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**

***Intent to Bid Deadline* –**
Monday, August 29, 2016, 1:00 p.m. ET (Local Time)

***Mandatory Pre-Bid Meeting (Conference Call)* –**
Wednesday, August 31, 2016, 11:00 a.m. ET (Local Time)

***Proposals Due* –**
Monday, September 26, 2016, by 1:00 p.m. ET (Local Time)

OMB16001–Health_Ins

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I. Introduction

On behalf of the State of Delaware, the State Employee Benefits Committee (SEBC) is seeking proposals to provide Third Party Administration services to the Group Health Insurance Program (GHIP) to approximately 122,500 active and retired employees of the State of Delaware and their dependents, including approximately 18,000 employees, retirees and their dependents from groups that also participate in the GHIP as permitted through Delaware Code.

For complete information about the State of Delaware's GHIP, please go to http://ben.omb.delaware.gov.

Public notice has been provided in accordance with 29 Del. C. § 6981. This RFP is available in electronic form through the State of Delaware Procurement website at www.bids.delaware.gov. Paper copies of this RFP will not be available.

Vendors may bid on:

1) **One or more of the following Medical Plan(s) currently in place today:**
   a) **PPO Plans only: First State Basic PPO, Comprehensive PPO, and the Port Authority Plan (POS),**
   b) **HMO Plan only,**
   c) **CDHP (HRA) only,**
   d) **Medicare Supplement only; and/or**
   e) **All medical plans.**
2) **A fully-insured group Medicare Advantage plan (which is not offered by the State of Delaware today).**
3) **All or any of the Medical Plan(s) listed in Paragraph #1 and the Medicare Advantage plan.**
4) **An alternative plan option outside of the plans required by the Delaware state code.**

Please note the following regarding responding to this RFP:

- **Generic responses or stock answers that do not address State-specific requirements will be deemed unresponsive. "Will discuss" and "will consider" are not appropriate answers.**
- **The State recognizes that certain elements of this RFP, particularly in Section IV.C Health Care Delivery, may not apply to every bidder.**

However, all questions are important to the State, and therefore a bidder must acknowledge that it believes the item does not apply and provide a reason why. (For example, "n/a for a fully-insured product.") Otherwise, the State will ask the bidder to reply in a follow-up question.

- **If a question is repeated in multiple sections and a bidder's answer is the same, the bidder should not refer to their answer in another section but copy it under each question.**

All bids must include the following, unless otherwise noted below:

- **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).**

- **Disease Management as part of the scope of services and pricing (optional for Medicare Supplement and Medicare Advantage plans).**

All bids that include proposals for either the Medicare Supplement plan or the Medicare Advantage plan must <u>at a 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):

- **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 proposals including this plan), and**

- **IV.G Medicare Advantage (for proposals including this plan).**

Award(s) will be made to one vendor for all medical plans or multiple vendors for any combination of medical plans. The SEBC will award contracts with an effective date of July 1, 2017 for all medical plans except for the Medicare Supplement and the Medicare Advantage plans. The SEBC

will award the contract for either the Medicare Supplement plan or the Medicare Advantage plan with an effective date of January 1, 2018.

NOTE: This RFP requests that bidders respond to other services (e.g., HSA administration, value-based contracting models) that may be in addition to or attached to the above plans and may or may not be awarded for an effective date of July 1, 2017 (for most medical plans) or January 1, 2018 (for the Medicare Supplement and the Medicare Advantage plans).

Important Dates (A full timeline is included in Section I.D.)

Contract Effective Date - all plans except Medicare Supplement and Medicare Advantage	**July 1, 2017**
Contract Effective Date – Medicare Supplement and Medicare Advantage	**January 1, 2018**
Open Enrollment	**Monday, May 8, 2017 through Thursday, May 25, 2017**
Bid Release Date	**Monday, August 15, 2016**
Intent to Bid Due[2]	**Monday, August 29, 2016, by 1:00 p.m. ET (Local Time)**
Mandatory Pre-Bid Meeting (Conference Call)[3]	**Wednesday, August 31, 2016, 11:00 a.m. ET (Local Time)**
Questions Due from Vendors	**Friday, September 2, 2016, by 1:00 p.m. ET (Local Time)**
Proposal Submissions Due	**Monday, September 26, 2016, by 1:00 p.m. ET (Local Time)**

A. Background and Overview

1.0 Organization Description

The SEBC is chaired by the Director of the Office of Management and Budget (OMB). The Committee is comprised of the Insurance Commissioner, the Chief Justice of the Supreme Court, the State Treasurer, the Director of the Office of Management and Budget, the Controller General, the Secretary of Finance, the Secretary of Health and Social Services, the Lieutenant Governor, and the President of the Correctional Officers Association of Delaware or their designees. The Statewide Benefits Office (SBO) is a division within the OMB. The SBO functions as the administrative arm of the SEBC responsible for the administration of all statewide benefit programs with the exception of pension and deferred compensation benefits. These programs include, but are not limited to, health, prescription, dental, vision, disability, life, flexible spending accounts, wellness and disease management programs, pre-tax commuter benefits, and supplemental benefits. Visit http://ben.omb.delaware.gov for information about the programs.

The SBO administers the Group Health Insurance Program (GHIP). The medical insurance component of the program is self-insured. Eligible participants include active, retired,

[2] IMPORTANT: Your bid will not be accepted if the State of Delaware does not receive an email confirmation of an Intent to Bid. See Section II.B.1 for details.

[3] IMPORTANT: Your bid will not be accepted if your organization does not participate in the Mandatory Pre-Bid Meeting (Conference Call). See Section II.B.4 for details.

school district, charter school, university, community college, non-state groups, and COBRA participants and their enrolled dependents. Plan participants are primarily located within the State of Delaware, although a small number of participants reside in other states and countries. There are multiple employer units and non-payroll groups located in three counties throughout the State, with each exercising a high degree of independence.

The SEBC contracts with Ceridian for administration of COBRA and with Human Management Services (HMS) for administration of employee assistance services. The dental and vision benefit plans are 100% employee pay-all and are not included with the health plan. The Pharmacy Benefit Manager (PBM) services are carved out and administered by Express Scripts. The selected organization(s) will be required to share specific claim and utilization data for all self-funded plans with the PBM vendor and data warehouse vendor and possibly other vendors to be determined in the future. The Port Authority Plan is a Point of Service plan available to a closed group of approximately 275 active employees and their dependents for a total population of approximately 550. The State of Delaware utilizes multiple electronic human resources programs, such as PeopleSoft, and vendor databases at separate locations in various formats to collect and store participant data.

