

State Health Benefit Plan (SHBP) Pharmacy Benefit Manager (PBM) RFP

RFP # 41900-001-000000047

Amendment #2 - Questions and Answers

	Question	Response
1.	<p>Please document the loss of members from the PPO to the HMOs at each open enrollment since the introduction of the \$100 copay for non-preferred drugs. Would DCH permit price negotiations if more than 35,000 members were to exit the PPO at each open enrollment phase? (1.8 Background)</p>	<p>The DCH expects Offerors to take membership decreases or increases into consideration when submitting the Financial Proposal. The \$100 co-payment for non-preferred drugs was implemented July 1, 2005 (before the SHBP plan year was changed to a calendar year Jan.-Dec.). In the Background section 1.8 on page 6, there are two charts that show the membership numbers. At the end of the open enrollment for July 1, 2005 plan year, 46,436 PPO/PPO Consumer Choice and Indemnity members moved to other HMO plans. When the SHBP moved to a calendar plan year January 1, 2006, 6,028 PPO/PPO Consumer Choice and Indemnity members moved to other plans.</p>
2.	<p>Is there a consultant of record working with the state on this project? If yes, who and what are the consultants' responsibilities? Will the consultant be responsible for proposal evaluation? (Evaluation criteria)</p>	<p>Currently, the DCH is considering Mercer Consulting for the evaluation of the Financial Proposal.</p>
3.	<p>The RFP states that the Offerors may not limit the time period of paid claims to be audited. Does the SHBP Plan understand the loss of timelines, and record setup to support proof of correct payment in archived claims and will DCH make allowances for the time delays associated with retrieving claims from storage for claims older than 2 years? (2.2.3 Business Requirements)</p>	<p>The successful PBM contractor shall be required to preserve and make available all of its records pertaining to the performance under the PBM Agreement for a period of five (5) years from the date of final payment under the PBM Agreement (as stipulated in the PBM Agreement included in the RFP).</p> <p>The DCH does not anticipate requiring audits of claims older than 2 years. However in the event there is a need to conduct audits of claims older than 2 years, the DCH does expect that every effort will be made by from the successful PBM Contractor with full cooperation to provide the necessary resources to support proof that claims are paid accurately according to retail contracts and plan benefit coverage rules.</p>

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4.	<p>The RFP states that DCH reserves the right to specify additional measures or change performance guarantee measures within 60 calendar days of prior notification. Will DCH allow additional pricing to cover the underwriting of such potential financial risk to the vendor? (2.2.6 Business Requirements)</p>	<p>Yes, if the DCH specifies a change to performance guarantees/liquidated damages, the DCH understands such requests will have to be evaluated by the successful PBM contractor's underwriting department.</p>
5.	<p>The RFP states that the Offeror must work with any existing DCH third party vendor and if necessary modify system at no cost to DCH to be able to interface with this vendor. Has SHBP required any new vendor to actually make adjustments to their system and not charge that IS development to SHBP in the past 2 years? Has SHBP required an existing vendor to change their process to accommodate the new vendor's formats or processes in the last 18 months? (2.2.8 Business Requirements)</p>	<p>Yes, in the past 2 years, the DCH has required new vendors to make adjustments to their systems and not charge for IS development to accommodate the SHBP PPO/PPO Consumer Choice and Indemnity health plans.</p> <p>Yes, in the last 18 months, the DCH has required existing vendors to make adjustments to their systems and not charge for IS development to accommodate the SHBP PPO/PPO Consumer Choice and Indemnity health plans.</p>
6.	<p>The RFP states Offeror must support open enrollment activities at DCH's request. If DCH is requesting Offeror staff presence, presentation and educational support at all open enrollment and benefit fairs across the state, will SHBP be prepared to limit the number of fairs to no more than 16 per year? (Section 2.4.5 Technical Requirements)</p>	<p>The numbers of benefit fairs and benefit meetings and/or retirees' meetings have varied significantly over the years, based on various factors such as major benefit changes, no benefit changes, special requests from the legislation to meet the membership's needs, etc. The DCH cannot limit for the number benefit fairs/meetings.</p> <p>Listed below are number of fairs/meetings for the past and upcoming open enrollment periods:</p> <ul style="list-style-type: none"> • Spring open enrollment (Apr 18-May 17, 2005) – 26 • Fall open enrollment (Oct 17- Nov. 8, 2005) – 12 • Fall open enrollment (Oct 10-Nov. 9, 2006) – planning 15 - 20

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<p>7.</p>	<p>The RFP states that the Offeror must be able to integrate medical and drug databases in order to support SHBP's disease state management program. Is DCH requesting staff resources to be responsible to do this integration on a routine basis or is the DCH requesting the exchange of pharmacy claim information with the medical claims vendor?(2.4.11 Technical Requirements)</p>	<p>The DCH is requesting the exchange of pharmacy claims data with the DCH Decision Support System (DSS) Vendor. The DCH also expects the successful PBM Contractor to provide staff resources to work in collaboration with the Disease State Management Vendor to interpret and evaluate claims data and make recommendations to improve patients' outcomes.</p>		
<p>8.</p>	<p>The contract renewal date is stated as 7/01/07, but the benefit year is stated as calendar year 2007, 2008 etc. Please review the termination date vs. the benefit date. Which is the correct date of contract, July 1 or January 1? (Section 1.7 Contract Term)</p>	<p>Both dates are correct. The PBM Agreement is based on the DCH fiscal year which is July 1 through June 30. The benefit plan year is based on a calendar year which is January 1 through December 31. The first year of the PBM Agreement will terminate June 30, 2007, with a renewal date of July 1, 2007. The benefit plan year will begin January 1, 2007.</p>		
<p>9.</p>	<p>In the Financial Proposal page 5 under the 2nd rebate DCH requirement it states, "Offeror must offer a minimum per claim rebate guarantee for the DCH based on each plan's respective formulary." Please clarify what is meant by each plan's respective formulary. (Section 3.2.20)</p>	<p>This statement appears in the Financial Proposal in the chart under "Section A1". The DCH Financial Proposal Requirement should read as:</p> <table border="1" data-bbox="911 1016 1906 1086"> <tr> <td data-bbox="911 1016 1167 1086"> <p>Rebates</p> </td> <td data-bbox="1167 1016 1906 1086"> <p>Offeror must offer a <u>minimum</u> 'per claim' rebate guarantee for the DCH based on the plan's formulary.</p> </td> </tr> </table> <p>This will be corrected in the revised Financial Proposal. The SHBP PPO/PPO Consumer Choice and Indemnity plans have the same Preferred Drug List (formulary).</p>	<p>Rebates</p>	<p>Offeror must offer a <u>minimum</u> 'per claim' rebate guarantee for the DCH based on the plan's formulary.</p>
<p>Rebates</p>	<p>Offeror must offer a <u>minimum</u> 'per claim' rebate guarantee for the DCH based on the plan's formulary.</p>			
<p>10.</p>	<p>Will specialty claims be filled at a specialty pharmacy as opposed to a network pharmacy? (Appendix F, Financial Section, D.1)</p>	<p>The current prescription drug program for the SHBP PPO/PPO/Consumer Choice and Indemnity health plans does not include a specialty pharmacy benefit. At this time, the DCH does not plan to include for January 1, 2007. Specialty pharmaceuticals that are covered under the benefit are handled like any other covered drug, subject to coverage rules. Specialty claims are filled at network pharmacies or submitted by the member on paper claims and this will continue in January 1, 2007.</p>		

