

**RFP for a Medical Third Party Administrator for the Group Health Insurance Program
OMB16001-Health_Ins**

Responses to Questions (Q&A)

September 12, 2016

No.	Reference:	Topic:	Question:	Answer:
1.	IV. Questionnaire B. Medical Plan Administration; 9.0 Provider Network; Pages 103-112 12.0 Access to Care/Providers; Pages 122-124 14.0 Provider Management; Pages 130-138 C. Health Care Delivery; 8.0 High Performance Networks; Pages 183-188	General	For all questions requesting a response by geographic location, how would you like us to respond? National, State of Delaware, Top 3 networks based on the census? Examples of these types of questions include, but are not limited to: leased/third party networks, provider turnover, member utilization, closed practices, board certified providers, etc.)	Unless otherwise specified in the instructions of a particular section or in the text of a particular question, please provide your responses based on the specific networks included in your proposal to the State of Delaware. For instance, if multiple network options are included in your proposal, your response should address all of the network options included in your proposal. If the instructions or particular question require a response “in the State of Delaware’s pertinent markets” (e.g., Section IV.C.8.2, page 182), and if this would require you to provide an excessive amount of detail, please respond based on your proposed network solution(s) for the state of Delaware (i.e., in general based on your experience in Delaware) as well as the top three metropolitan statistical areas (i.e., based on 3-digit ZIP codes) outside of Delaware based on the census file provided.
2.	V. Network Adequacy 1.0 GeoAccess page, 252;	Using the ZIP Code data provided in the GeoAccess reporting	Please confirm that the ZIP Codes in Appendix S, T, U under the ZIP definition tab are	No. Please use the ZIP codes associated with the GHIP population and provided in the

	Appendix S, Appendix T, Appendix U	templates (Appendices S, T and U), prepare and provide GeoAccess reports based on the standards included in the template.	to be used for the GeoAccess analysis and not the census file.	census file to run the GeoAccess analysis. The ZIP codes listed in Appendix S, T, and U include an indicator noting whether each ZIP code should be considered Urban (U), Suburban (S) or Rural (R), which will determine which access standards apply (i.e., A providers within X miles for Urban ZIP codes, B providers within Y miles for Suburban ZIP codes, etc.)
3.	V. Network Adequacy – 1.0 GeoAccess, p. 152	The results of your GeoAccess should be populated for your broad/traditional network and separately for any ACO, HPN or narrow networks included in your proposal. (continued . . .)	May we replicate Appendix S, T and U to provide results for the ACO/HPN or narrow networks?	Yes. Please replicate Appendix S, T and U to provide results for the ACO/HPN or narrow networks.
4.	V. Network Adequacy – 2.0 Provider Disruption	Part of the scoring criteria upon which all bidders will be evaluated is based on accurate completion of the <i>Provider Disruption</i> analysis, Appendix V. By completing the exhibits, you are required to determine whether the provider is in-network, out of network, or other. Please populate the Provider	Do you want us to provide ACO/HPN or narrow networks in the same format as Appendix V? Is it okay if we create separate columns on Appendix V to include results for all products or would the State prefer each product provided in a separate Appendix V format?	Yes, it is acceptable for bidders to provide a response for each product included in a bidder’s proposal separate Appendix V format. <i>Note: As an addition to the RFP Terms and Conditions, Section II.C.3.c.b: Instructions for submitting non-redacted electronic copies of the RFP documents, please include the Excel format of Appendices S, T and U (GeoAccess analyses).</i> Using the Appendix V file provided, bidders have been asked to indicate whether providers are in-

		Disruption exhibits for your broad/traditional network and separately for any ACO, HPN or narrow networks included in your proposal. DO NOT SORT THESE FILES. DO NOT DELETE ANY RECORDS.		network/participating ("Yes") or out of network/non-participating ("No"). We recognize that bidders may have shared savings/wrap network arrangements with certain out-of-network providers, and we want to make sure we categorize these providers accurately. Please include a separate indicator as needed for providers that are out-of-network/non-participating but have some level of contracted discounts or savings.
5.	COBRA – Appendix P - COBRA Admin	Appendix P – Medical ASO & Discounts	How many current and pending COBRA participants are there?	There are currently 734 participants in a waiting status and 50 participants who have elected COBRA coverage for health (excludes participants enrolled in COBRA vision or dental).
6.	COBRA – Appendix P - COBRA Admin	Appendix P – Medical ASO & Discounts	What is the average number of Qualifying Events per year?	There are approximately 2,450 Qualifying Events per year.
7.	COBRA – Appendix P - COBRA Admin	Appendix P – Medical ASO & Discounts	What is the average number of Initial Notices per year?	There are approximately 2,600 Initial Notices (“New Hire”) per year.
8.	COBRA – Appendix P - COBRA Admin	Appendix P – Medical ASO & Discounts	What is the average turn-over percentage?	The average turn-over for employees is 9%.
9.	COBRA – Appendix P - COBRA Admin	Appendix P – Medical ASO & Discounts	How many Direct Bill participants are there today?	There are 50 participants currently enrolled in a medical plan.
10.	General/IV. Questionnaire All	General/format	For response options in a check box format with instructions to “Pick one of the following”, is it acceptable to select more than one option if applicable?	Yes, as discussed during the Mandatory Conference Call, you may select more than one option as applicable.

11.	General/IV. Questionnaire All	General/format	Please confirm that responses are only to be bolded since check boxes are not enabled.	Yes, as discussed during the Mandatory Conference Call, please bold your selections. Do not use a colored font or highlighting.
12.	Section II/General Terms and Conditions p. 41-42 #5	<u>Discrepancies, Revisions and Omissions in the RFP</u> – The vendor is fully responsible for the completeness and accuracy of their proposal and for examining this RFP and all addenda. Failure to do so is at the sole risk of the vendor. Should the vendor find discrepancies, omissions, unclear or ambiguous intent or meaning, or terms not appropriate to the services requested in the Scope of Services or Minimum Requirements the vendor shall notify the contact for this RFP. at least ten (10) business days before the proposal due date by submitting the <i>RFP Terms and Conditions Exception Tracking</i> , Appendix F. (continued . . .)	Please confirm the due date for Appendix F. Ten (10) business days before the proposal opening is September 12. Does Appendix F also need to be included in the binder submission or is this Appendix solely for the purpose of Discrepancies, Revisions and Omissions in the RFP?	Confirmed. Ten business days before the proposal opening would be Monday, September 12 th . Please include the Appendix with the box checked that you do not have any exceptions. Note: Discrepancies, Revisions and Omissions in the RFP are items that a bidder believes are missing or incorrect requirements for the product or service, NOT exceptions by the vendor to a requirement or question as the exception applies only to their company’s product or services. For example, if you were being asked to manufacture pencils and the RFP called for blue <u>ink</u> , that is a discrepancy. If the RFP didn’t specify the color of lead, you may consider that an omission if it wasn’t clarified in a pre-bid meeting or a question and answer opportunity as part of the procurement process. If the answer or clarification is only black lead, you might respond in your bid that you can provide lead in various colors and provide that information and pricing.

13.	Appendix F, page 285	Exceptions Tracking	<p>Please confirm Appendix F is the only exhibit due 10 days before proposal opening to include any exceptions to the terms.</p> <p>Confirm Appendix B Response Exception Tracking need only be included in the full RFP response.</p>	<p>Confirmed. Appendix F is the only exhibit due ten business days before the proposal opening and Appendix B is required in the bid response. <i>Please see the explanation above in #12.</i></p>
14.	Appendices: Appendix E, page 284	Officer Certification Form	<p>May a non-officer individual with the authority to bind (vendor) to a contract be sufficient to execute all applicable signature documents for the purpose of this RFP?</p>	<p>Yes, a non-officer individual with the authority to bind your organization to a contract may execute all signature documents of the RFP.</p>
15.	Medicare Advantage Quote	General Question	<p>Is the State looking for us to provide Medicare Advantage specific Performance Guarantees, the commercial performance guarantees since the performance guarantees in Appendix C do not fit with Medicare Advantage?</p>	<p>Yes, TPAs that are submitting a bid on a Medicare Advantage plan should provide Medicare Advantage-specific Performance Guarantees.</p>
16.	Medicare Advantage Quote	Experience and Census files on CD-ROM	<p>The experience shows 22.5k members, while the census included shows 26k Post 65 eligibles. Can you confirm that the additional 3.5k are waivers, or where they are currently?</p>	<p>(To be provided)</p>
17.	Financial Exhibits	N/A	<p>Will the State accept the vendor's supplemental financial exhibits?</p>	<p>Yes, but all fees/shared savings payments/expenses/other costs must be itemized and described on the financial exhibits included with the RFP. As stated in the Minimum</p>