2.0 Background Information

Since July 1, 2007, the SEBC has contracted with Blue Cross Blue Shield of Delaware, now operating as Highmark Delaware, and Aetna as the Plan's third party medical claims administrators. The SEBC is now issuing a bid for a third party medical claims administrator that can provide GHIP participants with improved care management and significant unit cost reduction and/or significant reductions in the total cost of care per member without sacrificing the quality of care delivered for a contract award effective July 1, 2017. While the effective date is July 1, 2017, firms are encouraged to propose or illustrate creative delivery strategies that may not be market ready for July 1, 2017 but may be within the terms of this agreement.

The State would like to take bolder actions that focus on mitigating the total cost of care for both the GHIP and its participants while driving improvements in the health of the GHIP population. Therefore, the third party medical claims administrator (TPA) must be able to provide innovative cost containment features, including but not limited to centers of excellence, accountable care organizations and advanced primary care, to mitigate the high growth rates in GHIP expenditures over the last several years. In addition, the TPA must also have robust quality management processes in place to ensure that the providers participating in any cost containment program must meet strict quality guidelines. It will be favorable if firms can provide meaningful trend and cost guarantees with their proposal.

As the SEBC is looking for a TPA that can drive meaningful changes in the health and the cost of GHIP participants, **requiring targeted interventions and care delivery strategies that are materially different from traditional health management programs and fee-for-service pricing offered by most TPAs**, this RFP represents a significant departure from the requested scope of services covered in the last procurement of a TPA for the GHIP in 2011.

One of SEBC's goals is to foster increased competition among TPAs and health insurers, by rewarding distinctive performance with increased membership. With this in mind, based on the competitiveness of proposals received from bidders in response to this RFP, the SEBC may make awards including but not limited to the following configurations:

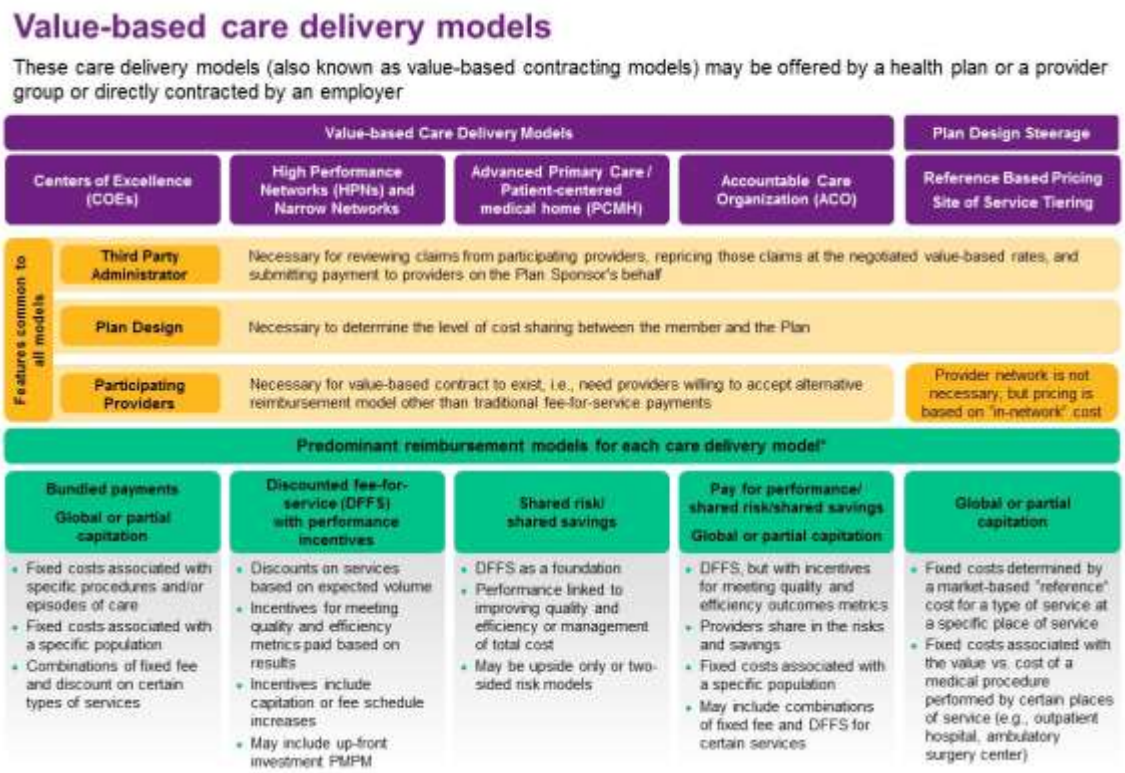
a. Award of one or more of the plan options that are required by Delaware Code exclusively to a single TPA (different from the current practice for the HMO and CDHP), if one TPA is able to deliver a superior value proposition to SEBC members throughout Delaware

b. Award of one or more plan options to one TPA for a limited geographic region, if able to deliver a superior value proposition; then a second TPA chosen either for the other geographic region(s) or as a statewide alternative

c. Award of one or more plan options exclusively to one TPA with a statewide network, wherein certain care management, provider risk-sharing, or other cost containment strategies may initially be restricted to a subset of the network, with a commitment to expand the reach of those cost containment strategies over time

d. Award of a new plan option outside of those required by Delaware Code, if supported by proposals from one or more bidders that would deliver substantial savings and superior outcomes to both members and SEBC if widely adopted.

The schematic below outlines several examples of care delivery models that are among the solutions that the SEBC would consider from bidders responding to this RFP. The key criteria for any of these models to work effectively, i.e., a TPA, a plan design and a network of one or more providers willing to contract for alternative reimbursement models, should be noted as it will be highly important for bidders' to respond with detailed descriptions of their capabilities to support each of these criteria.



Note: It is possible that these value-based care delivery models may have a reimbursement model other than the predominant models listed above.

TPAs will be considered to offer a stronger value proposition to the SEBC if they include contractual guarantees to migrate provider payments to value-based payment arrangements which promise or have the potential to reduce trend (or the growth rate in trend) for the SEBC and GHIP members while also maintaining or improving the quality of care. Below are examples of such arrangements, beginning with those that would be considered most favorably:

a. Existing contractual commitments or letter of intent between the TPA and network providers which include <u>downside risk</u> and upside sharing for managing the quality and total cost of care: for all GHIP medical spending for all GHIP members of the TPA within Delaware.

b. [Existing <u>downside risk</u> arrangement, as described above]: for a portion of GHIP spending, based on either select episodes of care or a subset of GHIP members of the TPA, based, for example based on attribution to select primary care providers in the network.

c. <u>Commitment</u> to introduce <u>downside and upside risk</u> sharing arrangements for some or all GHIP medical spending, including willingness of TPA to offer performance guarantees relative to adoption.

d. Existing contractual commitments between the TPA and network providers which include upside shared savings for managing the quality and total cost of care: for all GHIP members of the TPA within Delaware with future plans to put in some down side risk commitments.

e. [Existing upside shared savings arrangement, as described above]: for a portion of GHIP members that may be attributed to primary care providers participating in an Accountable Care Organization (ACO) or Clinically Integrated Network for purposes of clinical integration and adoption of value-based payment.

f. Commitment to introduce upside shared savings arrangements for some or all SEBC medical spending, including willingness of TPA to offer performance guarantees relative to adoption.