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11.	Is HEB willing to accept pricing by drug or is HEB looking for one price for brand specialty and one price for generic specialty? (Appendix F, financial section D.1)	It is assumed that the term "HEB" in this question is referring to the SHBP PPO/PPO Consumer Choice and Indemnity health plans. Yes, the DCH will accept pricing by drug in addition to one price for brand specialty and one price for generic specialty. A list of specialty pharmaceuticals for the SHBP PPO/PPO Consumer Choice and Indemnity health plans' prescription drug program will be sent to Offerors who provided Confidentiality Agreements.
12.	Under the heading "DCH's Statement of Ethics", the RFP refers to Section 3.7.1.1 and 3.7.1.2.of the RFP. We are unable to locate these sections in the RFP. Please advise. (Section 5.14)	Please disregard reference to Sections 3.7.1.1 and 3.7.1.2. These section references are not applicable to this RFP.
13.	Question is regarding the Contract section of the RFP, Page 37 of 95 (item 26) discusses Performance Bond or Letter Of Credit And Payment Bonds. Please confirm if this is to be the amount of costs required to administer the PBM plan and services that are part of that plan for each fiscal year only and not to cover the actual cost of the medications that are being dispensed (Plan costs or Total costs of all medications dispensed during the year in question).	The Performance Bond or Letter of Credit is for the amount equal to the value of the PBM Agreement for each fiscal year of the Agreement's term. The value of the PBM Agreement is the costs billed by the PBM required to administer the SHBP PPO/PPO Consumer Choice and Indemnity health plans' prescription drug program (excludes costs of medications dispensed).
14.	Since implementation of this program will be January 1, 2007, will there be a need to convert various accumulators for the members from the Plan for 2006? <i>RFP Section 3.2.3.4, page 26</i>	No, there will not be a need for converting accumulators. Question 3.2.2.4, contains parts such as Monthly, quarterly, annual drug benefit caps or Split or cusp claims (partial plan responsibility and partial patient responsibility once patient reaches cap), that were asked to assess the Offeror's capabilities.

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15.	<p>Please clarify the role of the successful contractor in the Disease State Management program. Since the program has contracted with United Healthcare as the DSM vendor, how does the DCH staff envision the contractor supporting this program? Does the contractor have only administrative processing system and benefits administration functions within the proposed pharmacy system or is there a greater role such as clinical education? What scope of work does the United Healthcare program cover at this time?</p> <p><i>RFP Section 2.4.11 (p. 16) and Section 3.2.11 (pp. 45-46)</i></p>	<p>The successful PBM contractor is expected to provide administrative processing, benefits administration and other contracted PBM services including clinical education and Utilization and Disease Management support to the current UM vendor through integrated and coordinated resources. In addition the successful PBM contractor is expected to develop and implement DSM programs targeted at specific diseases for therapy management that are as identified, discussed and agreed upon in clinical strategic planning meetings. United Healthcare currently provides DSM programs as outlined in the RFP. The successful PBM contractor is expected to provide support to these programs through educational mailings, monitoring, data sharing, and possess the capability of waiving member co-payments for specific drugs associated with the UM vendor's disease management programs.</p>
16.	<p>Does the State anticipate requiring the use of the NPI as of the date the system goes live on January 1, 2007?</p> <p><i>RFP Section 3.2.3.5, pp. 26 - 27</i></p>	<p>The DCH has not set an implementation date for the requirement of the National Provider Identifier (NPI). Health Care Providers, Health Plans (except small health plans), and Health Care Clearinghouses must comply with the NPI implementation specifications no later than May 23, 2007 and the DCH does expect the successful PBM Contractor to be compliant with HIPAA and CMS regulations. Other identifiers such as the DEA number will continue to be utilized.</p>
17.	<p>Does the State intend to require the use of the NPI as a standard identifier for prescribers or will the use of other identifiers, such as the DEA Number, be allowed?</p> <p><i>RFP Section 3.2.3.5, pp. 26 - 27</i></p>	<p>Please see the response to Question 16.</p>