				<p>Requirements Section 3.E, a fee only stated in a response to a question and not stated on the appropriate fee appendix will not be considered by the State. This is applicable for fees that may only be stated on a vendor's supplemental financial exhibits. However, assuming that all fees are itemized and described on the financial exhibits included with the RFP, a vendor may also submit a supplemental financial exhibit in the vendor's own format.</p>
18.	Addendum 2 and Page 8 of the RFP	<p>Addendum 2 – Insertion to the bolded call-out box that begins on page 7 of the RFP, I.0 Introduction:</p> <p><i>If your organization does not provide a fully insured quote along with your proposal response, regardless of the reason for the omission, please note this exception within Appendix B: Responses Exceptions Tracking form, provide a <u>detailed</u> explanation why your organization did not provide a fully insured quote, and submit it with your bid package. Otherwise, if your organization does not provide a fully</i></p>	<p>Based on the wording included in Addendum 2, would you please clarify if quoting fully insured is a requirement of the proposal?</p> <p>Page 8 - <i>All bids must include the following, unless otherwise noted below:</i></p> <p><i>Financial quotes on BOTH a self-funded basis AND fully-insured basis for the administration of EVERY plan included in each bidder's proposal (except for Medicare Advantage, for which only a fully-insured quote is necessary).</i></p>	<p>We are requesting that all bidders provide a fully insured quote, just as we are requesting that bidders respond to all other sections of the RFP questionnaire. However, if any bidder determines that a fully insured quote cannot be provided, just as if a question cannot be answered as it is not relevant to the bidder's proposal, we are requesting that any bidder in this situation will note the fact that they are not providing a fully insured quote, along with the rationale why, in <i>Appendix B: Responses Exceptions Tracking form</i>.</p> <p>Any bidder that does not provide a fully insured quote on a product included within your proposal (for which the bidder provides a self-funded quote), and there is no notation on <i>Appendix B: Responses Exceptions Tracking form</i> indicating that the bidder intentionally did not</p>

		<i>insured quote along with your proposal response, and this exception is not noted within Appendix B, your proposal will be considered incomplete.</i>		provide a fully insured quote, will be considered as having provided an incomplete response to the RFP.
19.	Fully Insured Quote and Trend Guarantee	General	Please provide either a file with claims paid by provider or a repricing file or an expanded disruption file that has paid claims for the most recent year available.	This data will not be provided. In your financial proposal, please outline all assumptions that you have made as a result of not having this data available.
20.	Appendix C Claims Administration Page 270	Intent of Standard/Performance Measure	Please confirm that for a performance guarantee metric with a target range shown (for example 95-97%) we would be considered as having met the intent of the request if our target for that metric was any number within that range (for example 95%.)	Confirmed – But, the State will give stronger consideration to bidders that are able to meet the higher end of the range.
21.	Fully Insured and ASO quotes	General	Please provide a large claim report listing all claimants over \$200k for the most recent rolling 12 month period that matches the most recent 12 months of monthly paid claims experience. Please provide diagnosis and prognosis for each claimant and indicate which plan each claimant is on.	This data will not be provided. In your financial proposal, please outline all assumptions that you have made as a result of not having this data available.
22.	Fully Insured and ASO quotes	General	Are any of the current plans grandfathered?	No, there are no grandfathered plans.

23.	Appendix Q – Fully-Insured Medical Premium Quotes	Format of response	Appendix Q has one Exhibit for PPO/POS Medical Premiums. We anticipate we will likely have one set of premiums for each PPO and POS plan and will not be able to include all plans in one exhibit. Please confirm that we can replicate this exhibit as to provide distinct premium rates for the Comprehensive PPO, First State Basic PPO, CDH Gold and POS plans.	Confirmed, bidders may replicate Appendix Q to provide distinct premium rates by medical plan.
24.	Fully Insured and ASO quotes	General	Please indicate if any benefit plan changes were made at the most recent renewal. If changes were made, please detail the benefit changes or provide benefit summaries for the previous plan year.	The only changes made to the medical plans effective 7/1/2016 were: (1) urgent care visit copays were reduced for the HMO (from \$25 to \$15 per visit) and for the PPO (from \$30 to \$20 per visit), and (2) hi-tech imaging copay was eliminated (from \$35 to \$0) when performed at a non-hospital freestanding facility. This is captured in the 2016 Benefit Enrollment Booklet, available at: http://ben.omb.delaware.gov/oe/documents/2016-booklet-color.pdf?ver=0427
25.	Appendix P- Medical ASO & Discounts	Format	Appendix P states that we should indicate the enrollment assumptions associated with our proposed administrative fee. If we anticipate that our fees may vary based on actual enrollment, should we replicate the ASO fee exhibit for each enrollment bracket, or provide only fees for	Yes, it is acceptable for bidders to replicate the fee exhibits when providing tiered fees based on GHIP enrollment.

			the bracket that assume total replacement of a plan?											
26.	Appendix V – Provider Disruption	Disruption	For the disruption analysis do we need to mark invalid records, excluded services and excluded providers based on quoting options as a No indicator on the disruption analysis? Or is it acceptable to exclude these records?	Bidders should mark any invalid records, excluded services and/or providers with a “No” indicator and note that the record is invalid or the service/provider is excluded. Please do not exclude any records in the disruption analysis.										
27.	Medicare Advantage Quote	General Question	Please provide the 2016 current medical only Post-65 retiree fee.	The current administrative fee for the Medicfill program is \$15.78 per subscriber per month.										
28.	FI and SF Quote	General Question	Please provide the current fees for all plans.	<p><u>Pass-Through DHIN Fee:</u> For both vendors there is a pass-through fee for participation in the Delaware Health Information Network (DHIN) of \$0.78 PEPM.</p> <p>Current administrative fees per subscriber per month for FY17:</p> <p>HIGHMARK</p> <table border="1"> <tr> <td>CDH</td> <td>\$42.25</td> </tr> <tr> <td>HMO</td> <td>\$39.72</td> </tr> <tr> <td>POS</td> <td>\$41.20</td> </tr> <tr> <td>PPO & First State Basic</td> <td>\$41.20</td> </tr> <tr> <td>Medicfill</td> <td>\$15.78</td> </tr> </table>	CDH	\$42.25	HMO	\$39.72	POS	\$41.20	PPO & First State Basic	\$41.20	Medicfill	\$15.78
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				<p><u>Included</u> in Highmark’s administrative fee:</p> <ul style="list-style-type: none"> • NIA Adv Radiology Review \$0.62 • Disease Mgt \$3.35 <p>AETNA</p> <table border="1"> <tr> <td>CDH</td> <td>\$51.11</td> </tr> <tr> <td>HMO</td> <td>\$48.06</td> </tr> </table> <p><u>Included</u> in Aetna’s administrative fee:</p> <ul style="list-style-type: none"> • NIA Facility Site of Selection \$0.07 • Disease Mgt \$4.18 • Wellness \$1.91 <p><u>Aetna’s cost per event or service:</u></p> <p>MedQuery Patient Safety \$1.75 Appeals and Grievances \$1.02</p>	CDH	\$51.11	HMO	\$48.06
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29.	Appendix S, T and U and 1.0 GeoAccess, page 252	The results of your GeoAccess should be populated for your broad/traditional network and separately for any ACO, HPN or narrow networks included in your proposal. (continued)	Please confirm that you will want three GeoAccess reports for each product quoted, providing each by Active (those listed as active full-time on the census), Retiree (those listed as Medicare eligible retiree on the census) and Participating Group GHIP (entire census).	<p>The State is requesting that the GeoAccess reports are produced as follows:</p> <ul style="list-style-type: none"> • For the five active medical plans (HMO, Comprehensive PPO, First State Basic PPO, CDHP, and closed POS/Port Authority plan) – 1 GeoAccess for Actives/Non-Medicare eligible Retirees (combined) for each network and/or plan included in a bidder’s response (if more than one network and/or plan is part of their proposal) • For the Medicare Supplemental plan – 1 GeoAccess for Medicare-eligible Retirees 				

				<ul style="list-style-type: none"> For the Medicare Advantage plan – 1 GeoAccess for Medicare-eligible Retirees for each MA network and/or MA plan included in a bidder’s response (if more than one network and/or plan is part of their proposal). 																								
30.	IV. Questionnaire 6.0 Behavioral Health Benefit Administration Question 6.31	Provide your employer book of business statistics for the following, based on paid claims for 2015. Please specify: admits/1,000, Days or visits/1,000 and average visits/days per episode of care.	Please define both “mental health” and “substance abuse” with applicable codes to ensure consistency among bidders.	<table border="1"> <thead> <tr> <th>DRG_CD</th> <th>DRG_DESC</th> <th>DRG_Group_Cd</th> <th>DRG_Group_Desc</th> </tr> </thead> <tbody> <tr> <td>895</td> <td>Alcohol/drug abuse or dependence w rehabilitation therapy</td> <td>20</td> <td>Alcohol/ Drug Use</td> </tr> <tr> <td>880</td> <td>Acute adjustment reaction & psychosocial dysfunction</td> <td>19</td> <td>Mental</td> </tr> <tr> <td>881</td> <td>Depressive neuroses</td> <td>19</td> <td>Mental</td> </tr> <tr> <td>897</td> <td>Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC</td> <td>20</td> <td>Alcohol/ Drug Use</td> </tr> <tr> <td colspan="4">All – Inpatient Type Rollup – MH/SA</td> </tr> </tbody> </table>	DRG_CD	DRG_DESC	DRG_Group_Cd	DRG_Group_Desc	895	Alcohol/drug abuse or dependence w rehabilitation therapy	20	Alcohol/ Drug Use	880	Acute adjustment reaction & psychosocial dysfunction	19	Mental	881	Depressive neuroses	19	Mental	897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	20	Alcohol/ Drug Use	All – Inpatient Type Rollup – MH/SA			
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31.	IV. Questionnaire 5.0 Health Savings Account (HSA) Administration Question 5.39	Will you report earnings on investments in a participant's HSA separately for amounts that may have exceeded the annual maximum?	Please provide further explanation on intent of this question. We are unsure if we are interpreting the question correctly.	The State expects the HSA administrator will provide reports to participants with details on any earnings/deposits that exceed the annual maximum contribution limit. This question addresses the bidders’																								

				capabilities to report on different sources of income into the account (e.g., earnings on investments, employee deposits, employer deposits).
32.	IV. Questionnaire 5.0 Network Financial Information Question 5.1	Does your organization have experience working with and assisting State purchasers (or other states/governments) with benefit design recommendations that support value-based purchasing success, including sharing performance/reporting data with them?	Please define what is meant by “value-based purchasing”...	Value-based purchasing refers to the value-based contracting models noted in the RFP Section IV.C. on page 148. As the Network Financial Information Section (IV.C.5.0) applies specifically to ACOs, this question is intended to assess bidders’ experience with designing benefits that support the effectiveness of an ACO model.
33.	IV. Questionnaire 6.0 Behavioral Health Benefit Administration Question 6.5	Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance: Indicate whether 6.5 Utilization management timing, criteria and sanctions for inpatient as well as outpatient services.	What is meant by “sanctions”? (last sentence)	“Sanctions” in this case refers to utilization management penalties for failure to pre-certify services.
34.	II. Terms and Conditions B. General Terms and Conditions Required Reporting of Fees and 2nd Tier Spend	A complete and accurate Usage Report (for illustrative purposes, Attachment 4) shall be furnished in an Excel format and submitted electronically to the	Please confirm our interpretation of this request: (Company) is a vendor of the SOD to provide claims administrative services. As	As stated in the last sentence, SBO will submit this report on your behalf. To confirm, only administrative fees are reported.

