether your POS rebate offer includes PBM "pre-funding" of rebates at the time of adjudication.

17. Confirm whether you have the ability to apply POS rebates only to specific drug classes/categories/benefit phases at State of Delaware's discretion.

18. Confirm that POS rebates will be applied to manual/paper claims.

19. Confirm frequency of updates to estimated POS rebates applied at the point of sale.

12. PBM Claims Processing

1. Indicate the number of claims processing platforms that your organization maintains, including the name of each platform, for both commercial and EGWP.

2. If you have more than one platform, indicate the platform on which State of Delaware would be placed. Why have you proposed this platform? For incumbent PBMs, is this the platform that State of Delaware is on with you today?

3. If you have more than one claims processing platform, do you plan to consolidate them to a single platform? If so when?

4. Are you planning any major upgrades to your claim processing platform(s) that will be used to process claims within the next 36 months?

5. How often do you back up claims system data?

6. Confirm whether all claims processing, clinical management and customer service systems are processing on the same platform for retail, mail and specialty claims. If not, is this a planned system upgrade? When?

7. Confirm members can submit out of network claims online.

8. Confirm the PBM can process out of network claims through the member's accumulators and clinical programs.

9. Do you offer a Compound network? Describe how this network is developed and maintained as well as expected value vs. allowance of compounds via your broad network options.

10. Do you offer any programs that would leverage 340B pricing? Please provide details. How many clients in your BOB are leveraging this program?

11. Confirm if your organization allows for members to receive medications imported from outside of the USA and describe how these claims are captured by your organization.

13. PBM Retail Network

1. We provided a claim transaction file with this RFP. Please see the included Retail Network Disruption Tab within the Financial Worksheets included with this RFP to be completed and uploaded with your response to the Financial Worksheets.

2. What percent of your network retail pharmacies do you perform on-site audits annually? (# audited network pharmacies / # of total network pharmacies) Do not include desk top audits or any other form of electronic audit in this calculation.

3. Do you have network pricing to provide a 90 day prescription fill at retail? If yes, please provide details of your offerings.

4. Confirm that your organization complies with the Consolidated Appropriations Act prohibition regarding gag clauses, which would prohibit a pharmacy from telling a patient if the cost of their prescription would cost less if they were to pay cash rather than use their prescription drug card. If you have any contracts with this language in place, please list out the retail chains.

5. What type of communications would take place for participating pharmacy providers when a significant client specific plan design change is implemented (e.g. mandatory 90 day program for maintenance medications)? Are these targeted to the pharmacies utilized by client members or are they limited to communication to the chain's corporate office?

6. How does your Fraud, Waste and Abuse (FWA) program identify pharmacies as “at risk” and what actions are taken? Outline specific medications/categories that are subject to higher scrutiny as part of your FWA program that would flag for network action.

14. PBM Mail Order Operations

1. Please complete the table below.

	Mail Service Facility #1	Mail Service Facility #2	Mail Service Facility #3	Mail Service Facility #4
a. Location				

b. Operating Hours (including time zone)				
c. Capacity (# of claims paid per day/maximum capacity of claims paid per day)				
d. Fill accuracy				
e. Turn Around Time				
f. Percent of mail service claims defined as clean claims as opposed to claims requiring intervention				
g. Disaster preparedness plan for mail order facilities				

2. If multiple mail order service providers, how do you select a provider(s) for State of Delaware. In addition, what is the rationale and describe the customer service experience

3. Is the mail order service affiliated with or owned by your company?

4. If the mail order service is not owned by your company, identify the name of the vendor and explain why this vendor was selected and how long the relationship has been in place.

5. Will your organization facilitate the transfer of a retail script to mail order on the member's behalf?

6. If there is a change to the prescription as written, is it your policy to make an outbound phone call to the member prior to the prescription being dispensed? If no, please explain including other modes of communication that may be used to contact the member.

7. Confirm that you take action (e.g. notify patient and/or physician) if a patient attempts to reorder a prescription with no refills remaining. If yes, please include the types of communication used.

8. Confirm a telephonic outreach will occur to the member when prescriptions are unable to be filled.

9. What is the amount of floor credit offered to a mail order patient? Is this amount adjustable per client?

10. What is your policy regarding prescription orders received without full payment once the floor credit has been exceeded?

11. Do you proactively notify the member by phone to advise them of a delay if a prescription is in-house for more than 5 days? If not, describe your practices.

12. Do you have the ability to partial bill a member for a 90 day mail order prescription? If so, are there any additional charges to the plan or member?

13. Please describe your dispensing and collection process for non-specialty claims that are not submitted with a member payment or current/valid credit card on file.

14. How are member accumulators (deductible and out of pocket) impacted when a non-specialty claim is mailed to a member but goes unpaid and is then charged back to the client or PBM?

15. Do you have a contingency/disaster preparedness plan for mail order facilities to ensure deliveries are not interrupted?

16. Does your organization have the ability to mail medications in multi-dose packaging, such that the member receives a packet containing all the medications they should take at morning, lunch or dinner?