In addition, the SEBC will consider more favorably TPA proposals that include cost containment strategies that promise to deliver savings to the SEBC and GHIP members, which may be prospectively forecasted by bidders, subject to actuarial review by the SEBC's benefits consultants, and which may be evaluated for performance on an annual basis. Following are examples of such strategies:

a. Performance guarantees from TPAs that include downside risk for increases in total cost of care above historical trends;

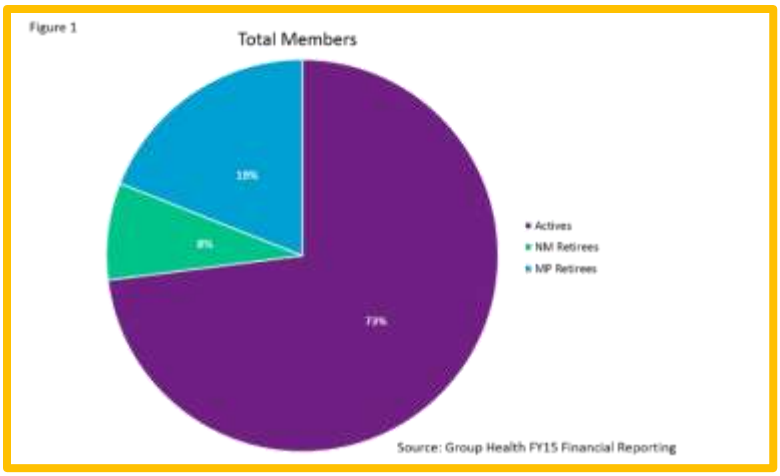
b. Provider acceptance of downside risk arrangements that promise reductions in total cost of care or reduced rate of increase in total cost of care;

c. Introduction of a narrow network for primary care, specialty care, hospital care, or care in one or more geographic regions, with projected reductions in total cost of care that have reasonable risk adjustment methods; or

d. Introduction of a high-performance network for primary care, specialty care, hospital care, or other care in one or more geographic regions, with reduced out-of-pocket cost sharing at the point of care to for members who seek care from providers within the high-performance network.

GHIP Background Information

The State of Delaware Group Health Insurance Program (GHIP) provides medical and prescription benefit coverage to over 122,000 covered lives. This includes approximately 31,000 active employees, 5,900 non-Medicare retirees and 17,000 Medicare retirees whose benefits are extended to their spouses and dependents. Also, covered are approximately 18,000 employees, retirees and their dependents from groups that also participate in the GHIP as permitted through Delaware Code. As shown in Figure 1, active employees and dependents represent over 70% of the GHIP's population with retirees representing the remainder.



The GHIP is self-insured and pays the actual claims (expenditures) incurred by the GHIP participants for services received under the health and prescription plans. Claim expenses represent approximately 96% of the GHIP's total expenditures. The SEBC is responsible for design of the plans available to the GHIP's participants and setting premium rates that can support the projected expenses of the GHIP. The percentage of employee and employer share of the premium rates is established in Delaware Code as are the actual plan offerings available to employees and retirees.[4]

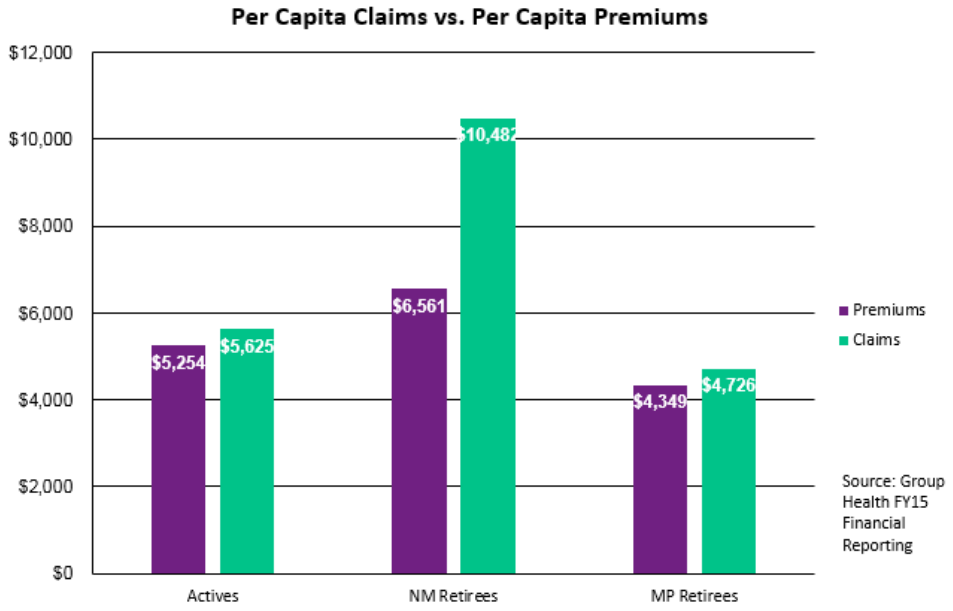
Due to restrictions placed on the GHIP by the Delaware Code, the SEBC cannot employ one of the more traditional levers to manage cost, i.e., shifting additional cost to plan participants through higher premium cost sharing (see chart below). Further, while increased cost sharing through plan design continues to be an option available to the SEBC, there has been limited support for increasing member out-of-pocket costs at the point of care, particularly in the absence of sufficient resources that would allow members to make an informed decision about their costs. The SEBC's efforts to promote additional health care consumerism have also been hindered by the low enrollment in the GHIP consumer directed plan option (i.e., <5% of the covered population). Therefore, one of the goals of this RFP process is to identify a third party administrator with a robust set of health care cost and quality transparency tools that would supply plan participants with the information needed to make informed decisions about their health care.

