



**State of Delaware
Office of Management & Budget
Statewide Benefits Office**

STATE EMPLOYEE BENEFITS COMMITTEE

**Request for Proposal for a Medical Third Party Administrator for
the Group Health Insurance Program**

Release Date: August 15, 2016

Addendum #1

August 17, 2016

OMB16001–Health_Ins

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1. The **Q&A deadline** on Page 42, Paragraph #6, incorrectly states that the deadline is Wednesday, September 7th. As stated on Page 10 in the *Important Dates* table, **Friday, September 2nd, (at 1:00 p.m. Local Time) is correct.**
2. Attached is a **revised Appendix R – Supplemental Financial Questions**. The document contains the redline feature so you can easily see what the changes are. Please accept the changes then replace the document in its entirety, keeping “Revised - Addendum #1” in the title.

APPENDIX R

REVISED – ADDENDUM #1

SUPPLEMENTAL FINANCIAL QUESTIONS

Purpose: To capture additional unit discount and cost of care factors to be incorporated into the financial analysis for this RFP.

Current State Market Detail

One copy of this table is to be completed for each of the three markets requested (listed below). It is intended to capture data on emerging network trends in selected markets so that this may be reflected in the financial analysis. Savings numbers reported should be shown as the incremental impact of this alternative delivery model relative to the standard offering in the market. Please include data on any narrow or alternative networks that are included as part of your most recent UDS submission.

Fill out a copy for each relevant geographical market for the 12 month time period consistent with the latest UDS submission

Limit Responses to Commercial Self-Funded Products

Current State Assessment (Current Year)

Markets:

1. Wilmington-Dover, DE Metropolitan Statistical Area (MSA)
2. Philadelphia, PA MSA
3. Salisbury, MD MSA

Model Name (However you would like it to be referred to in client communications)	
Model Type (i.e., ACO, APC) Provider shared savings arrangements, narrow network, custom network, any other performance based/shared savings arrangements, etc.)	
Network Name(s) (if applicable)	
Product Indicator(s) (if applicable)	
General Description	
Briefly describe the alternative delivery arrangements in this market	
Identify the top-5 hospitals and top-5 physician groups in this market and indicate whether or not they are included or excluded in each model	
Describe the downside risk provisions, if any, the provider groups are taking under each model (i.e. if the model has a cost target that is not met, does the provider have to pay back the shortfall?)	

Describe the financial incentive structure to the Hospitals under this model (i.e. quality bonus, shared savings, capitation levels, and any other PMPM fees such as patient or clinical management fees)	
Describe the financial incentive structure to the Primary Care Physicians under this model (i.e. quality bonus, shared savings, capitation levels, and any other PMPM fees such as patient or clinical management fees)	
Describe the financial incentive structure to the Specialty Care Physicians under this model (i.e. quality bonus, shared savings, capitation levels, and any other PMPM fees such as patient or clinical management fees)	
Describe and quantify any other fees associated with this model (i.e. network access fees, ACO PMPM care coordination fees, etc.)	
Quantify the percentage of members for this market attributed to or impacted by each model	
Quantify the percentage of total billed dollars for this market attributed to or impacted by each model	
Quantify the percentage of total allowed cost for this market attributed to or impacted by each model	
For the providers with whom you share a broad network contract / fee schedule but do not qualify as an in-network provider under this model, describe how your reimbursement arrangements are impacted. For example, will these providers still be subject to their broad network reimbursement arrangements or will a different reimbursement structure be used?	
How many different tiers of member benefits are generally used under this model? Please define how many tiers are typically used and describe the provider contract groupings that would fall under each benefit tier.	
Quantify the estimated utilization of in-network (or "Tier 1") providers under this model.	
Quantify the estimated utilization of other broad network providers under this model. This refers to providers with whom you may still share a broader PPO network contract with but who do not qualify as an in-network provider under this model.	
Quantify the estimated utilization of out-of-network providers under this model.	
Impact to Total Cost of Care	
Quantify the expected savings to Overall total cost of care for attributed/impacted spend under each model as a % of allowed charges both gross and net of financial incentives paid to providers under this model	
Quantify the expected savings to Inpatient Facility total cost of care for attributed/impacted spend under each model as a % of allowed charges both gross and net of financial incentives paid to providers under this model	
Quantify the expected savings to Outpatient Facility total cost of care for attributed/impacted spend under each model as a % of allowed charges both gross and net of financial incentives paid to providers under this model	