17. Does your organization have a program that allows pharmacies to sync medication refill timing for a member? If so, please explain how the process works and confirm all pharmacies have the ability to administer this offering.

18. Do you contract with multiple mail providers? If so, do you have the ability to direct the claim to provider with the most aggressive contract price?

15. PBM Formulary Management

1. We provided a claim transaction file with this RFP. Please populate the ‘Formulary Detail' tab within the provided Financial Worksheets. We are asking that all bidders (including incumbents) include a detailed breakout by NDC and drug name while also providing whether the particular claim is a maintenance medication, the number of unique members utilizing the drug, number of claims, and the formulary tier. Do not exclude generics, multisource brands, multisource generics, diabetic supplies, vaccines, expected generic launches, new to market blocks, or any other claim from your tiering analysis. Also, do not assume that drugs losing patent protection before State of Delaware’s effective date will be converted to generic and therefore will process on a lower tier. Please provide the tier on which each claim would process today, using your most up-to-date formulary listing. Confirm you have completed the ‘Formulary Detail' tab within Financial Worksheets based on the provided Claims Data and included with your response.

2. How will you handle communication to prescribers, pharmacists, and members of your formulary list/updates or any formulary disruption changes? Confirm that you will not assess charges for these communications. Please also indicate whether or not communication methods are different for prescribers, pharmacists, or members.
    a. Communicate formulary changes
    b. Timing
    c. Confirmation of no added cost

3. Describe the frequency for reviewing drugs for addition/deletion to the proposed formulary.
    a. Frequency of positive formulary updates
    b. Frequency of negative formulary updates
    c. Process for determining drug coverage on formulary

4. Confirm that the above noted frequency and process pertain to PBM's web-based formulary as well.

5. How quickly are new drugs added to the formulary?

6. Do you have a new to market block to ensure P&T review before formulary addition? Is the New to Market block available for all formulary types? If not available for all, list which do or do not have New to Market blocks available.

7. Formulary design for substance use and opioid use disorder treatment: is medication-assisted treatment (MAT) a covered benefit for members (including but not limited to buprenorphine, methadone, naltrexone) at rates equal to coverage for medications used to treat other forms of chronic illness?

8. Describe the formulary options that are available to State of Delaware (e.g., formularies with drug exclusions, those that maximize generics and exclusive specialty formularies). What are the savings ranges associated with each option compared with your standard? Please provide in table format. If an EGWP population exists for State of Delaware please provide chart for EGWP population separately.

9. List any drug classes that are grandfathered so that the formulary changes do not impact existing utilizers.

10. Describe how your organization uses health technology assessments (i.e. ICER) to negotiate discounts for medication pricing aligned with published value assessments.

11. Describe how your organization uses information developed by ICER to determine formulary placement.

12. Describe how your organization will actually promote biosimilar utilization outside of formulary coverage.

13. Describe how your organization helps educate members on OTC options for drugs (ie. OPill, Narcan, etc) even if a client does NOT cover OTCs on-benefit.

14. Describe the role of clinical guidelines in the development and maintenance for formularies and utilization management criteria.

15. Can you support custom changes to the formulary at the request of the client including the formation and support of a fully custom formulary.

16. PBM Clinical Management

1. Based on the current State of Delaware plan design and clinical programs, provide your organization's top 3 recommendations for program changes over the next three years to improve the management and desired outcomes of State of Delaware plans going forward. Please also consider the State of Delaware population, focus on member experience and communications, and unique role within the industry in your response.

2. Are your utilization management programs offered to State of Delaware as individual edits or as a bundle or package? Or are both options available to State of Delaware? Describe the pros/cons of the available options.

3. Describe how you integrate medical data with pharmacy data to provide clinical services to State of Delaware. Please outline any cost and ROI for this program. Please note this question is referring to data integration for clinical programs and not related to integrated accumulation tracking.

4. Confirm that no pre-certification or prior authorization apply for medication-assisted treatment (MAT)?

5. Confirm how your organization is compliant with MHPAEA requirements.

6. Provide sample reporting that supports what you are currently doing for clients including examples of POS edits (PA/step/QL), clinical programs focused on

improving adherence, FWA programming, any program that utilizes and integrates medical data.

7. Do you have a process in place to assist client access to the external review services of independent review organizations to perform external appeals? Please describe the approach you recommend with clients and any associated fees.

8. Pertaining to external review services of independent review organizations that perform external appeals, please name the organizations with whom you are contracted and indicate whether they are accredited or not.

9. Explain how your organization microsegments the population to identify members that are non-adherent. Discuss how you optimize the data to improve medication adherence for targeted patients including how you interface with the patient and provider. How are these efforts integrated or reported through your clinical programs?

10. Which disease states/conditions are you able to offer clinical performance guarantees (medication possession ratio, gaps in care closures, etc.) for State of Delaware without enrolling in a disease state management program offered by your organization? Please describe how you would achieve an improvement in population health for these disease states/conditions, and which metrics you would include in the guarantees (i.e. improved adherence, product selection, A1C improvement, etc.) and the methodology to measure the guarantees.