[4] Delaware Code, Title 29, Chapter 52 Web Address: http://delcode.delaware.gov/title29/c052/index.shtml

	Actives	Non Medicare	Medicare Primary
Premium Cost Share Percentage Split	State/Employee	State/Retiree	State/Retiree
Highmark Comprehensive PPO	86.75%/13.25%	86.75%/13.25%	
Highmark & Aetna HMO	93.5%/6.5%	93.5%/6.5%	
Highmark & Aetna Consumer Directed	95.0%/5.0%	95.0%/5.0%	
Highmark First State Basic	96.0%/4.0%	96.0%/4.0%	
Highmark Special Medicfill Supplement			100%/0%* 95.0%/5.0%**

*Retirees with full state share who retired before July 1, 2012
**Retirees with full state share who retired after July 1, 2012

The active and non-Medicare populations have always paid the same premium rates for each plan; however, the actual claims (expenditures) of the non-Medicare retiree population are significantly higher than the active population as illustrated in the chart below. The Medicare population receives secondary medical coverage through the GHIP as well as prescription drug benefits through an Employer Group Waiver Medicare Part D plan implemented in calendar year 2013. The premium rates for the Medicare population are more closely aligned with the actual claims (expenditures) of the population.



The following table outlines the actuarial value of each plan based upon in-network benefits as compared to a few sample plan designs available through the Marketplace. The State funds on average, 91.4% of the total premium of the plans.

	Sample Gold Plan**	Highmark First State Basic Plan	Highmark & Aetna CDHP (with HRA)	Sample Platinum Plan**	Highmark PPO	Highmark & Aetna HMO
Actuarial Value	80%	86.1%	87.0%	90%	90.3%	90.6%
Deductible (Single/Family)	$900/$1,800	$500/$1,000	$1,500/$3,000 +1,250/2,500 HRA	None	$0/$0	$0/$0
Out of Pocket Maximum (Single/Family) Medical Only	$4,500/$9,000	$2,000/$4,000	$4,500/$9,000	$4,500/$9,000	$4,500/$9,000	$4,500/$9000
In-Network Coinsurance	25%	10% Coinsurance	10% Coinsurance	10%	0%	0%
Primary Care	$30	10% Coinsurance	10% Coinsurance	$20	$20	$15
Specialist	$50	10% Coinsurance	10% Coinsurance	$40	$30	$25
Inpatient Facility	25% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	$200	$150	$150
Emergency Room	$300	Deductible & Coinsurance	Deductible & Coinsurance	$200	$150	$150
Out-of-Network Coinsurance	40%	30%	30%	30%	20%	N/A
Prescription Drug Benefit						
30-day Retail	$10/$40/$80	$8/$28/$50	$8/$28/$50	$5/$20/$50	$8/$28/$50	$8/$28/$50
90-day Retail & Mail	$25/$100/$200	$16/$56/$100	$16/$56/$100	$10/$50/$125	$16/$56/$100	$16/$56/$100
Out-of-Pocket Maximum (Single/Family)	$2,100/$4,200	$2,100/$4,200	$2,100/$4,200	$2,100/$4,200	$2,100/$4,200	$2,100/$4,200
Current Enrollment (as of 2016)						
As % of total	n/a	2%	3%	n/a	47.5%	47.5%

*Actuarial Value based on in-network benefits only, out-of-network feature increases value slightly.
**Sample Plan designs with split out of pocket maximums, medical and drug, and not specific to Delaware marketplace.

Several points should be noted about the CDH Gold plans with an HRA:

- Members receive an annual contribution from the State to fund the HRA, in the amount of $1,250 for single coverage/$2,500 for family coverage
- The full amount of the annual HRA contribution is made available to members on the first day of the plan year (July 1)
- The HRA can be used to pay for medical expenses during the deductible period and/or to pay other out of pocket costs incurred by the member
- Prescription copays do not count toward the deductible or out-of-pocket maximums and are not eligible for payment using the HRA
- Any available HRA funds are automatically used when the third party administrators adjudicate medical claims. Members are responsible for any remaining balance owed to the medical provider, and will receive an Explanation of Benefits (EOB) or Explanation of Payment (EOP) that shows any remaining payments required. It is the member's responsibility to follow-up with the provider to pay any remaining balance.
- Unused HRA funds will carry over to the next year as long as member remains enrolled in a Consumer-Directed Health Plan through the State of Delaware

- When a new hire enrolls in a Consumer-Directed Health Plan outside of the annual enrollment process or an employee changes tier level mid-year (an example: from individual to family), the HRA is prorated in accordance with the effective date of the enrollment or change in tier level. The chart below provides the time periods and level of proration:

Date of Enrollment or Tier Change	HRA Fund per Individual	HRA Fund per Family
July 1 – September 30	$1,250.00	$2,500.00
October 1 – December 31	$937.50	$1,875.00
January 1 – March 31	$625.00	$1,250.00
April 1 – June 30	$312.50	$625.00

The deductible remains the same regardless of date of enrollment or tier change.

Additional information about the CDH Gold Plan HRA fund end-of-plan year claim processing has been provided in Attachment 9.

GHIP Historical Review

Important to note is the passage of House Bill 81 during the 146th General Assembly[5] in 2011. This legislation marked the first and only significant change in State employee and retiree benefits since the onset of rising healthcare costs experienced nationally at the turn of the century. It represented the collective work of the administration, legislature and unions representing the majority of State employees, all of whom recognized the changing landscape and financial hardships being faced by public sector employers with regards to controlling costs and preserving health and pension benefits. The impetus behind House Bill 81 was the $80M deficit and contentious FY11 GHIP budget process. The cost sharing structure outlined previously was one of many outcomes of the legislation. Other changes included:

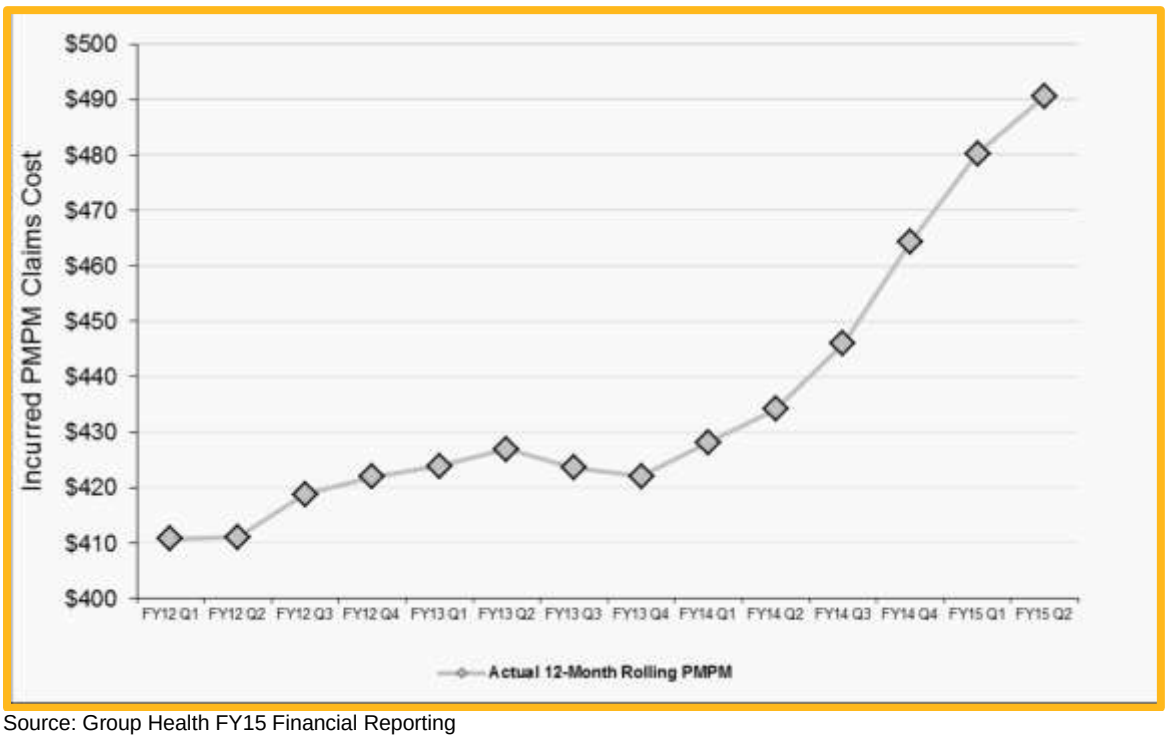
- Elimination of a free health plan replaced with a 4% cost share for employees and non-Medicare retirees enrolled in the First State Basic plan;
- A 5% cost share for Medicare retirees enrolled in the Medicare Supplement plan who retired after July 1, 2012;
- Slight increases in the number of service years required to vest for specific percentage of the State share for retiree health benefits; and
- The elimination of Double State Share for new employees as well as a flat $25 per month per contract for employees who remained eligible for Double State Share.[6]

[5] The legislature meets on a part-time basis from January through June each year.

[6] See 29 Del. C. § 5202(d) for complete details at http://delcode.delaware.gov/title29/c052/index.shtml

- Prior to the passage of House Bill 81, the SEBC's authority and responsibilities were the same; however, the absence of a set employee/retiree cost share left the SEBC with the added responsibility of balancing the GHIP budget through either plan design changes or increases in the employee/retiree share of the total premium rates.

While House Bill 81 did make changes and accomplished the intended objective of bringing the State employee and retiree health benefits in line with what was more common in the public sector environment, the growth rates experienced by the GHIP have continued to far exceed the State Operating budget growth and without additional change, appear to be unsustainable. Expenditures accelerated in FY14 after two years of relatively stable per member costs; however, this was not confirmed until updated expenditure projections became available in early February 2015 and as the SEBC began to deliberate over options to balance the FY16 GHIP budget. The following table was used during discussions with the SEBC and exemplifies the dramatic uptick in per member per month (PMPM) costs.



Source: Group Health FY15 Financial Reporting

As the projected deficit rose to $116.3M, the increase provided in the Governor's 2016 recommended budget for FY16 fell $60M short of the amount needed to fund the premium rates at a level equal to the expected GHIP expenditures. A similar scenario to that which the SEBC experienced during the FY11 GHIP budget process emerged and it was not until additional money was appropriated by the Joint Finance Committee and approved by the legislature as part of the State Operating Budget process that the SEBC was able to approve a balanced budget for FY16.

Employee and retiree healthcare was the largest cost driver in the State Operating Budget for FY16.

Included in epilogue in the FY16 Operating Budget bill was language requiring the formation of the State Employees Health Plan Task Force to study the State Group Health Plan with the purpose of finding cost savings and efficiencies. The Task Force met through the fall of CY2015 and issued a report to the Governor and General Assembly on December 16, 2015. Minutes and meeting materials from the seven meetings of the Task Force as well as the final Task Force Report are available for review at http://ben.omb.delaware.gov/hptf/index.shtml.

The report focuses on several short-and-long term actions for considerations, which are segmented by the following categories:

1. **Bending the cost curve**
2. Exploring opportunities to realign **provider payments**
3. **Benchmarking** GHIP plans and costs on a comparable basis
4. **Improving the health of the population**

According to the report[7], the State of Delaware's health risk in 2014 was higher than the nationwide average, indicating a higher than average illness burden in the State of Delaware population[8]. Additionally, the risk score of the population increased 20% for 2014 versus 2013. Another concerning finding from this report indicated that the State's prevalence for key chronic conditions such as diabetes and hypertension were approximately 10% greater in the GHIP population compared to the state benchmark. The presentation of the Delaware Center for Health Innovation (DCHI) also commented that the health of the entire state demographics contribute to the issue. As a result, a key recommendation of this report was that the State should leverage the significant contribution the GHIP makes to Delaware hospitals' revenue to support quicker adoption of changes including provider incentives such as pay for performance and/or bundled or episodic payments that balance lower costs with improving quality of care and patient outcomes, and that any exploration should recognize and coordinate with findings of the DCHI.

In February of 2013, CMMI awarded Delaware a "design" grant, which funded the development of the State Health Care Innovation Plan. The State applied for a SIM "testing" grant in July of 2014 to support the implementation and testing of the plan. The goal is the "Triple Aim" - improving the health of Delawareans, improving the patient experience of care, and reducing health care costs. Through the SIM initiative, Delaware is planning to build upon a strong local foundation for innovation in order to achieve this through a system-level transformative healthcare plan that can serve as a scalable model for the nation. The State aspires to develop and implement a plan for broad-based health system transformation, including new payment and delivery models, which will achieve the Triple Aim.

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[7] Final Report of the State Employees Health Plan Task Force, December 15, 2015, is at: http://ben.omb.delaware.gov/hptf/documents/task-force-report.pdf.

[8] Data reported by Truven Health Analytics, the data warehouse to the GHIP.

The health transformation approach is organized into several workstreams, with two that most closely dovetail with the goals of this RFP: delivery system transformation and payment model reform. **These workstreams have the goal of improving the delivery system to encourage "smarter" consumption and production of care and to change the focus of the State of Delaware from sickness to wellness.** The State Health Care Innovation Plan describes each workstream in further detail and can be read in its entirety here:
http://dhss.delaware.gov/dhcc/cmmi/files/choosehealthplan.pdf.

Since July 2014, the DCHI has been convening stakeholders to establish goals for primary care transformation as a key element of Delaware's Health Innovation Plan, contributing to broader aspirations for improved health, health care quality and experience, and affordability for all Delawareans. While the DCHI's early work has focused on primary care, in the future it aims to build on this foundation with improved behavioral health and specialty care, as well as better integration among primary care, behavioral health, and specialty care.