		State’s central procurement office no later than the 15th (or next business day after the 15th day) of each month, stating the administrative fees on this contract. <i>The SBO will submit this report on your behalf.</i>	such, we would only insert our ASO fees.	
35.	II. Terms and Conditions B. General Terms and Conditions Required Reporting of Fees and 2nd Tier Spend	“The successful Vendor will be required to accurately report on the participation by Diversity Suppliers which includes: minority (MBE), woman (WBE), veteran owned business (VOBE), or service disabled veteran owned business (SDVOBE) <u>under this awarded contract.</u> ”	We leverage our subcontractors to support all customers and can only report 2nd Tier <u>Indirect</u> spend. Based on the bolded/underlined portion of this question, are you requesting Direct, SOD-specific reporting on a 2 nd -tier basis?	Yes, only spending by certified Diversity Suppliers for sums that can be identified specific to the State of Delaware’s account. Awarded vendors will be asked for this information and SBO will submit this report on your behalf.
36.	Appendix C – Performance Guarantees	Overpayment Recovery – The percentage of overpaid funds recovered within the stated number days. Measure: 85% recovered within 120 calendar days Frequency: Quarterly Fee at Risk: 0.5%	How are you defining Overpayment Recovery (i.e., identified via audit; internally; etc.)? What would you consider the start date of the timeframe as well as the end date?	Overpayment Recovery will be defined in a manner that is mutually agreeable to the State and the selected TPA. Please provide your definition of Overpayment Recovery as it would apply in this performance measure. The start date would be the effective date of the plan (i.e., 7/1/2017 for active employee medical plans); the end date would be the end date of the contract period (either initial or renewal).

37.	IV. Questionnaire G. Medicare Advantage 6.0 Claims Administration Question 6.6	For the proposed claim office, what are the average elapsed times for the most recent full calendar year for the following (number of days): a. Between clean claim submission and repricing b. Between repricing and adjudication c. Between adjudication and transmission of EOB	What is meant by “repricing” for #6.6.a and b.?	Repricing” a Medicare Advantage claim refers to the process during claim adjudication of removing any offsets from the federal government when determining the member cost share and net plan cost.												
38.	IV. Questionnaire 10.0 Network Financial Information #10.13	Physician/Non-facility utilization and cost: Complete the following table indicating the commercial business for the most recent full calendar year. (continued . . .)	The codes are not consecutive and CPT4 codes for hospital claims are non-existent. We need clarification. Codes in question include: CPT 70460-26: CAT, head or brain, w contrast CPT 73610-26: X-Ray exam, ankle complete CPT 73721-26: MRI, any joint of lower extremity CPT 70460-26: CAT, head or brain, w contrast	<table border="1"> <thead> <tr> <th>Cpt_Cd</th> <th>Cpt_Short_Desc</th> <th>Cpt_Detailed_Description</th> </tr> </thead> <tbody> <tr> <td>70460</td> <td>Ct Head/Brain W/Dye</td> <td>Ct Head/Brn C+ Matrl</td> </tr> <tr> <td>73610</td> <td>X-Ray Exam Of Ankle</td> <td>Radex Ankle Compl Minimum 3 Views</td> </tr> <tr> <td>73721</td> <td>Mri Jnt Of Lwr Extre W/O Dye</td> <td>Mri Any Jt Lxtr C-Matrl</td> </tr> </tbody> </table>	Cpt_Cd	Cpt_Short_Desc	Cpt_Detailed_Description	70460	Ct Head/Brain W/Dye	Ct Head/Brn C+ Matrl	73610	X-Ray Exam Of Ankle	Radex Ankle Compl Minimum 3 Views	73721	Mri Jnt Of Lwr Extre W/O Dye	Mri Any Jt Lxtr C-Matrl
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73721	Mri Jnt Of Lwr Extre W/O Dye	Mri Any Jt Lxtr C-Matrl														
39.	Section VIII. Technical Standards File Layouts, #1.e.	Please confirm your ability and willingness to modify any existing or proposed file layouts as requested to	Please reconfirm this requirement as it is very broad, especially the reference to “various engagement and	Section IV.B Question 16.3 lists several fields relevant to value based contracting models (e.g., ACO, bundled payments) which are intended to be included on the TPA’s												

		accommodate value based payment models and various engagement and consumerism tools that may be implemented as part of an awarded contract.	consumerism tools” as it could reference many different items.	file to Truven. While these fields may not encompass the entire scope of modifications to existing or proposed file layouts, they do represent the majority of updates requested and reflect the type of information that the State would like Truven to collect in addition to the standard file feeds in place today.
40.	II. Terms and Conditions Section B. Contract Term/Rate Guarantee Periods	The term of the contract will be for three (3) years beginning July 1, 2017 (FY18, FY19 and FY20), with the exception of the Medicare Supplement and Medicare Advantage plans, which will have a three (3) year contract term beginning January 1, 2018 (FY18, FY19, FY20, FY21). (continued . . .)	Can we assume the financial terms guarantee applies to administrative fees verses a fully insured proposal? The statement specifically excludes Medicare Supplement and Medicare Advantage, but does not reference insured medical plans.	The financial terms would apply to fully insured proposals as well.

41.	II. Terms and Conditions B. General Terms and Conditions Offshore Vendor Activity	An <u>activity central to the Scope of Services cannot take place at a physical location outside of the United States</u> . Only support activities, including those by a subcontractor, may be performed at satellite facilities such as a foreign office or division. Failure to adhere to this requirement is cause for elimination from future consideration.	Can “support activities” include any portion of claim adjudication or enrollment work, recognizing that the majority of that work would reside in the United States? For example, would it be acceptable to the State if less than xx% of claim adjudication or manual enrollment records were handled by a subcontractor located outside of the United States?	Yes, it would be acceptable for subcontractors to process claim adjudication or manual enrollment records <u>if the records are transmitted securely</u> (i.e., SFTP file transfer or secured email). In your response, please provide a detailed explanation of services and data security measures and also include the percentage of claims estimated to be processed offshore for the State of Delaware’s account.
42.	Appendix C – Performance Guarantees	<p>Financial Guarantees Sub-section:</p> <p>Performance: Trend reduction through value-based contracting</p> <p>Standard: Verifiable reduction in the State’s per employee per year (PEPY) medical trend by 0.5% in Year 1 and 1.0% in Year 2 and each year afterward.</p> <p>Performance Measure: 0.5% in Year 1 1.0% in Year 2 and each year afterward</p>	What is the performance measurement methodology? What does success look like?	The methodology for this guarantee would be mutually agreed upon by the selected TPA and the State. Success will be measured as the reduction in the State’s PEPY medical trend by 0.5% in Year 1 and 1.0% in Year 2 and each year afterward.

43.	Appendix C - Performance Guarantees Pages 273-277	Data Security, Timeliness of Responding to CMS Demands, and Customer Service	In reference to the performance guarantees, there are a few items that the frequency of reporting is “ongoing”. Could you please define or clarify what is expected?	It is the State’s expectation that “ongoing” performance measures would be reported on by the selected TPA on a quarterly basis, provided that any urgent or high priority issues are escalated to the State prior to waiting until the next quarterly report.
44.	Minimum Requirements - #10	Please confirm that a designated member service manager will be assigned to this account. What percent of their time would be spend on the State’s account? As an exhibit, please provide a statement detailing such experience and a resume.	What primary responsibilities would this person be expected to take on?	The State expects that the primary responsibilities of the designated member service manager would encompass all of the typical account management responsibilities of someone within this role, including availability to address ad hoc questions/issues from the State, availability to participate in ongoing status calls/meetings, participation in ongoing reporting process (interpretation of results, raising process improvement recommendations based on reported results).
45.	Attachment 1 - Master Report List w-Legend	SBO - 30/Medicfill No Form (No Sanction)	We would need clarification on this report. Medicfill is a registered trademark of Highmark Blue Cross Blue Shield Delaware. What would you like us to confirm?	This report refers to S-COB (Spousal Coordination of Benefits) reporting. Currently, the SCOB policy has not required pensioners that cover a spouse to submit a SCOB form unless the spouse’s employment or health insurance status has changed since July 2012. Though we have not required Highmark to provide reporting on the Medicare primary spouses in recent years, in the event that we want to audit this group for compliance with the SCOB policy,

				this reporting may be required. The report would be applicable to Medicare Advantage plan participants as well.
46.	Questionnaire C. Health Care Delivery 4 – ACOs #4.1	Does the ACO have metrics (process, outcomes, goals, and benchmarks) to address the State's employees' and members' top 10 service/conditions that have demonstrated variation (cost and utilization)?	What are the State's employees' and members' top 10 service/conditions that have demonstrated variation (cost and utilization)?	Please assume that the top health services/conditions utilized by State's population is not materially different from other large employers with segments of the population enrolled in commercial insurance and in Medicare.
47.	Appendix C - Performance Guarantees	Timely Submission of Data to Data Mining Vendor	What does the State mean by Timely Submission of Data to Data Mining and Vendor Claims & eligibility sent by the 15th of the month for Claims & Enrollment files?	This requirement means that the TPA will need to send claims and eligibility files by the 15 th of the month; any later is not considered to be timely. For instance, data for the month of April must be sent by no later than May 15 th .