Disease/Condition	Guarantee offered	Metrics included in the guarantees	Guarantee measurement methodology
a. Diabetes			
b. Hypertension			
c. Congestive Heart Failure			
d. Dyslipidemia			
e. Asthma/COPD			
f. Depression			
g. Auto-immune			
h. Oncology			
i. Hemophilia			
j. Gastrointestinal			
k. Psoriasis			

11. Please describe medication possession ratio (MPR) and/or proportion of days covered (PDC) and how it's integrated or reported through your clinical programs.

12. Explain how your organization helps to improve MPR and/or PDC for patients. Many pharmacies, including some mail facilities, perform auto filling of prescriptions. This could lead to stockpiling and a falsely elevated MPR. What steps would your organization undertake to make sure these types of services don't falsely elevate ratios by claims not being reversed when not picked up or other reasons?

13. Please describe your refill-too-soon logic for retail and mail claims. Is State of Delaware able to adjust thresholds? What are your book of business thresholds for on-hand and look-back criteria?

14. Describe any clinical programs you offer that feature a de-prescribing component, whereby members are encouraged to discontinue therapy when it is no longer clinically necessary.

15. Please provide your clinical cost savings methodology? For example, if patient switches from Drug A to Drug B, how is the savings calculated? How do you prevent double counting, if savings are seen across multiple programs?
16. Describe your organization's holistic management approach to managing diabetes. Include details around weight management and de-prescribing of medication(s). Add details about any solutions your organization provides in-house as well as any solutions for which your organization partners with a third party vendor.

17. Describe your organization's holistic management approach to weight management. Include details around prescribing or de-prescribing of medication(s). Add details about any solutions your organization provides in-house as well as any solutions for which your organization partners with a third party vendor.

18. How does your organization address increasing costs for certain generic medications beyond the MAC list? Describe any price inflation programs you may have in place and provide details on drugs currently included.

19. Provide the percentage of manufacturer administration fees your organization received in the prior year for administering qualifying clinical programs.

20. Describe your Fraud, Waste and Abuse program(s), solutions to manage concerning behavior and any associated costs.

21. Describe any opioid management programs, enhancements, or strategies that would be available to State of Delaware. Include in your description relevant timing for implementation/sign off, member impact and communication strategy, ability to discontinue or opt out of future enhancements, proven outcomes and how they are measured/guaranteed, and auditability. For programs consisting of a multipart strategy, please specify if program components can be individually implemented, should State of Delaware not wish to implement entire program.

22. Please describe any programs you currently offer to address behavioral health programs other than opioid management. Include drug classes associated with each program, member outreach programs, and provide any published outcomes associated with each program.

23. How does PBM identify new market trends for potential misuse of medications which require Utilization Management? How quickly are programs put in place to manage these trends?

24. Your organization will guarantee a minimum of a 3 to 1 ROI on utilization management fees. This ROI guarantee should not include savings associated with ANY CDUR edits (clinical or administrative).

25. Describe the benefits to carve-in vs. carve-out PBM services, and the expected requirements for clients who change from one arrangement to the other with your organization.

26. Describe your organization's ability to manage specialty conditions - i.e. cancer, auto-immune, etc. - respective of drug utilization across benefit channel (medical vs. pharmacy).

27. Does your organization offer a high touch wrap around clinical program? Describe the program as well as any savings methodology and ROI, if offered.

28. How does you organization use pharmacogenomic testing to make sure that members are receiving the most appropriate medication for their genetic profile?

29. Does pharmacogenomic test coverage vary based on disease state and/or test panel? If so, please provide additional information about what panels are covered and, if applicable, for what diagnoses.

30. Please describe any care coordination activities your organization provides under medical and/or pharmacy programs as it pertains to medication genetic/genomic testing.

31. How does your organization intake any external pharmacogenomic test results as part of your standard DUR program?

32. How does your organization incorporate digital health point solution vendors (i.e. apps, wearables) into your existing suite of clinical programs?

33. How does your organization ensure that clinically-related activities from your staff or third-party partners is accessible via EMR's or at the point of sale in pharmacies?

34. Does you organization have capabilities to automatically approve prior authorization requests based on pharmacy, medical, or lab data already captured in your system?

17. PBM Specialty Pharmacy Management

1. Is the specialty service owned by your company?

2. If the specialty service is not owned by your company, identify the name of the vendor and explain why this vendor was selected and how long the relationship has been in place.

3. Specialty Pharmacy Staffing
   a. What types of clinicians are staffed within your specialty pharmacy program (include specialist backgrounds)?
   b. How many specialty clinicians are on staff?
   c. How many non-clinicians are on staff?
   d. Please differentiate the responsibilities of clinicians versus non-clinicians from both an administrative as well as a member-facing perspective.

4. Please provide your specialty pharmacy statistics for the last calendar year and the specialty pharmacy location proposed for State of Delaware.