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18.	<p>Does the vendor need to accept feeds for prescribers from each of the supported plans or will the Health Plan sponsor provide a single feed with their physician provider network?</p> <p><i>RFP Section 3.2.3.5, pp. 26 - 27</i></p>	<p>Please clarify the question. Is this question to assess whether or not, prescriptions are only covered when written by participating prescribers? If so, this is not the benefit design. The successful PBM Contractor does not have to accept prescriber feeds from the third party medical claims administrator because the drug benefit for the prescriptions for SHBP PPO/PPO Consumer Choice and Indemnity health plan members does not require that they are written by participating physicians.</p>
19.	<p>Please confirm that DCH anticipates that the contracted PBM will manage the entire rebate program? Section 2.4.10.d (page 16) makes reference to a "rebate vendor" while page 14 (point #23) of the contract states that a contractor responsibility is to negotiate, collect, and provide rebates.</p> <p>RFP Section 2.4.20.d Contract, page 14 #23</p>	<p>The DCH expects the successful PBM Contractor to manage and administer the entire rebate program including negotiating, collecting and providing rebates for the SHBP PPO/PPO Consumer Choice and Indemnity health plans' prescription drug program.</p>
20.	<p>Will the current lack of an office within the 50 mile radius of DCH's offices have a negative impact on our scoring?</p> <p>RFP Section 2.4.5</p>	<p>The current lack of an office within a 50 mile radius of the DCH's offices will not have a negative impact on scoring. It is a Mandatory Requirement that the successful PBM contractor opens an office within a 50 mile radius prior to the Go-Live effective date.</p>
21.	<p>Please expand on DCH's expectations for benchmark comparisons as outlined in RFP Section 2.4.13.d.</p> <p>RFP Section 2.4.13.d</p>	<p>As stated in Section 2.4.13.d – The DCH's expectations are that the successful PBM Contractor will produce reports which will allow the DCH to view how the SHBP PPO/PPO Consumer Choice and Indemnity health plans prescription drug program statistics compare to other drug programs' for clients similar in size/ and makeup and/or in the category of State Government employees/Public sector and/or to national statistics. The DCH's expectations also include looking at benchmark comparisons, viewing one time period in one year compared to the same period in another year (i.e. 2Q05 vs. 2Q06) should include claims detail data (Avg. Cost/Rx; Avg. Days Supply/Rx; Generic dispensing rate; PMPM plan cost; PMPM # of Rxs; utilization of a specific therapeutic category, etc. Benchmark comparisons should be established for any clinical programs that are implemented.</p>

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22.	Can DCH provide call volumes and talk time reports from the current vendor?	The call volume for six (6) months (Nov.05 – Apr.06) was 58,355 calls. Talk time statistics are not available.
23.	Can you please define the parameters and exact requirements for providing "electronic remittance of payment to providers" <i>Page 19; Section 2.4 Technical Requirement; Item 2.4.18 (c)</i>	This is the functionality requirement that claims payments to pharmacy providers be paid either by EFT (electronic funds transfer) or check. The system technical requirements are dictated by the banking institution and the PBM's IS department, but from a business financial operation the PBM's system needs to capture all providers banking information (routing number, ABA number, financial institution, etc.) and remit the payment electronically to the pharmacy providers' account on each payment cycle.
24.	Section 2.0 is titled as "Mandatory Requirements". This list is far more extensive than the requirements listed in Appendix A. Please confirm that only Appendix A must be addressed with affirmation within the proposal document. If a vendor has additional language or explanations to add to any of the additional items in Section 2 (that are not covered in Appendix A) where are those to be provided? <i>Page 8-19 of the RFP document; Appendix A</i>	Appendix A - Guide to Mandatory Requirements includes the requirements of Sections 2.1 Offeror Requirements and 2.2. Business Requirements of the RFP. These requirements are considered mandatory and must be affirmed by placing the word "yes" by each requirement in Appendix A and providing an authorized signature. Reference the page(s) of the Technical Questionnaire (3.0) where satisfaction of the Mandatory Requirements is substantiated. Other items in Section 2 include Submission Requirements (2.3) and a listing of the RFP Technical requirements (2.4). Please note that all responses to the technical requirements should be addressed under Section 3.0 Technical Questionnaire.
25.	Clarification on item 2.4.8, Is it the expectation of the State of Georgia that 100% of calls received by the customer service department be recorded? What is the requirement for storage and maintenance of recorded call in the customer service department? <i>Page 14; Section 2.4 Technical Requirements; Item 2.4.8 (d)</i>	Yes, the DCH expects 100% of calls received by the customer service department be recorded. The requirement for storage and maintenance of recorded calls is 12 months.

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26.	<p>Do the PA member notification letters need to be prepared in multiple languages? (English/Spanish/Vietnamese) or is having foreign language speaking staff available sufficient?</p> <p><i>Page 14; Section 2.4 Technical Requirements; Item 2.4.8 (e)</i></p>	<p>English is the required language for the PA member notification letters. It is sufficient to have foreign language speaking staff available to assist members in reference to the letters.</p>
27.	<p>In regards to agreement of 2.2.6 of the Business Requirements, are you in agreement that if changes are made to copay structure, formulary, etc. the PBM has the right to modify its' pricing?</p> <p><i>Page 9; Section 2.2 Business Requirements; Item 2.2.6</i></p>	<p>The DCH addresses issues concerning the PBM Agreement during the Agreement renewal period. However, the DCH is requesting rebate guarantees as stated in the Financial Proposal for the length of Agreement. Offerors should address this issue when submitting the rebate guarantees.</p>
28.	<p>Please confirm Medstat will continue to support DCH as the Data Warehouse Vendor for the new contract period?</p> <p><i>Page 10; Section 2.2 Business Requirements; Item 2.2.9</i></p>	<p>This procurement has been solicited and is currently under evaluation.</p>
29.	<p>How many 3rd party vendors would the PBM be required to interface with?</p> <p><i>Page 9-10; Section 2.2 Business Requirements; Item 2.2.8</i></p>	<p>The successful PBM Contractor will have to interface with two third party vendors, United Healthcare and the DCH DSS vendor (currently MedStat).</p>

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30.	<p>Can you provide us with a copy of the DCH eligibility data format/specs?</p> <p><i>Page 10; Section 2.2 Business Requirements; Item 2.2.9</i></p>	<p>The DCH eligibility data format and specs for the SHBP PPO/PPO Consumer Choice and Indemnity health plans was posted with the RFP as Attachment 1 – SHBP Eligibility format.</p>
31.	<p>To assist us in determine our ability to support the eligibility audit process, can you please describe in more detail the SHBP semi-annual eligibility auditing process?</p> <p><i>Page 11; Section 2.4 Technical Requirements; Item 2.4.1 (g)</i></p>	<p>This Question is no longer relevant and a response is not required. This Question will not be scored during the Technical Questionnaire evaluation process.</p>
32.	<p>To help evaluate the impact on administrative cost, what percentage of the claims are submitted by paper today?</p> <p><i>Financial Section; Section A:A1, Administrative, Clinical and Other Miscellaneous Fees & Section 2.4 Technical Requirements; Item 2.4.4 (a)</i></p>	<p>The percentage of paper claims is 1%.</p>
33.	<p>To help evaluate the impact on administrative costs, what percentage of claims are foreign claims today?</p> <p><i>Financial Section; Section A:A1, Administrative, Clinical and Other Miscellaneous Fees & Section 2.4 Technical Requirements; Item 2.4.4 (b)</i></p>	<p>Data not available. Foreign claims are not reported separately</p>