48.	Appendix C - Performance Guarantees	<p>Enrollment Support: Accurate enrollment materials will be distributed to State employees in advance of open enrollment period. To provide accurate information to members . . . , all standard communications prepared by Vendor shall contain clarification that not all Vendor’s programs, processes, services, etc. pertain to members of the State of Delaware’s Group Health Insurance Program. Additionally, the Plan Sponsor reserves the right to review in advance . . . All communications related to State of Delaware annual Open Enrollment . . .</p>	<p>We have an obligation to maintain member privacy. With that said, we think the requirement needs some exclusions or clarifications: “Additionally, the Plan Sponsor reserves the right to review in advance all print communications being mailed or available electronically to State of Delaware members, excluding member communications that are protected under privacy laws and regulations.” (A letter to a member about a claim, or an explanation of benefits, are examples of print communications that are mailed to members or available electronically that (vendor) could not allow to be subjected to state review.) Would the State consider this alternative language?</p>	<p>This is acceptable to the State. This performance requirement is related to communications that are broadly provided to all eligible employees for Open Enrollment; this does not include specific, member-identifiable communications with Protected Health Information, such as Explanation of Benefits forms, claims, etc.</p>
49.	Minimum Requirements – C. Benefit Administration #17	<p>Please confirm that your organization will provide communications including the production and distribution of promotional materials at no cost to the State and participants to approximately 125 human resource offices</p>	<p>Could you define what type and how many of communications the State would like. What type of distribution method is expected?</p>	<p>For 2016 Open Enrollment, the Statewide Benefits Office (SBO) hosted several events where employees, pensioners and HR/benefit representatives could attend: Employee Education Sessions - We held nine sessions.</p>

		<p>with the State of Delaware concerning the open enrollment period.</p>		<p>We asked our vendors to bring enough materials* for 150 participants at each session.</p> <p>Vendors also provided several (5-20) larger, more expensive giveaway items as part of a random drawing for participants (e.g., \$50 visa gift cards, iPads)</p> <p>Benefit Representative Meetings - We held three meetings.</p> <p>We asked our vendors to bring enough materials* for 100 participants at each session.</p> <p>Vendors also provided several (5-20) larger, more expensive giveaway items as part of a random drawing for participants (e.g., \$50 visa gift cards, iPads)</p> <p>Health Fairs – We held four fairs.</p> <p>We asked our vendors to bring enough materials* for 300 participants at each session.</p> <p><i>*Examples of promotional materials included printed full-color handouts/ brochures/ booklets about benefit offerings, as well as giveaway items like notebooks, pens, magnets; stress balls, water bottles and/or umbrellas. Vendors also provide electronic copies of the printed materials to SBO; If vendors could not bring giveaway items with them to the events, they shipped the materials ahead of time to a specific site so the materials would be at the event when they arrived.</i></p>
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				In addition, some of the participating groups under the health plan (e.g., University of Delaware and Delaware Transit Corporation) hold their own health fairs (approx. 1-5) each open enrollment where the health vendor attends.
50.	Attachment 1 - Master Report List w-Legend	Attachment 1 - Master Report List w-Legend	On the first tab, the first 9 rows are hidden. Do we need to address those reports or just ignore?	Please see the attached Revised Attachment 1 with the first nine rows revealed. Those reports are required and are referenced in the Legend.
51.	Attachment 1 - Master Report List w-Legend	SBO - 21 - Customer Service Report - Legend Info - Customer Service Report is provided 45 days after end of quarter; hard copy is provided at Quarterly Meeting.	What information is needed for this report?	The Customer Service Report includes the type of inquiry (appeals, claims, etc.), the line of business (IPA, PPO, etc.) and method of inquiry (telephone, internet, etc.). The first page of the report includes all plans while the second page provides the CDH Gold breakout (and therefore does not include the line of business).
52.	Attachment 1 - Master Report List w-Legend	SBO-31 - Enrollment Reports - Enrollment Reports show monthly enrollment by group and by tier due by 15th of each month.	Could you specify the group and tiers for this reporting requirement?	Refer to Attachment 6 on the disc, GHIP Groups. For each group, the number enrolled in each plan (PPO, HMO, etc.) per tier (employee only, employee and spouse, etc.).
53.	Attachment 1 - Master Report List w-Legend	SBO 32 - Performance, Medical Management and Financial Reports w/OPEB and Non-OPEB Reports - Performance, Medical Mgmt, Financial Report w OPEB and Non-	What type of reporting should be included with the Financial reporting? This ties back to Minimum Requirement 67 (Please confirm that your organization must provide financial reporting 45 days (under no circumstances to	Please see the attached reports as samples of quarterly financial reporting required by the State.

		OPEB Reports; due 45 days after end of quarter.	exceed 60 days) following the end of each quarter.) Could we get clarification around the types of reports they want to see in the performance reports?	
54.	D. Health Management 1.0 Health Mgt Program Admin #1.5	Initial outreach - Every bolded category - Initial outreach (i.e., nurse, auto-dialer, etc.)	There seems to be missing the checkbox for "Clinician." Should Clinician should be an option?	Yes, Clinician should be included as an option.
55.	Misc Question	Misc Question	<p>Please describe your current Case Management and Disease Management offering in greater detail.</p> <p>a. What is the prevalence rate by disease state?</p> <p>b. What is your Case Management reach/engagement rate?</p> <p>c. What percent of members with a chronic illness are identified as high risk, moderate risk and low risk? Of those, what percent are engaged telephonically?</p>	<p>For an overview of our current disease management tools, resources and services, please visit http://ben.omb.delaware.gov/delawell/index.shtml and select "2016-2017 Program Year." Services include the ability for members to work with a nurse coach telephonically to better manage conditions like diabetes, arthritis, COPD, heart disease and back pain. Our health vendors outreach to high risk participants via telephone and home mailings.</p> <p>a. See the chart at the end of this document which was taken from Page 12 of Task Force Final Report.</p> <p>b. Participation rate for disease management is approximately 3%.</p> <p>c. (To be provided)</p>
56.	Misc Question	Misc Question	Please provide the current ROI attained by the Case Management and Disease Management programs, as well	<p>Below are some of our past successes from FY2011-FY2015:</p> <ul style="list-style-type: none"> • Participants actively engaged with a nurse care manager in the disease

			as a list of clinical care and utilization improvement statistics.	<p>management program experienced an 18% higher clinical adherence (i.e., medication usage and recommended screenings) rate.</p> <ul style="list-style-type: none"> • Interactions with participants with chronic conditions have succeeded in improving inpatient utilization for members engaged in the chronic condition care program, with 13.2% improvement in hospital utilization. • Over 50% of health coaching participants reported increased fruit/vegetable intake, physical activity or ability to deal with stress • Savings of roughly \$16 million through the disease management program as measured by reduction in hospital admissions.
57.	Misc Question	Misc Question	Please provide additional insight into what is working well in Case Management and Disease Management and what you would like to see improved.	<p>Main areas for improvement include (1) the need to drive additional engagement in these current programs among the GHIP population appropriate for management, and (2) the need for performance guarantees related to these programs to be more focused on improvements in clinical outcomes and less focused on process and operational achievements. While the State understands the importance of running an operationally sound program, it is not sufficiently driving the desired outcomes in the population.</p>

58.	Misc Question	Misc Question	<p>Please describe your current wellness offering in greater detail.</p> <ol style="list-style-type: none"> a. What percent of members complete the Health Assessment each year? b. Of those that complete a Health Assessment, what percent participate in lifestyle modification programs? c. What lifestyle modification programs are offered today? d. What percent of members are outreached to by a Health Coach for telephonic counseling, and what percent perform their lifestyle modification programs online? e. Do you perform biometric screenings on site each year? If so, how many do you host, how many locations are they held at, and how many people participate? f. What results have been achieved with these current programs, risk reduction improvement, improvements in lifestyle modifications, please provide the actual results. 	<p>For an overview of our current wellness tools, resources and services, please visit http://ben.omb.delaware.gov/delawell/index.shtml and select “2016-2017 Program Year.”</p> <ol style="list-style-type: none"> a. The participation rate was approximately 6% in FY2015. b. The participation rate for health coaching was approximately 4% in FY2015. c. Telephonic health coaching (i.e., weight management, stress management, tobacco cessation, nutrition and physical activity), wellness and gym discounts and online programs and resources. d. Please see “b” for health coaching participation rate. e. The State of Delaware discontinued offering onsite health screenings in FY2016. Past participation in onsite screenings was low at 5%. Survey research conducted in 2014 revealed that State employees preferred to work with their own doctor and there were concerns of confidentiality and use of time. The State of Delaware currently encourages members to establish a relationship with their Primary Care Provider (PCP) and schedule an annual physical exam. Most preventive care is
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				<p>covered at 100%, so there is no charge to members for having a physical with their doctor.</p> <p>f. Over 50% of health coaching participants reported increased fruit/vegetable intake, physical activity or ability to deal with stress.</p>
59.	Misc Question	Misc Question	Are you currently, or will you be, incenting members to participate in your programs? If so, please describe the incentive plan.	There are no immediate plans to provide incentives to members; however, bidders should describe their perspective on what incentives (or other interventions/changes) would make these programs effective.
60.	Misc Question	Misc Question	How many educational forums (such as lunch and learns) do you hold each year and at how many locations?	As part of the Open Enrollment period, the Statewide Benefits Office hosts approximately nine employee education sessions (at three different locations) and three benefit representative meetings (at two different locations) each year. In addition, the Statewide Benefits Office is invited by various organizations throughout the year to present benefits information to their employees and/or hold an information table at employee fairs. The number of events can range from 15-45 and are throughout the State of Delaware.
61.	Misc Question	Misc Question	Do you currently have an onsite clinic? If so, how does the Wellness program integrate with the clinic personnel?	No, but the State would expect the selected TPA to share data with an onsite clinic and would coordinate as necessary on shared case management and disease management participants.