DCHI has achieved multi-stakeholder consensus on important elements related to Delaware's strategy to transition to statewide adoption of value-based payment and care delivery models. These include topics related to primary care practice transformation, care coordination, the integration of behavioral health with primary care, outcomes-based payment for population health management, and a proposed governance model by which Healthy Neighborhoods may organize to integrate public health, health care delivery, and community-based efforts to improve population health.[9] The DCHI was also tasked with implementing Delaware's State Health Care Innovation Plan catalyzed by the State Innovation Models (SIM) initiative, a national grant program administered by the Center for Medicare & Medicaid Innovation (CMMI). The goal of the SIM initiative is to support states to move toward value-based payment models and to improve population health. One of the main tenets of Delaware's State Health Care Innovation Plan is to assist hospitals and other providers in building infrastructure to accept financial risk for health care costs over time. The speed and degree of risk will largely depend on hospital and provider readiness (i.e. integration of care between PCP, specialists and facilities, evidence based practices and feedback systems, the strength of EMR records sharing, and ability to use data in clinical transformation efforts).

Delaware Health Information Network (DHIN)

The SEBC expects that the third party administrator(s) selected from this RFP will be an active participant in these efforts, including participating in the Delaware Health Information Network (DHIN) to create a single interface for providers and patients to access health information that supports care coordination, performance reviews and patient engagement.

[9] For further information about the DCHI, please visit http://www.dehealthinnovation.org/Health-Innovation. For DCHI publications, please visit http://www.dehealthinnovation.org/Health-Innovation/Publications.

The DHIN is a statutorily created not-for-profit instrumentality of the State of Delaware charged with the design, implementation, operation and maintenance of facilities for public and private use of health care information in the State. Specifically, the DHIN is the state-designated health information exchange ("HIE") and under that statute is charged with operating a statewide integrated health information network to enable communication of clinical and financial health information, to promote the efficient and effective communication among Delaware health care providers and stakeholders including hospitals, physicians, state agencies, payers, employers and laboratories, with the goal of promoting efficiencies in the healthcare delivery system.

The DHIN is nationally recognized in the rapidly growing and dynamic field of health information exchanges (HIEs). Launched in 2007, DHIN is the longest operating statewide HIE. It is designed as an interoperable network to exchange clinical information among all health care providers across the state to improve patient outcomes and patient-provider relationships. The system is designed to allow patient clinical information to be shared across all health care facilities and organizations and across public and private sectors. It has been built through a consensus process among the health care stakeholders, which has resulted in an exceptionally high participation rate:

- All of Delaware's acute care hospitals actively participate in the DHIN.
- All three of Delaware's Federally Qualified Health Centers exclusively receive clinical results via DHIN.
- Over 80% of Delaware's health care providers are receiving clinical results via DHIN.
- 90% of Delaware residents have clinical information available for query through DHIN.
- 80% of laboratory tests ordered or performed in Delaware are reported through DHIN.

The DHIN has also been tasked with housing and managing the Delaware All Payer Claims Database (APCD), which Governor Markell signed into law as Senate Bill 238 on July 21, 2016. Further details on the APCD can be found on the DHIN website: http://dhin.org/.

B. Proposal Objectives

The SEBC desires to contract with a third party medical claims administrator or administrators. Organizations must have prior experience directly related to the services requested in this RFP and must be able to demonstrate clearly their ability to:

- reduce the total cost of care for GHIP participants and the State;
- facilitate consumer choice of providers who deliver higher-quality care at a lower total cost of care;

- support financial rewards to providers who delivery higher-quality care and lower total cost of care;
- support investments in APC (as outlined in DCHI consensus paper[10]);
- build and maintain medical provider networks that are based on (1) traditional fee-for-service contracting, and (2) value-based contracting;
- minimize employee disruption while maximizing employee experience;
- provide GHIP participants with the tools and resources that will promote transparency in provider cost and quality and encourage participants to make informed decisions about their health;
- provide disease management programs that are effective at engaging members and steering them to the most effective care at the right time with the right providers;
- provide competitive financial terms, including quotes for both self-funded and fully insured administration of all plans included in each vendor's bid;
- enhance existing clinical performance guarantees to be more focused on health outcomes and measured on the State's own population (not the vendor's book of business)
- identify short-term and long-term solutions to slow the increase in health care expenditures for the State;
- provide excellent customer service to participants;
- leverage the work that the State has already put into its benefits website for members to access information and education on their benefits, to support the goal of driving consumerism;
- provide excellent account management services to the State, including timely reporting;
- maintain or improve existing performance guarantees to meet service metrics; and
- be responsive to requests of the SEBC.

This RFP is also requesting a proposal on a Medicare Supplement plan for retirees. In addition, based on each bidder's review of the locations of the current State retirees, if bidders have a group Medicare Advantage program that would service State retirees and be beneficial for the GHIP, please provide information on that plan along with rates for and effective date of January 1, 2018 for evaluation purposes. Please assume that if the

[10] See http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Primary-Care-Practice-Transformation.pdf.

State were to offer a Medicare Advantage plan, it would be as a full replacement group Medicare Advantage plan that mirrors the current Medicare Supplement plan design (i.e., passive PPO on a non-benefit differential basis that pays 100% of all Medicare services), provided that the Medicare Advantage plan provides adequate access to medical providers in all areas where retirees reside. Prescription drug coverage will remain carved out to Express Scripts, so any quotes on Medicare Advantage plans should only be for medical coverage with the assumption that care coordination would be necessary with Express Scripts.

C. Scope of Services

The selected organization(s) shall be required to provide the following services, at a minimum[11]:

a. Accept, process and pay claims from medical providers as a third party administrator.

b. Participant enrollment maintenance including the capability to accept and process enrollment files in the State's various designated formats.

c. Patient and provider education.

d. Management of at least one network of medical facilities and professionals that will provide medical services at a lower negotiated rate in exchange for participation in the network.

e. Minimal network disruption and adequate access to providers for traditional PPO, HMO, and consumer directed plans, or, if a narrow network is part of the selected organization's proposal (and therefore network disruption is unavoidable), then the selected provider must ensure that the narrow network provides adequate access to providers according to the standards outlined in Appendix S: *GeoAccess Open Access Network*, Appendix T: *GeoAccess HMO Network* and Appendix U: *GeoAccess Medicare Advantage Network* Given the fact that this is an evolving area of the marketplace, bidders that propose a model which will not be available statewide by July 1, 2017 will still be considered.

f. Currently maintain or plan to implement one or more of the following categories of "value-based contracting models" within all three counties in Delaware by July 1, 2019, meeting specific adoption targets over time:

   1. Provider risk sharing models consistent with those described in Section I.A.2 above.

   2. Advanced primary care across the network through care management funding and commitment to introduce models that promote integration of Behavioral Health and primary care