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<p>34.</p>	<p>Can you provide an estimate of the number of benefit fairs and enrollment meetings we will be requested to attend in person annually?</p> <p><i>Page 12; Section 2.4 Technical Section; Item 2.4.5 (g)</i></p>	<p>The staffing requirements for the successful PBM contractor to support the SHBP benefit fairs and enrollment meetings will vary based on various factors such as major benefit changes, no major benefit changes, special requests to meet the membership's needs, etc.</p> <p>Please see the response to Question 6.</p>
<p>35.</p>	<p>Please define provider. Are you referring to medical provider or pharmacy provider?</p> <p><i>Page 15; Section 2.4 Technical Section; Item 2.4.8 (h)</i></p>	<p>This requirement is referring to pharmacy providers.</p>
<p>36.</p>	<p>In adherence to 2.4.8 (n), is it acceptable for the PBM to provide physician communications to SHBP for coordination to the medical providers or will SHBP or their medical plan provide mail list? Approximately, how many medical providers would be considered for this mailing? How frequently are you requesting mailings to these providers?</p> <p><i>Page 15; Section 2.4 Technical Section; Item 2.4.8 (n)</i></p>	<p>The successful PBM contract is expected to provide physician communication. The number of medical providers that may receive mailings will vary and depend on the purpose and content of the mailings. The successful PBM contractor is expected to develop the content (approved by the DCH), the mailing list (approved by the DCH) and conduct the mailing based on the prescriber information captured in the PBM's database. The number of clinical mailings to physicians in First Calendar Quarter 2006 (clinical mailings include but not limited to poly pharmacy and controlled substances) were 14,257 letters.</p>
<p>37.</p>	<p>Can the DCH provide a list of drugs that are currently prior auth'd?</p> <p><i>Page 15; Section Technical Section; Item 2.4.8 (l)</i></p>	<p>The PA list will be sent to Offerors who provided Confidentiality Agreements.</p>

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38.	<p>If the State is seeking transparency and pass through pricing, why wouldn't the same standards apply with respect to pass through pricing for PBM's who own their mail order facility versus those PBMs who don't?</p> <p><i>Financial Proposal; Section A:A1; Mail Order Pricing</i></p>	<p>The DCH is seeking transparency and pass through pricing. The same standards do apply to all PBMs, those who own their own mail order facility and those who subcontract. The requirement will be revised in the Financial Proposal to reflect the following:</p> <p>Offeror must provide guaranteed mail order discounts and dispensing fees. Each SHBP mail order claim must be priced at the guaranteed rates. Offeror must agree to pass-through 100% of discounts and dispensing fees, as Offeror will <u>not</u> be allowed to retain a margin or "spread".</p>
39.	<p>Please confirm PBM is allowed to use "zero balance logic for retail claim adjudication.</p> <p><i>Financial Proposal; Section A:A1; Claim Pricing</i></p>	<p>Yes, the successful PBM will be allowed to use the "lesser of" also referred to as "zero balance logic" for retail claim adjudication. This means the members will pay the pharmacy the Usual and Customary (U&C) price or the co-payment whichever is the lesser of the two.</p>
40.	<p>Please identify what functions the designated liaison for DCH's Program Integrity Unit will be responsible for.</p> <p><i>Page 19; Section 2.4 Technical Requirement; Item 2.4.17 (d)</i></p>	<p>The functions of the designated liaison for the DCH's Program Integrity Unit will be on an "as needed basis" to assist the Unit in answering questions and/or clarifying issues for pharmacy providers and/or the DCH staff in reference to the successful PBM contractor's fraud and abuse program.</p>
41.	<p>Please clarify if this is a request for the PBM to provide/compile medical physician report cards.</p> <p><i>Page 18, Section 2.4 Technical Requirement; Item 2.4.15 (g)</i></p>	<p>The successful PBM contractor will provide pharmacy physician report cards which identifying the prescriber's prescription and utilization patterns This requirement is not for medical claims.</p>

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<p>42.</p>	<p>You have quoted DCH's percent of formulary RX at 82%. Please confirm whether or not this percentage includes generics?</p> <p><i>Financial Section; G Rebate Administration</i></p>	<p>This percentage is for brand name drugs.</p>
<p>43.</p>	<p>Are the 24 hour PA turnaround Time, and 72 hour appeals TAT calculated from the time that all information needed to review a request is received?</p> <ul style="list-style-type: none"> • Do these turnaround times cover weekends and holidays? • Do PA notification letters need to be prepared in multiple languages (English/Spanish/Vietnamese) or is having foreign language speaking staff available sufficient? <p><i>Page 14-1; Section 2.4 Technical Requirements; item 2.4.8 and 2.4.9.</i></p>	<p>The 24-hour PA turnaround time and the 72 hour appeals turnaround time are calculated from the time of the receipt of the initial PA request or appeal. The 72 hour appeals turnaround time is a "clean" appeal, (an appeal that does not require additional information in order to complete evaluation of the appeal). An appeal that requires follow-up information is pended until the additional information is received).</p> <ul style="list-style-type: none"> • Yes, turnaround times include weekends and holidays. • No, PA notification letters do not have to be prepared in multiple languages and having foreign language speaking staff is sufficient.
<p>44.</p>	<p>What is the current monthly PA volume for all 3 lines of business</p> <p><i>Page 15; Section 2.4 Technical Requirements; Item 2.4.8 (I) and Financial Section; A;A.1; Administrative, Clinical and Other Miscellaneous Fees</i></p>	<p>This RFP is only for two lines of business; both have the same prescription drug benefit program. The PA volume for the two (2) health plans, the SHBP PPO/PPO Consumer Choice and Indemnity, is combined and reported together. The most current PA volume data available is for the month of April – 5,036 prior authorizations.</p>