62.	Misc Question	Misc Question	Please confirm current HMO is self-funded along with PPO and HRA Plans.	Confirmed, current HMO, PPO and CDHP/HRA plans are all self-funded.
63.	Misc Question	Misc Question	Is it the State's intent that fully insured rates be offered regardless of plan enrollment?	Yes, fully insured rates would be regardless of plan enrollment.
64.	Misc Question	Misc Question	Will large claim data be made available?	This data will not be provided. In your financial proposal, please outline all assumptions that you have made as a result of not having this data available.
65.	Misc Question	Misc Question	(The) Census indicates 1,924 enrolled in Medicfill, but RFP indicates there are 17,000 Medicare Retirees and latest month of experience shows 22,513 employees?	(To be provided)
66.	Appendix P – Medical ASO & Discounts	Misc Question	Appendix P is set up to accommodate a single enrollment scenario by plan, but it is my understanding that we are being asked to quote on a multi-carrier basis, so are we able to modify the fee exhibits in Appendix P to provide our administrative fees on a tiered enrollment basis?	Confirmed, bidders may replicate Appendix P to provide distinct premium rates by medical plan.
67.	Misc Question	Misc Question	Is there a specific requirement for 2nd tier spending (MBE, WBE, etc.)?	No, the State of Delaware does not mandate that contractors utilize Diversity Suppliers for 2 nd Tier spend.
68.	Minimum Requirements – C. Benefit Administration #26.c.	(Reporting – Please confirm that at no cost to the State) That your	Indicates 3 Separate Employer Groups – will the State require 3 separate policy numbers?	The requirement of three separate employer groups is related to the account structure set-up by the State;

		<p>organization can set up the administration of the State's program into an organization of the data as three (3) separate groups – department or agencies, retirees/pensioners, and non-payroll – and include the corresponding State's accounting code and a designation of OPEB or non-OPEB status. (See Attachment 6 for a detailed breakdown of reporting expectations based on employer groups.)</p>		<p>bidders are being asked to respond whether they can establish structure that splits enrollment and claims experience into the three separate groups as required by the State.</p> <p>The State's expectation is that there would only be one (1) contract/policy which would encompass all of the services/plans/programs provided by the selected TPA.</p>
69.	<p>Minimum Requirements – C. Benefit Administration #26.d.</p>	<p>(Reporting – Please confirm that at no cost to the State) That your organization can manage customized tracking and bi-monthly reporting to the TPAs of IVF expenses for a small number of grandfathered members for services under a plan design that was modified in 2010.</p>	<p>Please provide further clarification around this requirement. Is there a separate grandfathered plan for these members?</p>	<p>There is not a separate plan for these members, but there is a separate grandfathered benefit for certain members only for IVF.</p> <p>This will require the TPA and the State's PBM to communicate on an ongoing basis about the utilization of medical and prescription benefits related to IVF for approximately 30 members with a higher lifetime benefit for IVF than the current GHIP participants (i.e., the lifetime limit for these participants is combined for medical and pharmacy benefits, whereas it is not a combined limit for the majority of GHIP participants).</p>

70.	Misc Question	Misc Question	Will the State allow contingency fees to be billed through the bank account (e.g. shared savings program, subrogation)?	Contingency fees and any other fees will need to be pre-approved within the current RFP/negotiation process and will need to be noted on the invoice sent to the State as back-up details supporting the TPA's request for payment.
71.	Questionnaire – VI. Financial Proposal 2.0 Financial Assumptions #2.2	Confirm your guaranteed fees include processing claim runout after termination. If yes, how long will you process claims after contract termination in a runout situation?	Does the State have a specific request as far as the term for run-out processing?	The requested term for run-out claims processing is twelve months after the contract termination date.
72.	Misc Question	Misc Question	What is the current OON reimbursement level?	This data will not be provided at this time.
73.	Misc Question	Misc Question	Regarding the Trend Guarantee: Is the trend guarantee meant to be aggregated across all plans? Please define <i>Base Year Risk Score</i> . Please confirm if unadjusted base costs refer to billed charges or paid claims.	The trend guarantee is meant to be aggregated across all plans. Please provide your definition of base year risk score; the final definition will be mutually agreed upon by the State and the selected TPA. Unadjusted base costs refer to paid claims.
74.	Misc Question	Misc Question	Please confirm Net Pay Med amounts in the claim data include Behavioral Health claims. Also, do net pay amounts include any service fees and/or capitation?	Confirmed. Net Pay Med includes Behavioral Health claims and does not include administrative fees or capitation.
75.	Questionnaire F. Medicare Supplement 3.0 Plan Design	Please review the current plan design (available at http://ben.omb.delaware .	According to the Retiree Group Special Medicfill Plan Summary, services outside the United States are covered if the	Services outside of the United States apply to emergency and urgent care only.

	#3.1	gov) and note any deviations to the State's Medicare Supplement plan that you cannot administer.	services meet Medicare criteria. Please confirm if this applies to all services or only emergency and urgent care services.	
76.	Section III. Minimum Requirements C. Benefit Administration #30	Please confirm your ability to store historical information by member with the Social Security Number and employee/retiree identification number as an access key.	Please explain what data elements are required to be tracked for historical information.	This is in reference to all data elements that the selected TPA will be responsible for tracking. It is necessary that the selected TPA will be able to store and report on the State's data using the State Employee ID number.
77.	Summary claims and enrollment file (July 2013 to June 2016); Provided on Password Protected Disc; Page 6	Summary claims and enrollment file (July 2013 to June 2016)	Can we please obtain the following information for Medicare eligible spouses and dependents covered by the Medicfill plan? It appears that data provided was only for Medicare subscribers: <ul style="list-style-type: none"> • Most recent 24 months of medical claims experience on a month by month basis for Medicare eligible spouses and Medicare eligible dependents containing the following information: <ul style="list-style-type: none"> - Medicare allowed amount - Medicare paid amount - Plan paid claims - Retiree cost share (copays, deductibles) 	(To be provided)
78.	Summary claims and enrollment file (July 2013 to June 2016); Provided on	Summary claims and enrollment file (July 2013 to June 2016);	Can we obtain the most recent 24 months of monthly membership counts for all	(To be provided)

	<p>Password Protected Disc; Page 6</p>		<p>Retiree Group Special Medicfill Plan retirees (please include eligible spouses and dependents) that correspond with Medicfill claims experience. It appears that original experience data did not include Medicare eligible spouses or dependents. Please clarify.</p>	
<p>79.</p>	<p>Section I. Introduction, (Bolded Box) Page 8</p>	<p>All bids that include proposals for either the Medicare Supplement plan or the Medicare Advantage plan must at a <u>minimum</u> complete the following sub-sections under Section IV. Questionnaire, along with other major sections of this RFP outside of the Questionnaire (i.e., Sections III, V, VI, VII, VIII and Appendices):</p> <ul style="list-style-type: none"> • IV.A Bidder Profile, • IV.C Health Care Delivery, • IV.D Health Management, • IV.E Member Support, Tools and Resources, • IV.F Medicare Supplement (for 	<p>Please confirm that for a proposal submission Group Medicare Advantage only that the vendor will complete ONLY the following subsections under Section IV, Questionnaire:</p> <ul style="list-style-type: none"> A – Bidder Profile C – Health care Delivery D – Health Management E – Member Support, Tolls, Resources G – Medicare Advantage <p>Please confirm that for a Medicare Advantage proposal submission, the Vendor WILL NOT include any other sections than those listed above.</p>	<p>Confirmed that these are the only sub-sections of Section IV. <i>Questionnaire</i> that are required.</p> <p>However, bidders are also required to respond the other major sections of the RFP which include:</p> <ul style="list-style-type: none"> • Minimum Requirements (Section III) • Network Adequacy (Section V) • Financial Proposal (VI) and • Technical Standards and Security Requirements (VIII) (for a fully-insured plan). <p>Ultimately, it is the bidder’s responsibility to review the RFP and reply to all requirements, questions and sections that apply to the plan designs in its bid. Please prepare your bid response accordingly.</p>