Quantify the expected savings to Professional total cost of care for attributed/impacted spend under each model as a % of allowed charges both gross and net of financial incentives paid to providers under this model	
Quantify the expected savings to Laboratory/Radiology/Pathology total cost of care for attributed/impacted spend under each model as a % of allowed charges both gross and net of financial incentives paid to providers under this model	
Impact to Network Discount	
Quantify the expected savings to Overall discount percentage for attributed/impacted spend under each model as a % of billed charges	
Quantify the expected savings to Inpatient discount percentage for attributed/impacted spend under each model as a % of billed charges	
Quantify the expected savings to Outpatient discount percentage for attributed/impacted spend under each model as a % of billed charges	
Quantify the expected savings to Professional discount percentage for attributed/impacted spend under each model as a % of billed charges	
Reduction in contracted fees for providers in each model, along with the assumed percentage of claims that will flow through these providers (which comprise the “in-network” providers under the model).	
Reduction in cost of out-of-network services based on any changes in the reimbursement schedule under the model (vs. the broad network reimbursement schedule), which could be comprised of the following elements:	
<p>A) Out-of-network contracted providers under the broad network that now become subject to a pure out-of-network reimbursement schedule. In other words, how are the reimbursement levels expected to change when providers move from an in-network contracted arrangement to this model's out-of-network reimbursement schedule?</p> <p>B) Out-of-network non-contracted providers that were previously subject to a reimbursement schedule and will remain subject to a reimbursement schedule (but potentially a different reimbursement schedule).</p>	
Total estimated savings for this model. Please outline any key assumptions not already disclosed (e.g., migration assumptions, etc.).	

Proposal Period Market Detail

One copy of this table to be completed for each market requested. Is intended to provide projected data on the period for the proposal on emerging market trends for selected markets that may be reflected in the financial analysis. Savings numbers reported should be shown as the incremental impact of this alternative delivery model relative to your standard offering in each of the three markets specified below.

Fill out a copy for each relevant geographical market for the time period consistent with the relevant proposal

Limit Responses to Commercial Self-Funded Products

Future State Assessment (Proposal Year)

Markets:

- 1. Wilmington-Dover, DE MSA
- 2. Philadelphia, PA MSA
- 3. Salisbury, MD MSA

Model Name (However you would like it to be referred to in client communications)	
Model Type (i.e., ACO, APC) Provider shared savings arrangements, narrow network, custom network, any other performance based/shared savings arrangements, etc.)	
Network Name(s) (if applicable)	
Product Indicator(s) (if applicable)	
General Description	
Describe any expected changes to the current state alternative delivery arrangements in this market including any new models expected to be launched during the Proposal Year.	
Identify the top-5 hospitals and top-5 physician groups in this market and indicate whether or not they will included or excluded in each model.	
Describe any expected changes in downside risk provisions, if any, the provider groups are taking under each model (i.e. if the model has a cost target that is not met, does the provider have to pay back the shortfall?).	
Describe any changes to financial incentive structure to the Hospitals under this model (i.e. quality bonus, shared savings, capitation levels, and any other PMPM fees such as patient or clinical management fees).	
Describe any changes to financial incentive structure to the Primary Care Physicians under this model (i.e. quality bonus, shared savings, capitation levels, and any other PMPM fees such as patient or clinical management fees).	
Describe any changes to financial incentive structure to the Specialty Care Physicians under this model (i.e. quality bonus, shared savings, capitation levels, and any other PMPM fees such as patient or clinical management fees)	
Describe and quantify expected changes to any other fees associated with this model (i.e., network access fees, ACO PMPM care coordination fees, etc.).	

Quantify the percentage of members for this market expected to be attributed to or impacted by each model.	
Quantify the percentage of total billed dollars for this market expected to be attributed to or impacted by each model.	
Quantify the percentage of total allowed cost for this market expected to be attributed to or impacted by each model.	
For the providers with whom you share a broad network contract / fee schedule but do not qualify as an in-network provider under this model, describe how your reimbursement arrangements are impacted. For example, will these providers still be subject to their broad network reimbursement arrangements or will a different reimbursement structure be used?	
How many different tiers of member benefits are generally used under this model? Please define how many tiers are typically used and describe the provider contract groupings that would fall under each benefit tier.	
Quantify the estimated utilization of in-network (or "Tier 1") providers under this model.	
Quantify the estimated utilization of other broad network providers under this model. This refers to providers with whom you may still share a broader PPO network contract with but who do not qualify as an in-network provider under this model.	
Quantify the estimated utilization of out-of-network providers under this model.	
Impact to Total Cost of Care	
Quantify the incremental expected savings from current state to Overall total cost of care for attributed/impacted spend under each model as a % of allowed charges both gross and net of financial incentives paid to providers under this model.	
Quantify the incremental expected savings from current state to Inpatient Facility total cost of care for attributed/impacted spend under each model as a % of allowed charges both gross and net of financial incentives paid to providers under this model.	
Quantify the incremental expected savings from current state to Outpatient Facility total cost of care for attributed/impacted spend under each model as a % of allowed charges both gross and net of financial incentives paid to providers under this model.	
Quantify the incremental expected savings from current state to Professional total cost of care for attributed/impacted spend under each model as a % of allowed charges both gross and net of financial incentives paid to providers under this model.	
Quantify the incremental expected savings from current state to Laboratory/Radiology/Pathology total cost of care for attributed/impacted spend under each model as a % of allowed charges both gross and net of financial incentives paid to providers under this model.	
Impact to Network Discount	
Quantify the incremental expected change to Overall discount percentage for attributed/impacted spend under each model as a % of billed charges.	