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45.	<p>What is the current monthly Appeals volume for all 3 lines of business</p> <p><i>Financial Section; A;A.1; Administrative, Clinical and Other Miscellaneous Fees</i></p>	<p>For the SHBP PPO/PPO Consumer Choice and Indemnity health plans, the only data available is for first quarter 2006 (Jan.-Mar.) – 236 first level appeals and 11 second level appeals.</p>
46.	<p>2.4.5 – Please outline your current account management structure including positions, responsibilities and time dedicated to the State.</p>	<p>The current PBM account management structure is:</p> <ul style="list-style-type: none">• <u>Regional Director</u> – responsibilities include overall for the account, the contractual agreement including strategic oversight and input, contract negotiations; the account management and clinical teams, etc. Time – 20%• <u>Account Director</u> – responsibilities include overall account relationship and including strategic planning in relation to plan performance; consultative services; recommendations for benefit design and cost containment opportunities, and analysis of plan performance; oversight for all contractual services under the PBM Agreement for the DCH SHBP plans; and manages all account and/or staff working on this account. This person is a registered pharmacist and time dedicated to account is approximately 60 to 70%.• <u>Account Manager</u>– responsibilities include day-to-day operations management and all services to support those operations. Time dedicated to account is 100%.• <u>Clinical Program Pharmacy Program</u> – this Pharmacist is responsible for all clinical support services including but not limited to presentations/support, PA criteria development, evaluation of clinical studies, analysis of plan specific clinical programs and initiatives, recommendations for cost containment opportunities, and analysis of plan performance. Time dedicated to account is 100%. Time dedicated to account is 100%.

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47.	2.4.2 – Please detail DCH's current Medicare Part D strategy. Please provide greater detail and specifics on the Medicare "wraparound" benefits desired. Please specify the coverage the DCH will provide for retirees.	The DCH has implemented the "wrap around" option for Medicare Part D Prescription Drug Plan (as outlined under CMS) January 1, 2007. The SHBP PPO/PPO Consumer Choice and Indemnity health plans coordinate the pharmacy benefit for retirees who enroll in Medicare Part D. The prescription drug benefit for the retirees is the same benefit for the active employees. This means the SHBP member should pay the lower of the SHBP or PDP co-payment (after the deductible has been satisfied if the PDP the member joined has a deductible). The SHBP plan is the secondary payor. During the deductible period, the member would pay the SHBP co-payment.
48.	2.4.3.i – Please provide clarity around DCH's expectations about access to adjudication and associates systems.	The successful PBM contractor is expected to provide access to the DCH designated staff and the designated staff from the third party medical claims administrator that will allow the viewing of claims information including but limited to member's claims history, individual claim adjudication; coverage rules and prior authorizations, claims information by specific drug or therapeutic category, etc.
49.	2.4.3.j – Does DCH currently have the ability to process compound claims electronically at an individual NDC level of each component NDC.	No, the current PBM vendor for the DCH does not have the ability to process compound claims electronically at an individual NDC level for each ingredient/drug.
50.	2.4.8.f – Please clarify DCH's current customer service arrangement and expectations about a designated and dedicated core customer service team. What percentage and number of calls does DCH expect to be handled by this team? Can team members handle non-DCH calls when there are no DCH member calls waiting?	The DCH's current member services team is a designated team that is made up of 20-40 customer service representatives (CSRs). The CSRs are required to answer telephone calls from the SHBP PPO/PPO Consumer Choice and Indemnity from members, providers and DCH staff first. The DCH expects the SHBP PPO/PPO Consumer Choice and Indemnity health plans to receive top priority with core team handling 95% of the calls. Yes, the team may handle non-DCH calls when there are no SHBP PPO/PPO Consumer Choice and Indemnity calls waiting.
51.	2.4.17.e – Please clarify DCH's expectations about documentation, access to systems and training support for fraud and abuse programs.	The DCH expects the successful PBM contractor to provide a copy of the Pharmacy Provider's Manual addressing pharmacy auditing policies and procedures, be able to view claim data and training to interpret audit reports.

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52.	3.2.10.12 – Please provide details of the current step therapy offering and expectations for the future.	The DCH is expecting the successful PBM contactor to identify and recommend clinical opportunities that will improve patient outcomes. The most frequently prescribed drugs that are subject to step therapy are identified on the Preferred Drug List with the notations PDMP (which stands for Progressive Drug Management Program-the DCH's step therapy program). The Preferred Drug List is located on DCH's website www.dch.georgia.gov
53.	3.2.18.7 – What is DCH's intent in regards to an annual Electronic Data Processing systems audit?	It is the intent of the DCH to verify the accuracy of the claims pricing and claims adjudication systems. The successful PBM contractor is expected to submit a SAS-70 annually.
54.	3.2.19 –Does the DCH plan to offer a mail benefit? If so, what is the expected timing and expectation of this offering? In addition, is a mail order pharmacy considered a "participating pharmacy" in the retail pharmacy network?	The DCH does not plan to offer a mail order benefit for the Plan Year 2007, which begins January 1, 2007.
55.	3.2.20 - Does the DCH plan to offer a specialty program, under the pharmacy benefit, in the future?	Please see the response to Question 10.
56.	Is electronic delivery through posting on the DCH website acceptable when delivering a copy of the PDL? Is electronic delivery through posting on the vendor website acceptable?	Yes, electronic delivery through posting on the DCH website acceptable when delivering a copy of the PDL. Electronic delivery through posting on the vendor website is not acceptable.
57.	Please clarify "days supply" with regards to retail and mail order prescription copays. Will DCH consider a change to their current structure in the future?	The "days supply" is a 30-day supply for retail. There is no mail benefit. The DCH is open to the successful PBM contractor's recommendations that will improve the performance of the plan and the rationale to support recommendations.

Questions and Answers

58.	3.2.3.6 - If a subcontractor provides pharmacy administration for a bidding organization, is the DCH requesting access to the subcontractor's claims system or is view only access through the bidding administrator's customer web-based portal acceptable?	The DCH will accept the view only access through the successful PBM contractor's customer web-based portal.
59.	3.2.5.2 - Does the DCH require the General Manager position to be solely focused on the pharmacy administration or is it acceptable the General Manager has overall accountability for all existing services provided to the DCH by this vendor including pharmacy administration?	The DCH requires the General Manager to have overall accountability for all existing services provided to the DCH by the successful PBM contractor including pharmacy administration. The DCH understands the job title may vary based on company.
60.	3.2.8.8 - Does the current vendor's services include a designated or dedicated customer service team segregated for the active and retired population? If so, what are the average number of weekly calls for actives and the average number for retirees?	No, the existing PBM vendor's designated customer service team does not segregate for the active and retired population.
61.	3.2.8.15 - What is the current ratio of CSRs to membership served?	There are currently 20-30 CSRs for a membership of 289,856 lives.
62.	3.2.8.35 - If your standard SPD for medical services includes a section for pharmacy administration and you have an existing contract with the DCH, is it acceptable to include the pharmacy SPD language in the same overall medical SPD for that plan offering? Please also provide a copy of the current pharmacy SPD.	The Summary Plan description for SHBP PPO/PPO Consumer Choice ad Indemnity health plans does not contain a section or the prescription drug program (pharmacy benefit). A copy of the SPD can be obtained from the DCH website: www.dch.ga.gov