		<p>proposals including this plan), and</p> <ul style="list-style-type: none"> • IV.G Medicare Advantage (for proposals including this plan). 		
80.	State of Delaware Group Health Insurance Program, New Rates Effective July 1, 2016 - From State Website	Fully-Insured Medical Premium Quotes	Are there 2017 renewal rates available or any additional rate history for the Medicfill plan?	Special Medicfill rates for the 2016 and 2017 plan years are posted at http://ben.omb.delaware.gov/script/retiree_medicare.shtml .
81.	State of Delaware- Group Special Medicfill Guide to Benefits- From State Website	Benefit Design for Non-Medicare Covered Services	Please confirm Private Duty Nursing is the only non-Medicare covered service on this plan. If there are additional, can you please provide the specific benefits?	The Special Medicfill benefit booklets for the 2016 and 2017 plan years are posted at http://ben.omb.delaware.gov/medical/bcbs/index.shtml . Details on coverage for private duty nursing and other covered benefits are fully described in these booklets.
82.	Attachment 6- Census 07.29.2016	Census	Are there any working aged members included on the census? That is, any retirees that are 65 or older, but still actively working?	If a State retiree returns to work as a permanent full time employee, he or she would then have their benefits through the active group and be shown on the census provided with this RFF, regardless of their age. If a retiree returns to work as a casual/seasonal employee, then he or she maintains their health benefits through the pension group and would not be shown on the census provided.
83.	State of Delaware Group Health Insurance Program, New Rates Effective July	Employer Contribution to Premium	Please confirm the average contribution of the State of Delaware to the retiree's total premium. If it varies at all, can	State of Delaware Rates tables for non-Medicare and Medicare eligible pensioners along with the percentage of premium paid by the state based on

	1, 2016- From State Website		you please specify the variances?	<p>service years can be found at http://www.delawarepensions.com/PDF/2016RateSheets/Rates%20-%20Non-MED%20EFF%207.1.16New.pdf and http://www.delawarepensions.com/PDF/2016RateSheets/Published%20Rates%20-%20MED%20EFF%201.1.16%20Website.pdf. The percentage of pensioners who receive state share contributions toward their premiums and the corresponding state share percentages are as follows:</p> <ul style="list-style-type: none"> • Receiving 100% of State Share: 94% of enrolled pensioners • Receiving 75% of State Share: 3% of enrolled pensioners • Receiving 50% of State Share: 2% of enrolled pensioners • Receiving 0% of State Share: 1% of enrolled pensioners
84.	Attachment 6- Claims and Enrollment 071113 - 063016, Medicfill tab	Claims Data	Please confirm the copayments/coinsurance listed on the claims data applies only to the Rx.	The copayments/ coinsurance listed on the claims data consist of mostly Rx copayments/coinsurance, however, a small portion of these amounts are copay med/copay insurance.
85.	Page 11 of RFP & Attachment 6 - Claims and Enrollment 071113 - 063016, Medicfill tab	Claims Data	We recognize that dental and vision benefit plans are 100% employee-pay-all. Can you confirm that the claims data is exclusive of these benefits?	Confirmed. The claims data is exclusive of the dental and vision benefits.

86.	Section 1- Important Dates, p. 10	Timeline for Rate Delivery	Will (vendor) have the opportunity to firm up at least the CMS reimbursement portion of the 2018 rating upon release of the Ratebook?	Yes. CMS typically releases the Rate Book at the end of July for the following year; i.e., the 2017 rate book was released on July 29, 2016.
87.	Appendices/ Appendix D.	<p>1st question: Second Paragraph:</p> <p><i>Vendor will base the Claim Trend Guarantee calculation on a full year of 2016 claims. Vendor will require 2016 monthly incurred claims and capitation charges, by plan, paid through March 31, 2017 with corresponding monthly enrollment for a continuously enrolled population.</i></p>	<p>*Requesting clarification on this statement, given the timing of the RFP response and the requested incurred timeframe. Is the assumption the actual trends used for guarantee will be presented and agreed upon in 2017.</p> <p>Penalties – are the penalties below illustrative only and proposed by the carriers, or are these the reductions being requested?</p>	<p>The State is comfortable with the bidders responding with their general agreement or disagreement with the guarantee, with a detailed explanation of a bidder’s feedback if there are any points of disagreement with the proposed trend guarantee.</p> <p>Regarding the question of penalties, these are the proposed penalties for this guarantee.</p>

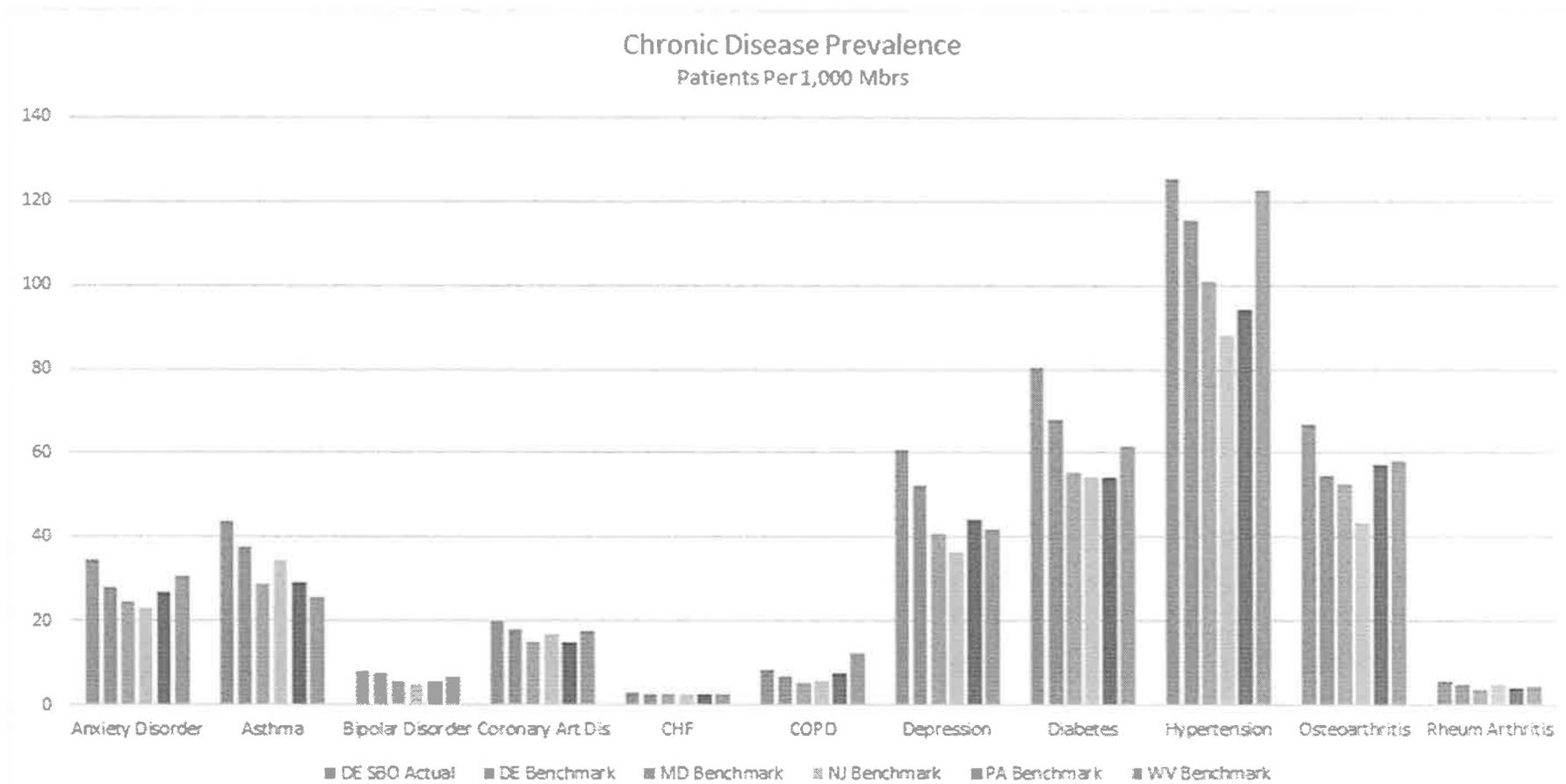
***Financial Trend Projection Chart**

Term	Year 1	Year 2	Year 3	Year 4	Year 5
Unadjusted Base Costs PMPM					
Base Year Risk Score					
Adjusted Base Cost PMPM					
Benchmark Trend Rates (cumulative)					

Annual Trend Guarantee Rate (Cumulative)					
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Item	Illustrative Trend Factor
Annual Trend	__%
Guaranteed Trend Factor	__%
Actual 2017 Trend	Reduction to 2017 ASO Fee
Less than 6.0%	No Penalty
6.0% to 7.0%	-2.50%
7.1% to 8.0%	-5.00%
8.1% to 9.0%	-7.50%
9.1% or Greater	-10.00%

(continued on the next page . . .)



REVISED Attachment 1 - Master Report List Template
Due dates can be revised only upon mutual agreement.

Note: Vendor-specific list will include columns for Path, Sending Contact, Receiving Contact, Vendor Remarks, and SBO Storage Location.