	Specialty Pharmacy
a. Location	
b. Operating Hours (including timezone)	
c. Capacity (# of claims paid per day/maximum capacity of claims paid per day)	
d. Fill accuracy	
e. Turn Around Time	
f. Percent of claims defined as clean claims as opposed to claims requiring intervention	*Percent.*
g. Number of calls received	

h. Number of outbound calls made	
i. Number of calls with a nurse or pharmacist	
j. Average length of calls with a nurse or pharmacist	

5. Please describe your dispensing and collection process for specialty claims that are not submitted with a member payment or current/valid credit card on file.

6. How are member accumulators (deductible and out of pocket) impacted when a specialty claim is mailed to a member but goes unpaid and is then charged back to the client or PBM?

7. Please provide a list of which Specialty products are eligible for clinical management, such as step therapy, quantity limits, prior authorization, or other management programs available.

8. Provide your organization's approach to managing specialty medication use across the pharmacy and medical benefits to deliver a coordinated and consistent approach, and provide two examples of employers for which you are managing drugs that are adjudicated through both the medical and pharmacy benefits in this regard today (e.g., optimizing site of care, managing Prior Authorization).

9. Do utilization management edits apply to drugs filled through buy and bill?

10. Are you able to integrate medical claim data, pharmacy data and lab values to create a comprehensive data set for your clients? If so, please explain how the data is reported.

11. Please describe any program you have directing site of care management, fees for the program, ROI, and member experience.

12. Would PBM support a customized medical carve-out list (as opposed to your standard or suggested list for drugs directed from the medical benefit to the PBM for fulfillment)? Is there any fee associated with this?

13. With the growing specialty pipeline, specifically around Rare Conditions, how is your organization managing and/or coordinating overall coverage of this category/medications with the other vendors of State of Delaware?

14. Describe your organization's approach to managing the newest pipeline specialty agents, including gene therapies and biosimilars.

15. Describe your network and cost management approach for gene therapies. How do you treat current gene therapy and what is your strategy for future gene therapy? Include current and prospective innovations in contracting, client payment schedule, and/or value add services associated with potential therapy.

    Confirm what management strategies are available for cell and gene therapies when they are covered through the pharmacy benefit.

16. How can a member receiving a one-time, potentially curative gene therapy be tracked over time to ensure the product is resulting in certain clinical outcomes; including if the member changes insurance or employer.

17. Please describe your infusion services capabilities including home care capabilities and availability of infusion suites. In addition, please describe your process to promote cost effective infusion sites of care and ability to integrate/partner with vendors to accomplish this goal.

18. Does your organization provide or contract with Centers of Excellence for the management of patients with targeted specialty disease states (e.g. Hemophilia, Rheumatoid Arthritis)? If applicable, please provide details of additional targeted disease states.

19. Describe how your organization is developing and implementing tighter utilization management edits to limit use of specialty drugs to a targeted, defined population that will yield the most health care value. In addition, please comment on the utilization of smart edits for long term specialty patients.

20. Do new specialty drugs go through your new to market block process? Also, comment on the develop of utilization management for new specialty medications once they are removed from new to market block.

21. Provide your organization's approach to requiring supporting documentation for approval of specialty prior authorizations. If only physical attestation is required instead of chart documentation, what is your organization's approach to auditing prescribers to ensure diagnosis and trial/failure requirements were truly met?

22. What is your organization's approach to managing days of supply for specialty drugs (e.g., do you allow, require or encourage 90 day fills of specialty medications in lieu of lower supply options)? How does this impact rebates?

23. Does your organization have the ability to guarantee trend or an inflation caps on specialty drugs? If so describe your approach to capping inflation for these products, and what happens should inflation exceed the cap.

24. Are partial fill programs available for new starts? Do they target certain drugs? If yes, please provide the drugs that are targeted.

25. Describe and provide examples of any aggressive dose optimization initiatives and waste management programs (such as weight-based dosing or vial management) currently available to manage the utilization of specialty drugs that differentiates your organization from the marketplace. In addition, please address any new initiatives in development to address this issue.

26. Please confirm your willingness to support carving-out all specialty drugs to another benefit and/or vendor, if this method is determined to be cost effective to State of Delaware and its participants.

27. Describe your willingness to help State of Delaware drive Hemophilia patients to facilities that have 340b pricing.

28. Describe your willingness to allow the fulfillment of specific specialty drug classes to be carved out to another vendor (i.e. fertility drugs for a fertility management vendor, hemophilia etc.) without negatively impacting State of Delaware's specialty drug pricing.

29. With the growing number of Oncology drugs, how do you assist guiding prescribers to the most cost and clinically effective treatment outside of confirming diagnoses, including pharmacogenomic testing results. What additional support services are available? How are members educated about home care options for infusion?

30. Describe any innovative contracting approaches (e.g. specialty rebates, outcomes, clinical management, etc.) your organization has with providers, pharmaceutical manufacturers or other parties for specific drugs or therapy classes.

31. With the further release of biosimilars and verified generic specialty products, how does your organization address these products and ensure that they are priced competitively currently, and how does your organization anticipate this practice changing as the biosimilar landscape expands and evolves?