Questions and Answers

63.	3.2.9.23 - Does the DCH require the bidding vendors to duplicate the existing prior authorization list?	Yes, the DCH will require the successful PBM contractor to duplicate the exiting prior authorization list.
64.	Are you open to evidence-based PDL management that may place a brand in Tier 1, and place a generic outside of tier 1, if it maximizes value for the State of Georgia?	The DCH expects the successful PBM contractor to support and provide evidence-based PDL management. Yes, the DCH is open to an evidence-based PDL management that may place a brand in Tier 1, and place a generic in a higher Tier, if it provides optimum clinical outcomes and maximizes value for the SHBP PPO/PPO Consumer Choice and Indemnity health plans.
65.	Please confirm the Performance Guarantee metrics are applicable for the initial contract period of 1-1-2007 to 6-30-2007 and then will renew for the full contract period of 7-1-2007 to 6-30-2008 and each fiscal contract period thereafter through 6-30-2011 Attachment G: Performance Guarantees	The initial PBM Agreement and Performances Guarantees /Liquidated Damages will be from the date the Agreement is signed until June 30, 2007. Then it will be renewed for the full contract period of 7-1-2007 to 6-30-2008 and each fiscal contract period thereafter through 6-30-2011.
66.	1 - Implementation. Please confirm if the implementation penalty only applies to 1-1-2007 at 8:00am or does it also apply to future renewals and if so, is that on a fiscal year or calendar year basis? Attachment G: Performance Guarantees	This only applies to 1-1-2007 at 8:00am.
67.	3 - Homeland Security. Is the \$5,000 per occurrence penalty payable: monthly, quarterly or annually? Attachment G: Performance Guarantees	Annually
68.	4 - HIPAA Compliance. Is the \$5,000 per occurrence penalty payable: monthly, quarterly or annually? Attachment G: Performance Guarantees	Annually

Pursuant to RFP # 41900-001-0000000047
For Pharmacy Benefit Manager

Questions and Answers

69.	5 - Fraud & Abuse. Please clarify if there are two separate guarantees for Fraud and Abuse. It appears there metric for maintaining at \$1,000 per calendar day and another metric for submitting at \$1,000 per day. Attachment G: Performance Guarantees	Yes, there are two separate guarantees and a Performance Guarantee /Liquidated Damage for each one.
70.	8 - Geographic Access. Please clarify the last sentence under the guarantee column. "Contractor will report compliance and pay semi-annually on or by". Should there be some more language after "by"? Attachment G: Performance Guarantees	No, the DCH and the successful PBM contractor will decide on the date upon finalizing the PBM Agreement.
71.	12 - System Downtime. Please clarify the last sentence under the guarantee column. "Contractor will report compliance and pay DCH and pharmacies quarterly". What is meant by paying pharmacies? Attachment G: Performance Guarantees	This Performance Guarantee/ Liquidated Damage refers to the successful PBM Contractor paying pharmacies for "switching fees" for claims that could not be processed when the PBM's system is down.
72.	33 - Client satisfaction survey. Just to clarify as it is not in the guarantee column. Would this be payable annually? Attachment G: Performance Guarantees	Annually
73.	34 - Customized Member and Provider surveys. Just to clarify as it is not in the guarantee column. Would this be payable annually? Attachment G: Performance Guarantees	Annually
74.	36 - SAS-70. Just to clarify as it is not in the guarantee column. Would this be payable annually? Attachment G: Performance Guarantees	Annually

Questions and Answers

75.	38 - Pass-through payment. Just to clarify as it is not in the guarantee column. Would this be payable annually? Attachment G: Performance Guarantees	Annually
76.	General appendix question: Should all the grids in this appendix labeled as Calendar Years 2007, CY 2008, CY 2009, CY 2010, and CY 2011 be labeled as Fiscal Years : 1-1-2007 to 6-30-2007 then from 7-1-2007 to 6-30-2008 then from 7-1-2008 to 6-30-2009 then from 7-1-2009 to 6-30-2010 then from 7-1-2010 to 6-30-2011? Appendix F: Financial Proposal	For Appendix F – the Financial Proposal, all grids will be labeled as Fiscal Years: Agreement effective date (see page 2 of RFP; Section 1.4 – Schedule of Events - 8/06) to 6-30-2007 then from 7-1-2007 to 6-30-2008 then from 7-1-2008 to 6-30-2009 then from 7-1-2009 to 6-30-2010 then from 7-1-2010 to 6-30-2011. The Financial Proposal is revised to reflect this change.
77.	F1. Administrative Fees. Please clarify, "Postage costs (i.e., the cost of stamps or meters) should be treated as pass-through costs and not included in the proposed administrative fee". What postage costs are you referring to specifically? Appendix F: Financial Proposal	This refers to postage for mailings to members and providers such as benefit change notification letters to members, clinical mailings, etc.
78.	F1. Administrative Fees. Is it possible to quote the fee on a Per Employee Per Month basis rather than a Per Paid claim basis? Appendix F: Financial Proposal	Yes, please see revised Financial Proposal.
79.	Please provide an example describing the question in section: 3.2.3.18	This question is being asked to see if there any system edits inherent in your organization’s system, which can be entered by pharmacists at POS and cannot be removed at the request of an individual client. If for example, prescription pharmacists are allowed to override
80.	Will additional questions be allowed regarding the claims data provided via disk since it will be received past the question deadline?	The DCH will allow questions only in relation to claims data and the revised Financial Proposal until Tuesday June 20, 2006. Please see revised schedule on the DCH website.