Reference (See Legend)	Report Description	Direction	Frequency	Method	Due Date
SBO-1	ASO Invoice & Summary Back-Up	Vendor to State	Monthly	Secure website	Wednesday following last Friday of each month
SBO-2	Weekly Claims Invoice & Summary Back-Up	Vendor to State	Weekly	Secure website	Each Wednesday
SBO-3	Membership Listing - Non-Payroll Groups (NEBS)	Vendor to State	Monthly	All placed on SOD Secure Server	1st Saturday of Each Month
SBO-4	Membership Listing (PHRST, COBRA, and UD)	Vendor to State	Monthly	All placed on SOD Secure Server	1st Saturday of Each Month
SBO-5	Payroll Reconciliation-PHRST (Part A-1 and A-2)NOTE: * and Quarterly Meeting reports due 3 business days prior to meeting and overview are due 3 business days after the meeting. Hard copy to be provided at meeting.)	State to Vendor	Monthly	File retrieved from State Server	Wednesday prior to the last pay of the month
SBO-6	Payroll Reconciliation-PHRST (SBO)(Part B)	Vendor to State	Monthly	Vendor splits State's recon report into 2 files and places on SOD server	Data is entered on two reports and resent to website approximately one week after State posts it.
	Payroll Reconciliation Feedback PHRST (Part C)	Vendor to State	Monthly as needed	SBO places on SOD server for Vendor pickup	Follow ups are delivered to Vendor prior to posting of next month's payroll
Weekly 834 Enrollment Files					
SBO - 9	PHRST	State to Vendor	Weekly	State Server	Posted on secure website by Monday of each week
SBO - 10	Pension	Pension Office to Vendor	Weekly	State Secure Website	Every Monday
SBO - 11	U of D (University of Delaware)	UoD to Vendor	Weekly	State Secure Website	Every Monday
SBO - 12	DART (aka DTC)	DTC to Vendor	Bi-Monthly	Vendor Server	10th and 25th of each month
	NEBS (Participating Groups)	State to Vendor	Weekly	SFTP	Every Monday
834 Enrollment File Discrepancy Reporting					
SBO - 13	PHRST	Vendor to PHRST Groups	Weekly as needed	Secure e-mail	Within one week of file submission, if required

REVISED Attachment 1 - Master Report List Template
Due dates can be revised only upon mutual agreement.

Note: Vendor-specific list will include columns for Path, Sending Contact, Receiving Contact, Vendor Remarks, and SBO Storage Location.

Reference (See Legend)	Report Description	Direction	Frequency	Method	Due Date
SBO - 14	Pension	Vendor to Pension Office	Weekly	Secure e-mail	Within one week of file submission, if required
SBO - 15	U of D	Vendor to U of D	Weekly	Secure e-mail	Within one week of file submission, if required
SBO - 16	DART (aka DTC)	Vendor to DTC	Weekly	Secure e-mail	Within one week of file submission, if required
	NEBS	Vendor to SBO	Weekly	Secure e-mail	Within one week of file submission, if required
Reconciliation Reporting					
SBO - 5	Payroll File for Reconciliation (Part A)	State to Vendor	Monthly	File retrieved from State Server	Wednesday prior to the last pay of the month
SBO - 6	Payroll Reconciliation (Part B)	Vendor to State	Monthly	Secure e-mail.	Data is entered on three reports and resent to website approximately one week after State posts it.
SBO - 7	Pension Payroll Reconciliation Feedback (Part C)	Vendor to State	Monthly-as needed	Pension places on SOD server for Vendor pickup	Follow-ups are delivered to Vendor prior to posting of next month's payroll
Wellness Reporting					
	Aggregate DelaWELL Health Management Program Participation Report	Vendor to State	Monthly	Email	15 days after the end of the month
	DelaWELL Health Management Program Participation Report (Detailed)	Vendor to State	Monthly	Email	15 days after the end of the month only if it is determined an incentive will be provided.
	Annual Preventive Exam Participation Report	Vendor to State	Annually	Email	6 weeks after the close of the program year
	Annual Wellness Profile Aggregate Report	Vendor to State	Annually	Email	6 weeks after the close of the program year
	Annual Savings Cohort Report	Vendor to State	Annually	Email	6 weeks after the close of the program year
	Annual Wellness Profile T1T2 Comparison Report	Vendor to State	Annually	Email	6 weeks after the close of the program year

REVISED Attachment 1 - Master Report List Template

Due dates can be revised only upon mutual agreement.

Note: Vendor-specific list will include columns for Path, Sending Contact, Receiving Contact, Vendor Remarks, and SBO Storage Location.

Reference (See Legend)	Report Description	Direction	Frequency	Method	Due Date
Disease Management Reporting					
	Operational & Clinical Program Participation Dashboard	Vendor to State	Quarterly	Email	30 days after the end of the quarter
	Blues on Call Activity	Vendor to State	Quarterly	Email	30 days after the end of the quarter
	Web Portal Activity	Vendor to State	Quarterly	Email	30 days after the end of the quarter
	Annual Utilization & Financial Review	Vendor to State	Quarterly	Email	mid-October following end of PY
	Annual Clinical Performance Review	Vendor to State	Quarterly	Email	mid-October following end of PY
Other Reporting					
SBO - 17	Aging Report (formerly known as TEFRA/DEFRA) (Pension Office receives differently; U of D; Statewide Benefits; Non-Payroll Groups)	Vendor to State	Monthly & Annual	SFTP	First Wednesday of Month
SBO - 18	Infertility Approval Request	Vendor to State	As needed	Secure e-mail	As necessary
SBO - 19	IVF Rx Report for IVF Grandfathered Members	State to Vendor	Quarterly	Secure e-mail	45 Days After End of Qtr.
SBO - 20	IVF Report Total for Grandfathered and Non-grandfathered Members	Vendor to State	Quarterly	Secure e-mail	3 days prior to quarterly meeting
SBO - 21	Customer Service Report	Vendor to State	Quarterly	Secure e-mail	3 days prior to quarterly meeting
SBO - 22	Subscriber Satisfaction Survey	Vendor to State	Biannual	Secure e-mail	3 days prior to Quarterly Mtg Twice a Year = December and June
SBO - 23	Spousal COB Report: List of contract holders effective 7-1 who are non-compliant (No form and sanctioned) with S-COB Policy.	Vendor to State	Annually	Secure e-mail (Date to be announced to move to server)	annually the 4th Monday following the close of OE
SBO - 24	S-COB Report-No Form. Contract holder/spouse non-compliant as has not submitted S-COB form.	Vendor to State	Weekly	Secure e-mail (Date to be announced to move to server)	Every Friday

REVISED Attachment 1 - Master Report List Template
Due dates can be revised only upon mutual agreement.

Note: Vendor-specific list will include columns for Path, Sending Contact, Receiving Contact, Vendor Remarks, and SBO Storage Location.

Reference (See Legend)	Report Description	Direction	Frequency	Method	Due Date
SBO - 25	S-COB Report-Non-Compliant. Contract holder/spouse non-compliant with S-COB policy.	Vendor to State	Weekly	Secure e-mail (Date to be announced to move to server)	Every Friday
SBO - 26	S-COB Report Research Lists	Vendor to State	Weekly	Secure e-mail (Date to be announced to move to server)	As needed
SBO - 30	Medicfill No Form (No sanction)	Vendor to State	Annually	Secure E-Mail	Ad-Hoc
SBO - 31	Enrollment Reports	Vendor to State	Monthly	E-Mail	15th of Month
SBO - 32	Performance, Medical Management and Financial Reports w/OPEB and Non-OPEB Reports	Vendor to State	Quarterly	E-Mail	45 days following end of quarter
SBO - 33	Appeals Report	Vendor to State	Quarterly	Secure E-Mail	3 days prior to quarterly meeting
SBO - 38	Managed Care Tracking Report	Vendor to State	Quarterly	Email	20th of month following due date of Quarterly Report
	SSAE 16 Report	Vendor to State	Annually	Email	December 1 following report year
SBO - 41	NIA (High Tech Radiology) Semi-Annual Financial Report	Vendor to State	Semi-Annual	Secure email	Two reporting periods: 7-1 to 12-31 and 1-1 to 6-30
SBO - 42	NIA (High Tech Radiology) Quarterly Activity Report	Vendor to State	Quarterly	Secure email	Two months following close of quarter
SBO - 43	Account Management Team Report	State to Vendor	Quarterly	Secure email	30 days following end of the calendar quarter
SBO - 46	CDH Gold Plan HRA Reports	HM DE to State	Weekly	Server w e-mail notice	Weekly=Tuesday
SBO - 47	CDH Gold-Fiscal Year End Report	Vendor to State	Annually	Server w e-mail notice	10/15
SBO - 48	CDH Gold-Fiscal Year Start-Up Enrollment of ALL Members Report	Vendor to State	Annually	Server w-email notice	7/20
SBO - 49	CDH Gold-Quarterly-Annual HRA Fund Report per Plan Year by Group	Vendor to State	Quarterly and Annually	Server w-email notice & hard copy at Quarterly/Annual Meeting	45 days following end of quarter

REVISED Attachment 1 - Master Report List Template
Due dates can be revised only upon mutual agreement.

Note: Vendor-specific list will include columns for Path, Sending Contact, Receiving Contact, Vendor Remarks, and SBO Storage Location.