32. Please describe if your organization prefers low or high WAC biosimilars and how this approach benefits State of Delaware.

33. Describe how you plan to promote the utilization of biosimilar agents to lower costs for plans and members and confirm if all biosimilars will be subject to the same strategies to increase utilization. Provide examples of drug classes and/or

originator products and corresponding biosimilars and solutions available to ensure cost effective utilization.

34. If a specialty drug is shipped and then lost (e.g., not received by the member, kept in the heat during delivery, etc.), and a replacement is sent to the member, how is the old claim handled? Would this entail a reversal? What is the financial impact to the member and plan?

35. Please provide overall book of business PA approval rates and turnaround times. Please also provide PA approval rates for the following categories: oncology, autoimmune conditions (provide data for specific conditions, such as RA, psoriasis, Crohn's disease, etc., separately if available), gene therapies, hemophilia, pulmonary conditions (including CF and pulmonary arterial hypertension), IVIG products and other rare conditions.

36. Describe any pay for performance or other incentives for providers to prescribe lowest net cost specialty agents.

37. Please describe any partnerships with specialty-specific vendors/point solutions that have not already been discussed.

38. In addition to those previously provided, please list the conditions for which treatment pathways are utilized. Include requirements or incentives are in place for prescribers to follow these pathways and describe any outcomes.

18. PBM Data, Reporting and Analysis

1. What peer group would you recommend for State of Delaware? Please indicate how many clients and estimated members would be included in the peer benchmark for quarterly reports.

2. Please provide a listing of all peer groups that clients can select from.

3. Please provide State of Delaware with sample utilization, cost and performance summary reporting utilizing State of Delaware-specific claims data provided as part of this RFP.

4. Beyond traditional utilization reports, confirm your ability to provide reports that include the following data elements: Total number of approved or denied claims inclusive of reject codes and reject code descriptions
   a. Total number of prior authorization requests by origin (e.g. rejected claim vs. prior authorization request without rejected claim) with approvals vs. denied vs. walkaway/abandonment
   b. Total number of denied requests on appeal, broken out by first appeal and second appeal

c. Member Service Metrics and Performance Guarantees
d. ACA and non-ACA preventive reporting for the specific list that State of Delaware is using
e. Compliance Metrics such as Medication Possession Ratio (MPR) or Proportion of Days Covered (PDC)
f. Point of Sale Rebates, including total amount of Point-of-Sale Rebates in aggregate, by channel, by drug tier, by therapeutic class, and split between member/plan share.
g. Point of Sale Rebate reporting showing the rebates applied at the point of sale compared to the actual rebates invoiced to the manufacturers (% of invoiced rebates applied at PoS)
h. Cost and Performance Summary with rebates factored in
i. Cost and Performance Summary without rebates factored in
j. Rebate reporting including break-outs of actual rebates by type (specialty vs. non-specialty, formulary rebates, manufacturer administrative fees, payments due to inflationary caps or other unique contracting arrangements, etc.) and by plan/group
k. Rebate reporting by drug class and individual drug
l. Rebate reporting showing actual rebates invoiced vs. collected vs. minimum guaranteed
m. Reporting showing actual Manufacturer Administrative Fees collected vs. paid to State of Delaware
n. Specialty pharmacy reporting including site of care
o. Report on non-rebate pharmaceutical manufacturer funds kept/retained/billed for administering clinical programs

5. Confirm that rebate reporting by individual drug and drug class can be shared on all drugs and drug classes.

6. Confirm that bidder has the ability to provide NDC-11 level rebate reporting.

7. What type of reports are included in your standard reporting package and indicate what data/reports will be shared directly with the client or their representative?

   What is the frequency and timing of the standard reporting package and confirm these reports be provided proactively by your organization?

8. Confirm peer groups for reports can be customized to provide a CDHP only cut, including plan design elements such as CDHP preventive drug list used, and percentage of groups that are full replacement CDHP.

9. Confirm peer groups for reports can be customized, for example, to provide pre-65/active or post-65/retiree only cuts, union or non-union only, etc.

10. Confirm that PBM will provide first fill reporting on a monthly basis at no additional cost. The confirmed report will include disease states, medication, quantity, pricing, and number of utilizers as deemed important to alert Case Managers, and other clinical staff of the need for participant outreach.

11. Describe your organization's ability to report utilization by diagnosis for drugs with multiple indications (e.g. Humira - rheumatoid arthritis, psoriasis, etc.). Additionally, if this is available but requires certain prerequisites, please define these prerequisites.

12. Confirm there are no additional fees for ad-hoc reports requested by State of Delaware.

13. Describe your standard process and turnaround time for ad hoc reporting requests

14. Confirm your organization will provide your methodology when providing any ad hoc reporting or modeling requests.

15. Confirm your organization will provide access to data technicians to facilitate ad hoc reports and data requests at no additional charge, if awarded the business.

16. Confirm your ability to provide reporting on high cost claimants with custom thresholds and data points.

17. Describe how your organization uses medical and lab data, if provided for the client.

18. Provide book of business overall approval/denial rates for medical necessity exceptions.

19. Confirm that approval / denial rates for medical necessity exceptions can be provided for specific medication and therapeutic categories.