Questions and Answers

<p>81.</p>	<p>What amount of the drug spend is attributable to Medicare eligibles? Do the Pharmacy Expenditures and Patients included in the chart on page 6 of 182 include Medicare lives? If so, please provide the non-Medicare Expenditures and Patients separately. Section 1.0 Introduction, 1.8 Background (page 6 of 182)</p>	<p>The pharmacy expenditures in the chart on page 6 included Medicare and non-Medicare lives. Please see the SHBP PPO/PPO Consumer Choice and Indemnity health plans' drug spend for Medicare eligibles and the Total Membership for the First Calendar Quarter 2006 (Jan-Mar) below:</p> <table border="1" data-bbox="907 427 1902 597"> <thead> <tr> <th data-bbox="907 427 1159 495">Age Range</th> <th data-bbox="1159 427 1411 495">Patients</th> <th data-bbox="1411 427 1663 495">Rx Count</th> <th data-bbox="1663 427 1902 495">Pharmacy Expenditures</th> </tr> </thead> <tbody> <tr> <td data-bbox="907 495 1159 529">65 & older</td> <td data-bbox="1159 495 1411 529">58,691</td> <td data-bbox="1411 495 1663 529">462,421</td> <td data-bbox="1663 495 1902 529">\$23,221,476.92</td> </tr> <tr> <td data-bbox="907 529 1159 597">Total Membership</td> <td data-bbox="1159 529 1411 597">290,587</td> <td data-bbox="1411 529 1663 597">1,411,397</td> <td data-bbox="1663 529 1902 597">\$79,086,124</td> </tr> </tbody> </table>	Age Range	Patients	Rx Count	Pharmacy Expenditures	65 & older	58,691	462,421	\$23,221,476.92	Total Membership	290,587	1,411,397	\$79,086,124
Age Range	Patients	Rx Count	Pharmacy Expenditures											
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<p>82.</p>	<p>Does DCH anticipate the PBM providing disease management programs? According to the chart provided on page 7 of 182, UHC maintains responsibility for disease management programs. However, DCH's questionnaire points to the PBM's involvement in disease management. What is the State's intent for the future with regard to disease management, and what is the role of the PBM? Section 1.0 Introduction (page 7 of 182)</p>	<p>Please see the response to Question 14.</p>												
<p>83.</p>	<p>How is the State currently handling specialty drugs since they are not a part of the current PBM plan? What is DCH's intent for the future with regard to specialty drug management? Section 1.0 Introduction (page 7 of 182)</p>	<p>Please see the response to Question 10.</p>												
<p>84.</p>	<p>How does your current PBM currently process and price compounds? Section 3.0 Technical Questionnaire (3.2.3.19 page 28 of 182)</p>	<p>Currently, the compounds pay according to the NDC of the most expensive ingredient at the submitted cost up to a maximum of \$299.99. Compound claims with a submitted cost of \geq\$300 require prior authorization. Compounds claims can be processed at a retail pharmacy or submitted by a member as a paper claims.</p>												

Questions and Answers

85.	<p>Can DCH explain the difference between the Mandatory Requirements presented in Section 2.0 of the RFP and the Guide to Mandatory Requirements in Appendix A? Upon review, it appears that all of the requirements referenced in Appendix A also appear in Section 2.0, yet the list of requirements in Appendix A is much shorter.</p> <p>Section 2.0 Mandatory Requirements (page 8 of 182) and Appendix A (page 66 of 182)</p>	Please see response to Question #24.
86.	<p>In the indemnification language for the contract, will it be permissible for the PBM to exclude pharmaceutical manufacturers and retail pharmacies due to their being independent entities over which the PBM has no operational control?</p> <p>Section 2.2.5 (Page 9 of 182)</p>	No, there will be no exclusions.
87.	<p>Please quantify the open enrollment activities and benefit fairs that the account team will support.</p> <p>Section 2.4.5.g (p. 13 of 182)</p>	Please see the response to Question 6.

Questions and Answers

87.	<p>Please confirm that the Medicare Part D secondary benefit design for SHBP PPO and Indemnity mirror the benefit design offered to the active employees and pre-Medicare retirees. Are there any variances in the plan design, network allowed, or formulary offered? Does the wrap-around include coverage for non-Medicare Part D covered drugs? Are Part B drugs covered as part of the secondary wrap benefit? Does SHBP maintain any coverage rules or prior authorizations as part of the secondary coverage or does SHBP assume the primary payor will control these items? If the PBM which is awarded the contract is also a PDP, would DCH allow the PBM/PDP to conduct targeted marketing of the PDP and the potential advantages of service where both the secondary and primary benefits are provided by the same entity?</p> <p>Section 2.4.2.b. (page 11 of 182)</p>	Please see the response to Question 47.
89.	<p>10. Please define the “denominator” in the calculation of meeting DCH’s requirement of 95% of all pharmacies in Georgia to be in the network. The 95% is of what total number?</p> <p>Section 2.4.6.a (p. 13 of 182)</p>	The “denominator” is the number of available licensed retail pharmacies in the Primary Service Area (the State of Georgia). As of June 16, 2006, there were 2,222 licensed retail pharmacies.

Questions and Answers

90.	<p>May the Member Customer Service representatives that are designated and dedicated to SHBP respond to other calls when not answering DCH calls?</p> <p>Section 2.4.8.f (p. 14 of 182)</p>	Please see the response to Question 50.
91.	<p>If the rebate vendor is the same as the PBM, is the requirement to transmit paid claims data weekly nullified?</p> <p>Section 2.4.10.d (p. 16 of 182)</p>	Yes.
92.	<p>Please provide sample reports that may be required by DCH.</p> <p>Section 2.4.15.f (p. 18 of 182)</p>	<p>The DCH will not provide sample reports because the reports are proprietary and may vary by Offeror. The report package be revised, revised (possibly), and agreed upon with the successful PBM Contractor. The standard reports of the successful PBM Contractor should include but limited to the list below:</p> <p><i>Financial Reports:</i></p> <ul style="list-style-type: none"> • Overall plan performance (plan cost, PMPM measures, % utilizing members, etc.) • Rx Measures (cost per Rx, days supply, etc.) • Member Demographics • Monthly summary • Cost sharing analysis <p><i>Utilization Reports:</i></p> <ul style="list-style-type: none"> • Individual group number • Claims summary report • Claims detail report • PMPM report • PDL utilization analysis • Therapeutic class analysis • Drug utilization Review reports