[11] This is a general list of services. Details are set forth in the Minimum Qualifications and Questionnaire sections.

i. Advanced Primary Care

a. Care management funding: provide upfront care management funding as part of the outcomes-based payment model(s) introduced by the plan, consistent with the recommendations of the Delaware Center for Health Innovation

b. Reporting: contribute reporting metrics to the Delaware Health Information Network (DHIN) for inclusion in Delaware's Common Scorecard

ii. Behavioral Health Integration

a. Demonstrate a willingness to test new models of integrating Behavioral Health (including substance abuse) and Primary Care in Delaware

b. Participate in roll-out of these new models statewide

3. Introduce methods to steer members to high performing providers (through networks or centers of excellence), consistent with those described in Section I.A.2 above. Such methods could include, but are not limited to:

i. Providing same day, next day, after hours and weekend access to primary care physicians

ii. Providing alternatives to emergency room care for non-emergent conditions (urgent care and telemedicine)

iii. Providing access to specialists in 7-10 business days

iv. Providing enhanced 24/7 care management, online portals, telemedicine, and health navigators not available in the State's traditional PPO or HMO plans

It should be noted that the State makes no guarantees of volume in terms of member steerage toward any new or existing plans or programs included in any bidder's proposal. The State is willing to work with the selected organization(s) to develop and implement solutions that will drive steerage – e.g., communications, possibly plan design changes, etc. – even though the State will not make any guarantees of projected membership in each plan.

g. Provide supplemental coverage to Medicare-eligible retirees and their Medicare-eligible dependents, either in the form of a Medicare Supplement or group Medicare Advantage plan.

h. Dedicated, knowledgeable, and accessible member support services.

i. Distribution of member ID cards and benefit information.

j. Secure and multifunctional member website that allows convenient access to enrollment, plan information, and member tools (i.e., provider finder, medical procedure cost estimator).

k. Meaningful and timely management reporting, with the expectation that the amount of focus on metrics related to value-based contracting models will increase over time.

l. Integration with the State's data warehouse provider, Truven Health Analytics, and the DHIN.

m. Dedicated, expert, and accessible account management staff.

n. Support for all program related member communications including open enrollment, direct mailings, and other types of media.

o. Superior program implementation support.

D. Timetable/Deadlines

The following timetable is expected to apply during this RFP process:

Event	Target (Local ET Time)
RFP Released	Monday 08/15/16
Intent to Bid Deadline [12]	Monday 08/29/16, 1:00 p.m.
Mandatory Pre-Bid Meeting (Conference Call) [13]	Wed 08/31/16, 11:00 a.m.
Follow-up Questions due to SBO from Confirmed Bidders	Friday 09/02/16, 1:00 p.m.
Responses to Questions to Confirmed Vendors	By Monday, 09/12/16
Deadline for Bids	Monday 09/26/16, 1:00 p.m.

[12] IMPORTANT: Your bid will not be accepted if the State of Delaware does not receive an email confirmation of an Intent to Bid. See Section II.B.1 for details.

[13] IMPORTANT: Your bid will not be accepted if your organization does not participate in the Mandatory Pre-Bid Meeting. See Section II.B.4 for details. The Mandatory Pre-Bid Meeting will be a conference call to discuss bid submission requirements, a claim of confidential and proprietary information, along with formatting requirements for the hard copies and electronic copies. Additionally, we will review the technology requirements. All other topics will be addressed in the written Question and Answer process.

Notification of Finalists - Invitation to Interview	By Friday, 10/21/16
Finalist Interviews [14]	Monday and Tuesday, 10/31/16 and 11/01/16
Contract Award	November, 2016
Non-Incumbents must have a signed contract by April 1, 2017 in order to accept file feeds to prepare for Open Enrollment	Saturday, 04/01/17
Open Enrollment	May, 2017
Plan Effective Date	Saturday, 07/01/17

E. Evaluation Process

1.0 Proposal Review Committee

The Proposal Review Committee (PRC) will review all proposals submitted that meet the requirements of the RFP. The PRC shall be comprised of representatives from each of the following offices:

- Office of Management and Budget
- Controller General's Office
- Department of Finance
- Department of Health and Social Services
- State Insurance Commissioner's Office
- State Treasurer's Office
- Chief Justice of the Supreme Court
- Lieutenant Governor's Office (currently vacant)
- President of the Correctional Officers Association of Delaware

The SBO shall determine the firms that meet requirements pursuant to selection criteria of the RFP and procedures established in 29 Del. C. § 6981 and 6982. The PRC reserves full

[14] The SEBC will require each of the finalists to make a presentation in Dover, Delaware, at the expense of the proposing firm. In addition to communicating your organization's capabilities to fulfill the requirements in the RFP, the presentation will require a demonstration of regarding customer service and account management on-line functions. Because the finalist notifications may go out as late as a week or two beforehand, **SAVE THE DATES** of Monday and Tuesday, October 31 and November 1, 2016.

discretion to determine the competence and responsibility, professionally and/or financially, of vendors. Vendors are to provide in a timely manner any and all information the PRC may deem necessary to make a decision. The PRC shall interview at least one (1) of the qualified firms.

The minimum requirements are mandatory. Failure to meet any of the minimum requirements outlined in the RFP may result in disqualification of the proposal submitted by your organization.

The SEBC will not respond to a question in the question and answer process that asks whether or not a bid would be disqualified if the vendor does not meet a specific minimum requirement. The bid must be submitted and then analyzed in its entirety.

The proposing firm's ability to meet the Technology and Data Requirements in Section VIII are also considered a minimum requirement.

The PRC shall make a recommendation regarding the award of contract to the SEBC who shall have final authority, in accordance with the provisions of this RFP and 29 Del.C. §6982, to award a contract to the successful firm or firms as determined by the SEBC in its sole discretion to be in the best interests of the State of Delaware. The SEBC may negotiate with one or more firms during the same period and may, at its discretion, terminate negotiations with any or all firms. The SEBC reserves the right to reject any and all proposals. Pursuant to 29 Del. C. § 6986, the SEBC may award a contract to two or more vendors if the SEBC determines that it is in the best interest of the State. For this procurement, the SEBC may award some or all of the plan designs to multiple vendors.

2.0 Evaluation Criteria

All proposals shall be evaluated using the same criteria and scoring process. The scoring will be based on two major subcategories: ability of the bidders to demonstrate their capabilities as traditional TPAs, and ability of the bidders to articulate the components of their proposals that involve value-based contracting models. Each plan will be evaluated on a standalone basis (e.g., PPO plans will be evaluated separately from HMO, CDHP, etc.).