20. Confirm that State of Delaware will be provided with at least 15 licenses to access your organization's online reporting tool.

21. Describe your organization's first fill reporting to other vendors to use in targeting for disease or condition management. At what frequency and which disease states does your standard reporting support. Please include any associated fees to support this reporting.

22. Confirm you will provide accurate and timely Medicare Part D reporting support for any retiree population for whom State of Delaware receives a subsidy. Please outline the timing for all EGWP and/or RDS subsidy reporting.

23. Is Medicare Part D reporting included in the base admin fee? If not, outline any additional charges.

24. Your organization agrees to provide access to a secure online data management tool for State of Delaware's staff and/or their third party representatives that is user friendly and links to the claims adjudication system and contains prescription drug information, medical and pharmacy paid claims, including but not limited to plan administration components such as eligibility, PAs, pharmacy locator, pharmacy and direct claims history, and drug coverage, subject to Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards and other legal limitations. Your organization agrees to provide training and ongoing, unlimited support services to State of Delaware's staff and their third party representatives. It is expected that the download of detailed reports must be quick and not time out.

25. For the secure online data management tool described above, please outline if there are additional "buy-up" or enhanced options available for referral management (e.g. to/from condition management vendor), the ability to view to alert case managers to gaps in care identified by or intervened on by the PBM, and enhanced care coordination. Provide screen shots or demo logon to view functionality. If additional fees apply, please describe.

26. Your organization agrees to guarantee that Case Managers, and other clinical staff from Client's vendor partners interacting with members, will have direct access to real-time or near real-time patient-level pharmacy information to support clinical intervention efforts. The online, real-time information access must include at a minimum, prescription drug history, eligibility information, financial opportunities for lower cost options and/or lower cost site of care, alerts on medication adherence and gaps in care issues, and PA information including any provider submitted information.

27. Your organization agrees to send data to the client's [proprietary] data warehouse.

19. PBM Integration with Other Vendors

1. Do you share client data with data warehouse(s)? If so, how many clients and which data warehouses?

2. Do you share data with third party data warehouse vendor(s)? If so, please provide any applicable fees in order to provide data to these vendor(s).

3. Are there any limitations placed on client data shared with data warehouse(s) or other entities? If so, please describe.

4. Please describe how you would work with State of Delaware's current vendors in the following areas. State proposed fees at risk for optimal coordination and accuracy.
   - Data transfer
   - Condition management
   - Health Risk Appraisal
   - Wellness Programs
   - Compliance Monitoring
   - Gaps in care programs
   - Data warehouse
   - HDHP administration
   - Data to/from medical carriers for broader integration
   - Internal benefit plan audits
   - RDS files to CMS and administrator
   - Drug Cost Management (e.g., Rx Savings Solutions)
   - Expert Medical Opinion
   - Navigation Services
   - Other ad hoc requests as needed

5. Describe how your organization would coordinate with State of Delaware's medical, wellness, behavioral health and other vendors. Please include specific processes and frequency outlining how first fill, lab, specialty, claims data and other information is shared and used to improve patient care, coordination and outcomes.

6. Describe your current or future strategy to partner with other health care providers including pharmacies and clinics (i.e. onsite/nearsite) inclusive of clinical information and drug fulfillment.

21. Legislation and Transparency Requirements

1. Confirm your organization will not charge State of Delaware for any program related to compliance with legislative updates, including but not limited to: preventive care services or shared accumulators (deductibles and/or out of pocket maximums), as well as providing data to government entities on State of Delaware's behalf (such as RxDC reporting).

2. Describe how your organization will provide guidance to State of Delaware on changes needed to plan design and/or program design due to legislative updates. Please provide a response for both federal laws as well as state laws.

3. How will your organization accept responsibility if the guidance provided to State of Delaware around changes needed for compliance with legislative updates is not accurate?

4. Please describe your position on medications noted in the Patient Protection and Affordable Care Act (PPACA) relative to coverage of preventive care services. Please explain which drugs are included at no cost-share (e.g., OTC, Rx, brands, generics, single entity, combination products, etc.) and outline any restrictions that apply (such as age, gender, written prescription, quantity limitations). Please note if your proposed restrictions vary from the CDC's Advisory Committee on Immunization Practices (ACIP), HRSA-supported Women's Preventive Services Guidelines and the USPSTF recommendations and why.

5. Confirm how your organization demonstrates compliance with regulations that impact the PBM industry including: administration of ACA and IRS preventative drug lists where required, MHPAEA requirements, anti-steerage legislation and state laws as they exist impacting an employer conducting business in that state.

6. Confirm how PBM monitors, prepares for and communicates with clients about pending and confirmed federal and state regulations impacting the pharmacy benefit for the plan and/or for members?

7. Describe your organization's ability to customize State of Delaware's ACA Preventive Drug List; including your ability to maintain updates subsequent to State of Delaware's customization requests, as needed.