Questions and Answers

93.	<p>Please distinguish between “recoupments” and “recoveries”.</p> <p>Section 2.4.18.a (page 19 of 182)</p>	<p>The terms may be used interchangeably however for the DCH “recoveries” refers to funds collected due to overpayments identified through an auditing process and “recoupments” are funds collected to due to overpayments (taking back an overpayment).</p>
94.	<p>Please describe DCH’s intent for the future with regard to mail service pharmacy.</p> <p>Section 3.2.19.2</p>	<p>Please see the response to Question 54.</p>
95.	<p>Where are the “boxes” by each requirement that are referenced in the introductory paragraph to the Guide to Mandatory Requirements?</p> <p>Appendix A (page 66 of 182)</p>	<p>Unfortunately the grid lines did not transfer with the document, please see the response to Question 24.</p>
96.	<p>What was the volume of paper claims for DCH during 2005?</p> <p>Section 4 Bid Evaluation, 4.2.3 Technical Questionnaire Evaluation (page 61 of 182)</p>	<p>The number of billed member submitted paper claims for 2005 (Jan- Dec) were 100,950.</p>
97.	<p>With regard to the sample contract provided in Appendix E, there are multiple forms requiring signatures. Was it DCH’s intent to provide this document merely as a sample and to complete Appendix E? Based on the instructions provided in Section 4.0, it is our understanding that the only forms that we are required to submit back to DCH along with our proposal are Appendices A, B, C, E and F. Please confirm.</p> <p>Appendix E</p>	<p>The DCH provided the sample PBM Agreement and Appendixes in order to allow Offerors the opportunity to fully review and understand the scope and requirements of the services to be provided for the SHBP PPO/PPO Consume Choice and Indemnity health plans’ prescription drug program. The sample PBM Agreement, Appendix E, does not require a signature, nor does the Financial Proposal Appendix F.</p> <p>Signatures are only required for Appendix A, B, C and D.</p>

Questions and Answers

<p>98.</p>	<p>Under the current PBM Agreement with DCH's existing vendor is Zero Balance Logic (ZBL) turned on or off? On page 7 of 182, the description allows for ZBL to be on. However, in Appendix F A1, the description of the members' cost portion requires ZBL to be turned off. Though it is apparent that the current contract with your existing vendor allows ZBL, is it DCH's intent to change to not allow retail pharmacies to collect the lesser of U&C or the members' copay? If so, would DCH explain its rationale for shifting from an Agreement in which ZBL was permitted to one in which it is not permitted, acknowledging the anticipated network turmoil?</p> <p>Appendix F A1 (page 155 of 163)</p>	<p>Under the current PBM Agreement with DCH's existing vendor, the Zero Balance Logic (ZBL) or the "Lesser of Logic" is turned on. The Financial Proposal Appendix F, Section A1 will be revised to reflect that ZBL will be allowed.</p>
<p>99.</p>	<p>Please provide discount information at your earliest convenience. I didn't see it at first glance on the CD which just arrived in my office.</p>	<p>The DCH is not providing a set discount rate for retail pharmacies and is requesting for Offerors to submit discount information in the Financial Proposal, Appendix F.</p>
<p>100.</p>	<p>Please provide de-identified detail for claimants in excess of \$25,000 or other standard level of high claimant reporting.</p>	<p>This data is not available.</p>
<p>101.</p>	<p>Plan Design - Page 7 Current Pharmacy Benefit - Please provide confirmation of current plan design if there are any provisions beyond the information on page 7 and specify all clinical programs currently in place.</p>	<p>There is no additional information about the pharmacy benefit however Offerors may review the Preferred Drug List on the DCH website: www.dch.ga.gov. Also please see Question</p>

Questions and Answers

102.	<ul style="list-style-type: none">• How does the current contract read with regard to the following: Termination of contract, what are penalties? What are their guaranteed retail discounts and dispensing fee's? What is their current MOD discounts and dispensing fees? How are rebates paid, all scripts, rebatable scripts? When are they paid, are they transparent? what are the amounts? Does their current contract allow for 90 days at retail? If so, how is it administered, under what discounts?	For the answer to this Question, the Offer must submit an Open records request to: pjohnson@dch.ga.gov
103.	<ul style="list-style-type: none">• Is there a consideration or requirement to make mail order an option for maintenance drugs?	No, the DCH is not considering a mail order benefit for the upcoming plan year beginning January 1, 2007.
104.	<ul style="list-style-type: none">• 2.2 (Business Requirements) - there is a reference to an affidavit to be provided with a website link to the Offeror's pharmacy network listing. Should there be a specific document contained within the forms to be completed or should we provide documentation on our letter head?	It is acceptable to submit this information on your organization's letterhead.

Questions and Answers

105.	2.4.9 item g (Clinical Programs/Utilization Management) - What is the DCH approved criteria for prior authorizations and appeal requests?	The DCH is looking to the successful PBM contractor to provide the necessary clinical expertise and clinical consultation to recommend clinically sound guidelines and criteria. The DCH's current PBM vendor considers their prior authorization and appeals criteria proprietary because the DCH approved criteria for prior authorizations and appeal requests also contains the PBM's criteria, this information will not be released.
106.	2.4.10 item c (Preferred Drug and Rebate Management) - please explain how the current process works for the State regarding "holding rebate contracts with manufacturers". Who is the current rebate vendor?	The current rebate vendor is the current PBM vendor.
107.	2.4.11 item a (Disease State Management) - please clarify or expand on this item. What type of integration process is currently in place? What is the current support level - is there an estimated cost?	Please see the response to Question 14. The level of support by the current PBM vendor is the maintenance of the DSM programs that include a co-payment waiver component (zero co-payment) for specific eligible members for certain drugs based on disease state and clinical expertise when needed.
108.	2.4.12 #f (Disease State Management) - Please clarify what "accommodate separate drug coverage rules per enrolled plan members" means?	The successful PBM Contractor must "accommodate separate drug coverage rules per enrolled plan members" which means for the Contractor must be able to implement and maintain include a co-payment waiver feature (zero co-payment) for specific eligible members for certain drugs based on disease state DSM programs for the SHBP PPO/PPO Consumer Choice and Indemnity health plans.
109.	Can a list be provided by the state of all pharmacies so that we can ensure that we are accurately assessing the participation levels relative the 95% standard?	No, the DCH does not have a list of all pharmacies in the State of Georgia. Please see the response Question 89.
110.	In Exhibit B, information regarding claims, days supply, etc. is provided. However, there is no information regarding quantity dispensed which is needed to perform an accurate and thorough analysis. Would it be possible to obtain this information?	The DCH is in process of investigating this question.