Quantify the incremental expected change to Inpatient discount percentage for attributed/impacted spend under each model as a % of billed charges.	
Quantify the incremental expected change to Outpatient discount percentage for attributed/impacted spend under each model as a % of billed charges.	
Quantify the incremental expected change to Professional discount percentage for attributed/impacted spend under each model as a % of billed charges.	
Reduction in contracted fees for providers in each model, along with the assumed percentage of claims that will flow through these providers (which comprise the “in-network” providers under the model).	
Reduction in cost of out-of-network services based on any changes in the reimbursement schedule under the model (vs. the broad network reimbursement schedule), which could be comprised of the following elements:	
<p>A) Out-of-network contracted providers under the broad network that now become subject to a pure out-of-network reimbursement schedule. In other words, how are the reimbursement levels expected to change when providers move from an in-network contracted arrangement to this model's out-of-network reimbursement schedule?</p> <p>B) Out-of-network non-contracted providers that were previously subject to a reimbursement schedule and will remain subject to a reimbursement schedule (but potentially a different reimbursement schedule).</p>	
Total estimated savings for this model. Please outline any key assumptions not already disclosed (e.g., migration assumptions, etc.).	

(continued on the next page)

Network Discount Savings (as % of Billed) for Impacted Spend						
	Model Name	Total - All Service Categories	Inpatient	Outpatient	Professional	Lab / Rad / Path
<i>Examples</i>	ACO 1	2.0%	4.0%	1.0%	0.0%	0.0%
	ACO 2					
	HPN 1					

Proposal Period Summary

This is intended to capture additional discount and care management adjustment data and factors to be used to reflect emerging market difference for the proposal period. One copy of this table should reflect all alternative delivery models and each of the three markets specified above (i.e., Wilmington-Dover, DE MSA; Philadelphia, PA MSA; and Salisbury, MD MSA). Savings numbers reported should be shown as the incremental impact of this alternative delivery model relative to your standard offering in the market.

Please complete a copy for each alternative delivery model.

Model 1

	Model Name	Model Type	Network Name (If applicable)	Product Name (If applicable)	Geographic Coverage	List of Eligible 3-Digit Zips	% of Members Impacted by this model	% of Billed Impacted by this model	% of Allowed Impacted by this model
<i>Examples</i>	ACO 1	ACO		PPO1	Market 1	001, 002 ,003	25%	23%	20%
	ACO 2	ACO		PPO1	Market 2				
	HPN 1	Narrow Network		PPO2	Market 1				

Total Cost of Care Savings (% of Allowed) for Impacted Spend											
	Gross (Before Provider Incentives)					Net (After Provider Incentives)					
	Model Name	Total - All Service Categories	Inpatient	Outpatient	Professional	Lab / Rad / Path	Total - All Service Categories	Inpatient	Outpatient	Professional	Lab / Rad / Path
<i>Examples</i>	ACO 1	5.0%	7.0%	4.0%	2.0%	1.0%	2.5%	3.5%	2.0%	1.0%	0.5%
	ACO 2										
	HPN 1										

Network Discount Savings (as % of Billed) for Impacted Spend						
	Model Name	Total - All Service Categories	Inpatient	Outpatient	Professional	Lab / Rad / Path
<i>Examples</i>	ACO 1	2.0%	4.0%	1.0%	0.0%	0.0%
	ACO 2					
	HPN 1					

Network Tier Cost Comparison

This is intended to compare the provider reimbursement levels across the various contracting tiers under the broad network (e.g., in-network contracted, in-network non-contracted, out-of-network) to the provider reimbursement levels under the alternative delivery model. This table should reflect all alternative delivery models and each of the three markets specified above (i.e., Wilmington-Dover, DE MSA; Philadelphia, PA MSA; and Salisbury, MD MSA). From the information in this table, we should be able to determine how the reimbursements to providers are expected to change when a claim moves from any of the current broad network contract tiers to any of the future network contract tiers.

Notes on abbreviations:

IN = In-Network

OON = Out-of-Network

		Alternative Health Care Delivery Model - Provider Contract Tier				
Model Name	Broad Network - Provider Contract Tier	IN Contracted (Tier 1)	IN Contracted (Tier 2, if applicable)	Out-of-Network Contracted (if applicable)	Out-of-Network Non-Contracted	
<i>Examples</i>	ACO 1	IN Contracted	0.928 (indicates that Tier 1 is 7.2% lower cost than in-network under broad)	1.000	1.300	1.100
		OON Contracted (i.e. wrap network)	0.714	0.769	1.000	0.800
		OON Non-Contracted	0.844	0.909	1.250	1.000
	ACO 2	IN Contracted				
		OON Contracted (i.e. wrap network)				
		OON Non-Contracted				
	HPN 1	IN Contracted				
		OON Contracted (i.e. wrap network)				
		OON Non-Contracted				
	IN Contracted					
	OON Contracted (i.e. wrap network)					
	OON Non-Contracted					