8. Confirm if your organization currently has an internet based, self-service tool that is compliant with the regulations in the Transparency in Coverage (TiC) and Consolidated Appropriations Act, 2021 (CAA) effective 1/1/2024.

9. Confirm the tool will incorporate any impact of rebates, as required.

10. Provide your organization's procedures for assisting clients with the prescription drug data collection (RxDC) requirements for applicable annual requirements, including specifically which reports/data you will provide on State of Delaware's behalf. Please confirm what data points you would need from State of Delaware in order to complete your obligations to provide data. Please confirm that medical and pharmacy data points will be included for relevant reporting requirements.

11. Provide details regarding HIPAA compliance including current programs, employee training, internal organizational charts, handling of violations, etc. Applicable HIPAA process-related documentation should be attached as part of your RFP response.

12. Please confirm that you have reviewed and can support the State of Delaware's current Commercial appeals process at the below link which includes Level I through IV appeals.

22. Retiree Solutions - Pharmacy Benefits

1. Provide the following information for the primary member service center office being proposed for State of Delaware Retirees. This information should be provided as an average and be related to normal business hours for the most recently available 12-month period.]
   a. Location
   b. Hours of Operation (including timezone)
   c. Answering time to a live person (# of seconds)
   d. Length of call (# of minutes)
   e. Abandonment rate
   f. # Calls received per day
   g. % First-time calls successfully resolved
   h. . % Calls referred for management resolution
   i. What % of your call center associates are certified pharmacy technicians?
   j. What is your call center turnover rate excluding employees during their first 90 days working for your organization?
   k. What percentage of the call center conversations are recorded?

	Member Service Center
a. Location	
b. Hours of operation (including timezone)	
c. Answering time to a live person (# of seconds)	
d. Length of call (# of minutes)	
e. Abandonment rate	
f. # Calls received per day	
g. % First-time calls successfully resolved	
h. % Calls referred for management resolution	
i. What % of your call center associates are certified pharmacy technicians?	
j. What is your call center turnover rate excluding employees during their first 90 days working for your organization?	
k. What percentage of the call center conversations are recorded?	

1. Please provide the following information for the Implementation Manager, Account Manager (the day to day contact), Account Executive, Clinical pharmacist, and Financial Analyst that will be servicing State of Delaware's Retiree Population:
   a. Name
   b. Title
   c. Location
   d. Phone Number
   e. Description of qualifications and experience
   f. Backup Contract
   g. Years of Service at the company
   h. Number of other clients responsible for including State of Delaware

	Implementation Manager	Account Manager (the day to day contact)	Account Executive	Clinical pharmacist	Financial Analyst	Customer Service Manager	Executive Sponsor
Name							
Title							
Location							
Phone Number							
Description of qualifications and experience							
Backup contact							
Years of service at the company							
Number of other clients responsible for, including State of Delaware							

2. What online and mobile device capabilities are available to PBM retirees? Provide the URL, app name, and temporary login ID. Are these services available and functional to members via a mobile-enabled website and/or a smartphone application? For Smartphone Application, please specify if this functionality is native to the application or mobile web interface.

	Website	Mobile App	Comments
a. URL/Mobile App Name and temporary login ID			
b. Interactive health management tools			
c. Health information			
d. Submit inquiries to customer services			

e. Mail Service order status check			
f. Medication profile			
g. Pricing: Retail			
h. Pricing: Mail			
i. Pricing: Specialty			
j. Alternative drugs within a therapeutic class			
k. Pharmacy locator			
l. EOB			
m. Specialty Drug services			
n. Summary Cost Statement (e.g., FSA)			
o. Drug pricing information at different retailers within the Rx network			
p. Drug pricing information at the same retailers within the Rx network (e.g., different locations of the same chain)			
q. Pricing information for the cost of injectable products			
r. Text messaging capabilities			
s. Email messaging capabilities			
t. Print temporary ID card online			
u. Single Sign-on (SSO)			

3. Do you offer assistance to clients with RDS financial reconciliation cost reporting to CMS on the client's behalf?

4. Confirm your ability to administer an Employer Group Waiver Plan (EGWP) PDP.

5. Please complete the table below listing the number of EGWP lives covered by your plan as of the listed dates.

	Jan 2022	Jan 2023	Jan 2024
# of Lives			

6. Provide a general description of your self-insured EGWP capabilities including market share (number of plans and members covered) and how EGWPs fit into your overall retiree health care benefit portfolio.

7. Indicate your organization's total Part D membership for non-EGWP plans.

8. Are both fully-insured and self-funded options available? Are there any member size restrictions?

9. Confirm that you have filed a plan design with CMS that mirrors the current plan design for State of Delaware.

10. Confirm that you are able to match the current State of Delaware EGWP plan provisions precisely; describe any required variations in plan design.

11. Explain how your P&T Committee meets CMS' PDP requirements for objectivity and validity.

12. What are the formulary options and how is utilization management included (or not) in each option?

13. Explain the differences between your standard formulary and the formulary used with the EGWP.

14. Can you support custom changes to the formulary at the request of the client including the formation and support of a fully custom formulary?