Reference (See Legend)	Report Description	Direction	Frequency	Method	Due Date
SBO - 2	Weekly Claims Back-up	Vendor to State	Weekly	Email	Each Week by Wednesday
SBO - 50	Medicare Eligible Report (Those suspected to be eligible per claims, etc.)	HM DE to State	Weekly and Quarterly	Secure email	Each Week by Wednesday
SBO - 51	Recovery: Overpayment/Incorrect Payment	HM DE to State	Quarterly	Secure email	30 days following end of quarter
SBO - 52	Other States Resident Assessments	HM DE to State	Quarterly	Secure email	30 days following end of quarter
SBO - 53	Issues Log for Monthly Conference Call & Overview of Discussion. NOTE: Issue Logs and Qrtly Meeting reports are due 3 business days prior to meeting and overviews are due 3 business days after the meeting. Hard copy to be provided at meeting.	Vendor to State	Monthly	Email	3 business days prior to Monthly Conference Call with Follow-up 3 business days after Monthly Conference Call.
SBO - 54	Benefit Representative Contact Listing (NOTE: Two listings. PHRST (State) Groups and Non-Payroll Groups	State to Vendor	Pre-OE and as updated	E-Mail	Pre-OE and as updated
Other File Feeds					
SBO - 35	PBM/Rx Eligibility Feed	Vendor to Express Scripts	Weekly	Secure Website	Every Tuesday
SBO - 36	Monthly Claims and Provider Files	Vendor to Truven	Monthly	Secure Website	20th of the month
SBO - 37	Monthly Enrollment	Vendor to Truven	Monthly	Secure website	15th of the month
	Wellness Profile Data	Vendor to Truven	Monthly	Secure website	15th of the month
	Monthly Enrollment	Vendor to DHIN	Monthly	secure website	1st Saturday of every month
	Daily ER and Admissions Report	DHIN to Vendor	Daily	secure website	Daily

Report Name	Legend, Explanation, Notes, etc. per Report No. <i>Italicized reports do not correspond with the Report List, but are required.</i>
SBO - 1	<i>Monthly administrative charges invoice and summary back up to support those charges. Vendor sends to OMB's Financial Operations Unit for payment.</i>
SBO - 2	Weekly claims cost with back up to support those charges. Vendor sends to OMB's Financial Operations Unit for payment.
SBO - 3	<i>Membership listing per agency, school district, non-payroll group sent by Vendor to OMB's Financial Operations Unit and to each non-payroll group for internal reconciliation purposes.</i>
SBO - 4	<i>Membership listing per PHRST, COBRA, UofD (University of Delaware).</i>
SBO - 5	Payroll Reconciliation for PHRST group (Part A). PHRST places on server; SBO renames and Vendor picks up and separates into 2 files: "On State but Not (Vendor)" and "On (Vendor) but Not State" See Comments for SBO - 5 and SBO - 6) and places back on State server. SBO picks up both, reviews and comments,
SBO - 6	Payroll Reconciliation (Recon File) for PHRST group (Part B) is two files (1=on State not on HD; 2= on Vendor not State). SBO works report; stores on T drive.
SBO - 7	Payroll Reconciliation for PHRST group (Part C). SBO e-mails Vendor that file ready to be picked up.
SBO - 8	<i>Payroll Reconciliation for Pension Office. N/A</i>
SBO - 9	Electronic Enrollment (Part A) from SBO each Monday to server for Vendor pick up.
SBO - 10	Electronic Enrollment (Part B) from Pension Office each Monday to server for Vendor pick up.
SBO - 11	Electronic Enrollment (Part C) from University of Delaware each Monday to server for Vendor pick up.
SBO - 12	Electronic Enrollment (Part D) from Dart (DTC) to server for Vendor pick up on 10th and 25th of each month for purpose highlighting concerns.
SBO - 13	Electronic Enrollment Feedback (Part A) from Vendor to State agencies and schools in PHRST by secure e-mail for Benefit Representatives to investigate concerns further.
SBO - 14	Electronic Enrollment Feedback (Part A) from Vendor to Pension Office via server for purpose of
SBO - 15	Electronic Enrollment Feedback (Part B) from Vendor to University of Delaware via server for purpose of
SBO - 16	Electronic Enrollment Feedback (Part D) from Vendor to Dart (DTC) via server for purpose of
SBO - 17	Ageing Report shows those approaching age 65; SBO separates by agency, schools, and sends to Ben Rep for follow up processing (see Ben Rep website with TEFRA/DEFRA information)
SBO - 18	Infertility Approval Request is sent by Vendor to SBO as part of HD's approval to receive IVF services. SBO asks Vendor via e-mail to review for prior utilization and if so what amount was used. Vendor tracks utilization (including meds via ESI) until limit hit.
SBO - 19	Shows recent utilization of meds of "grandfathered" members as tracked by ESI; Vendor receives reports and records amounts used for tracking purposes to determine when cap is hit. Vendor advises when cap is reached and terminates health and script coverage for IVF services.
SBO - 20	IVF Reporting is two separate pages: Grandfathered and Non-Grandfathered. Grandfathered shows last several quarters dollar ranges (\$25,000 to \$30,000) and number of members at maximum benefit of \$30; also shows number of members remaining eligible for benefit. Non-grandfathered shows same quarters; number of members approved per quarter; number of members between \$8,000 and \$10,000; number of members at maximum benefit at \$10,000.

Report Name	Legend, Explanation, Notes, etc. per Report No. <i>Italicized reports do not correspond with the Report List, but are required.</i>
SBO - 21	Customer Service Report is provided 45 days after end of quarter; hard copy is provided at Quarterly Meeting. It includes the type of inquiry (appeals, claims, etc), the line of business (IPA, PPO, etc) and method of inquiry (telephone, internet, etc). The first page of the report includes all plans while the second page provides the CDH Gold breakout (and therefore does not include the line of business).
SBO - 22	Subscriber Satisfaction Surveys are mailed to subscribers twice a year and results provided usually at Quarterly Meeting held in December and June.
SBO - 23	S-COB Report showing members Non-Compliant as of 7-1. Due after open enrollment closes but before 7-1.
SBO - 24	S-COB Report showing members Non-Compliant as No S-COB Form was submitted. Due every Friday.
SBO - 25	S-COB Report showing members Non-Compliant w S-COB Policy.
SBO - 26	S-COB Report of members being researched to determine status. Weekly as needed.
SBO - 27	Adult Dependent COB Report showing members Non-Compliant as No AD COB Form was submitted. Due every Friday.
SBO - 28	Adult Dependent COB Report showing members Non-Compliant as contract holder/adult dependent non-compliant with Adult Dep Policy.
SBO - 29	Adult Dependent COB Report of members being researched to determine status.
SBO - 30	Medicfill No Form (No sanction)
SBO - 31	Enrollment Reports show monthly enrollment by group and by tier due by 15th of each month.
SBO - 32	Performance, Medical Mgmt, Financial Report w OPEB and Non-OPEB Reports; due 45 days after end of quarter.
SBO - 33	Appeals being processed by Vendor; three pages. First page shows number by month for whole fiscal year and type (administrative and medical) of appeal; outcome (overturned, upheld, pending); and total for month. Second page shows external appeals (based on medical necessity) by month for whole fiscal year the status of medical appeal (closed and open; overturned, upheld, or pending) and total appeals for month. Third page shows three past months of non-external.
SBO - 34	<i>Case Mgmt of former Accordant Members (NOTE: As of 11-13 only one member)</i>
SBO - 35	Vendor's weekly file to ESI containing new or termed members, new dependents, address changes, group number changes, COB status, etc.
SBO - 36	Vendor to Truven of monthly claims and providers.
SBO - 37	Vendor to Truven of monthly enrollment.
SBO - 38	<i>Medical Facts Report (FKA Managed Care Tracking Report)</i>
SBO - 39	Annual statement for State's Auditor.
SBO - 40	<i>Qrtly OPL Report shows status of "other provider liability" (workers comp, automobile, etc) and collection of those claims paid by health plan when should have been processed under other provider liability.</i>
SBO - 41	NIA (High Tech Radiology) Financial semi-annual reporting.
SBO - 42	NIA (High Tech Radiology) Quarterly Activity reporting shows utilization of High Tech Radiology (MRI, PET, etc.) services.

Report Name	Legend, Explanation, Notes, etc. per Report No. <i>Italicized reports do not correspond with the Report List, but are required.</i>
SBO - 43	Account Mgmt Team Survey is SBO's evaluation of Vendor Team's performance during last fiscal quarter. Impacts PGs for fiscal year.
SBO - 44	Vendor to Alert of monthly claims and providers.
SBO - 45	HD to Alert of monthly enrollment.
SBO - 46	CDH Gold Plan HRA Fund Reports show weekly and quarterly HRA Fund utilization.
SBO - 47	CDH Gold Plan Fiscal Year End Report: Provides end of fiscal year utilization, forfeited HRA Funds, etc.
SBO - 48	CDH Gold Fiscal Year Start-Up Enrollment of all members: Indicate the HRA Funds rolled over from previous fiscal year and current fiscal year. Look for members who moved from other vendor(s) to Vendor and other vendor(s) to Vendor and notify new carrier of previous year's HRA Fund balance to ensure accurate HRA Fund dollars are available to member.
SBO - 49	CDH Gold Quarterly and Annual Reports: Indicates the HRA Funds per member on quarterly and annual basis.
SBO - 50	Vendor sends weekly list of "suspect" Medicare eligible members; Pension Office does follow-up as necessary; FYI for SBO.
SBO - 51	Recovery of Overpayments/Incorrect payments report.
SBO - 52	Some states require the State to pay via Vendor a fee/tax for members living in those designated states (NY, MASS, Michigan).
SBO - 53	Issues Log is prepared by Vendor and provided to SBO 3 working days before MCC to track status of issues of concerns. Discussion, status, etc resulting from MCC is recorded in overview of MCC and sent to SBO 3 days following MCC. Issue Log and overview is maintained on T for reference.
SBO - 54	List of Ben Reps as prepared by SBO to be provided to Vendor during OE and any other time throughout plan year as updates occur to enable Vendor to contact Ben Reps directly.