15. Describe your fraud, waste and abuse program and confirm that you will provide all CMS required filings related to certification of compliance to the waste fraud and abuse requirements.

16. Describe your member appeals process and confirm that it meets all CMS requirements.

17. Provide your book-of-business prescription drug event (PDE) error rate for 2021 and 2022.

18. Confirm that you can administer the EGWP on a self-insured basis, with pass-back to State of Delaware of all third party funding sources including CMS direct subsidies, pharma coverage gap discounts, CMS catastrophic reinsurance, DIR payments and CMS low income subsidies.

19. Describe your arrangements for EGWP implementation and account management, including the coordination between your EGWP teams and your commercial pharmacy benefit teams in the event you are awarded contracts for both the commercial pharmacy benefit plan and the EGWP. Provide an EGWP implementation plan and a summary of the key EGWP implementation and account management team members you would assign to State of Delaware.

20. Indicate whether you have implemented a self-insured EGWP that has moved from another PBM to your organization. What special steps are required to effect a smooth EGWP-to-EGWP conversion?

21. Describe your arrangement for EGWP claim and member services including structure, locations, staffing, hours and related support services. Are your EGWP service functions separate from your commercial account service functions?

22. Please describe any differences between Commercial and EGWP Account Management requirements.

23. Confirm the EGWP implementation manager will not manage more than 5 EGWP clients at a time.

24. State of Delaware would prefer a single service center to handle both Commercial & EGWP plans. Confirm your Customer Service Representatives will be dedicated and thoroughly cross-trained on all aspects of the various plan designs. Will the same dedicated customer service team handle both EGWP and Commercial member calls?

25. Your member services support (call center) will be the same for retirees in the EGWP PDP and active membership.

26. Confirm that all CMS required communications are included in the proposed base administrative fees.

27. Provide a communication timeline that aligns with CMS requirements.

28. EGWP member communications can be customized based upon State of Delaware's requirements at no cost the State.

29. Please confirm that PBM has transferred from a HICN-based identification method to the MBI identification method, and that the correct MBIs have been secured for members enrolled in State of Delaware's EGWP.

30. Your organization can manage low-income subsidies with an EGWP.

31. For your EGWP book of business, what is the average risk factor developed by the Federal Government that is applied to their direct payment? What is the range of risk factors for your book of business?

32. Provide a description of your process for coordinating Part B/D overlap drugs to ensure primary payment from Part B when appropriate.

33. Provide a description of your process on how your organization determines a Medicare Part D versus non-Medicare Part D medication.

34. Please confirm that all solutions mentioned in this section will be available on July 1 2026 for Commercial and January 1 2027 for EGWP.

35. Confirm that all claims, including any wrap, reversals, $0 ingredient cost claims, and supplemental coverage claims are included in all guarantee true-ups at year end.

36. Please confirm that all EGWP generics are included in the generic pricing guarantees, including generics in the EGWP wrap/supplemental coverage?

37. Confirm that PBM will provide examples of all standard and required CMS communications for EGWP members and indicate which materials can be customized by State of Delaware.

38. Describe options available to State of Delaware in regards to clinical programs available and required by CMS (for example, Prior Authorization programs, Medication Therapy Management programs, etc.).
39. List any clinical programs that are not available to EGWP clients.

23. Technical Standards and Security Requirements

1. Strong Password Requirement - A strong password requirement is applicable to your member facing secure website if members/participants can access any personally-identifiable information. This would typically be for their personal account with claim or claim-type data. It also applies for “super-users”, Statewide Benefits Office personnel, for activities such as accessing reports with personally-identifiable information. It is not a requirement for the vendor's internal data access system.
   Requirements of a strong password are available here Identity and Access Management Guidelines Please confirm that you comply or would by the effective date of the contract if awarded.
2. Additional Data Requests - Please confirm your agreement that if you are awarded the contract and then request additional data, whether or not on a file feed or in a report, the State shall determine the cost of supplying the data and may deny the request.

3. Threats - The SANS Institute and the FBI have released a document describing the Top 20 Internet Security Threats. For your review, the document is available at https://www.cisecurity.org/controls/cis-controls-list/. The contractor confirms that any systems or software provided by the contractor are free of the vulnerabilities listed in that document. (A response that security threats are always changing is not acceptable.)
4. Please state whether or not Delaware data will be transmitted via email or accessible on a mobile device. If so, the following requirements apply. Delaware Information Security Policy
5. Link to Enrollment Website
   During the Open Enrollment period, employees have the ability to access their benefit choices through a single portal to enroll in some benefits and be linked to other benefit websites. Please confirm that your organization has the capability to link your website from the State's single sign-on site, a PeopleSoft based program.
6. As an exhibit, please provide a diagram with ports that clearly documents the user's interaction with your organization's website and the State. The network diagram should follow the example in Attachment 2, Network Diagram Template.

24. Reference Documents

1. Reference documentation is located on the Manage Documents page. A link has been provided in the left-hand side menu.