For all bidders including one or more value-based contracting models in their proposal, it is the bidder's responsibility within their response to include and delineate the bidder's traditional TPA capabilities from the value-based care delivery model features in order to get full credit for the relevant sections in the scoring criteria outlined below.

The following criteria shall be used by the PRC to evaluate proposals:

Topic	Points Awarded		Description
	Non-Medicare Plans	Medicare Plans Only	
Traditional TPA Criteria – 100 points toward overall total score			

Topic	Points Awarded		Description
	Non-Medicare Plans	Medicare Plans Only	
Financial Terms	30 points	35 points for Medicare Supplement 30 points for Medicare Advantage	Reasonable and competitive administrative fees. Reasonable, transparent, and competitive provider/network discounts. Willing to offer financial guarantees, in addition to those outlined in the minimum qualifications.
Adequate Network Access	20 points	n/a for Medicare Supplement 20 points for Medicare Advantage	For PPO, HMO and CDH plans, maintains provider networks in all three counties with adequate access to providers. Bidder can articulate how it maintains its traditional network of providers with appropriate levels of clinical and quality oversight. Member disruption under bidder's broad PPO/HMO network is limited.
Plan Administration	15 points	20 points for Medicare Supplement 15 points for Medicate Advantage	Demonstrated ability to administer all eligibility and claim administration functions of a typical third party administrator. Proven ability to perform the services as outlined in the Scope of Services. Ability to duplicate existing plan designs and match existing clinical programs. Qualifications and experience of the organization's personnel to provide excellent customer service to GHIP participants and Statewide Benefits office.
Plan Design Capabilities and Services	13 points	18 points for Medicare Supplement	Ability to administer existing plan designs. Proven ability to deliver effective medical management programs. Ability to support the

Topic	Points Awarded		Description
	Non-Medicare Plans	Medicare Plans Only	
		13 points for Medicare Advantage	communication of GHIP benefit changes to participants during Open Enrollment. Accomplished account management personnel and the ability to be responsive and solve problems for members and the Statewide Benefits team.
Experience and References	10 points	15 points for Medicare Supplement 10 points for Medicare Advantage	Has outstanding references. Able to demonstrate, through proposed solutions, experience and references, an ability to meet the State's needs. Future plans for expansion of provider network in Delaware (if not already robust in-state).
Tools and Technology	5 points	5 points	Multiple access points for members to connect with bidder's online tools and resources. Offers tools and resources that will provide GHIP participants with transparency into provider costs and quality. Able to leverage the work that the State has completed on the member benefits website to educate GHIP participants on ways to be an effective health care consumer. Demonstration of vendor's account management tools that will be used to manage the State's population *(to be demonstrated at a finalist meeting).*
Integration	5 points	5 points	Willingness and ability to integrate with other benefit programs and vendors supporting State employees. Willingness and ability to partner with other community health resources (e.g., on-site/near-site health clinics) to coordinate care for GHIP participants.

Topic	Points Awarded		Description
	Non-Medicare Plans	Medicare Plans Only	
Responsiveness	2 points	2 points	Compliance with the submission requirements of the bid including format, clarity, conformity, realistic responses, and completeness, as well as responsiveness to requests during the evaluation process.
Total Points – Traditional TPA Subcategory	**100 points**	**100 points**	Subcategory represents up to 100 points towards each bidder's overall total score. For Medicare plans only – value-based contracting criteria are optional. Compliance with the submission requirements of the bid including format, clarity, conformity, realistic responses, and completeness, as well as responsiveness to requests during the evaluation process. If a bidder's proposal does not include any value-based contracting criteria, then the subcategory Traditional TPA Criteria will represent 100% of the overall total score.
Value-based Contracting Criteria – 25 points toward overall total score			
Better Member Service, Tools and Resources	4 points	4 points	Bidder has integrated data about providers participating in the value-based model into new or existing online member tools and resources (e.g., provider search tool, provider cost and quality transparency tool, medical procedure cost estimator, etc.)

Topic	Points Awarded		Description
	Non-Medicare Plans	Medicare Plans Only	
Better Care Management (Chronic and Acute Conditions)	4 points	4 points	Bidder describes how it would ensure care coordination is taking place for members that access providers participating in the value-based contracting model. Bidder describes how it would integrate the value-based contracting model with other State benefit programs (e.g., telemedicine, onsite clinic) and other community health programs (e.g., DCHI initiatives like Healthy Neighborhoods).
Improved Quality of Care	4 points	4 points	Bidder's response clearly articulates the overall efficiency, quality metrics and patient experience criteria used to understand how the value-based contracting model is better for the member and for the State.
Lower Cost of Care	4 points	4 points	Bidder is willing to offer performance guarantees related to value-based contracting model, including financial metrics and outcome-based clinical and utilization metrics, which all contribute to supporting the goal of reducing the total cost of care while not sacrificing quality. Provider contracts contain a mix of downside risk and upside risk.

Topic	Points Awarded		Description
	Non-Medicare Plans	Medicare Plans Only	
Provider Contracting Solutions	4 points	4 points	Bidder has a well-articulated plan for how it will maintain the network of providers within the value-based contracting model. Provider network either includes dominant or critical players in the provider marketplace, or includes an acceptable alternative(s) for those players so that member access to care is preserved at an adequate level for the member's network area.
Operational Capabilities	5 points	5 points	Value-based (VB) model included in bidder's proposal and is ready by 7/1/17. Or, VB model included in bidder's proposal; while not ready today, will be by 7/1/19. Value-based contracting model has oversight from clinical, operational and financial management level employees. Bidder's response to the following questions on its reporting capabilities for plan sponsors will meet the State's needs: how frequently, how granular? Will data be employer-specific or based on the bidder's entire book of business associated with the value-based contracting model? The degree of flexibility that the State will have from a plan design standpoint and how can it steer employees to the value-based contracting model to really achieve the desired results.
Total Points – Value-based	**25 points**	**25 points**	Subcategory represents 20% of overall total score.

Topic	Points Awarded		Description
	Non-Medicare Plans	Medicare Plans Only	
Contracting Criteria Subcategory			Medicare plans only – value-based contracting criteria are optional. If a bidder's proposal does not include any value-based contracting criteria, then the subcategory Traditional TPA Criteria will represent 100% of the overall total score.
Grand Total	**125 points**	**125 points**	Represents weighted average score from the subcategories Traditional TPA Criteria (80% of overall total score) and Value-based Contracting Criteria (20% of overall total score).

The SEBC will use the information contained in each bidder's proposal to determine whether that bidder will be selected as a finalist and for contract negotiations. The proposal the SEBC selects will be a working document. As such, the SEBC will expect the proposing firm to honor all representations made in its proposal.

It is the proposing firm's sole responsibility to submit information relative to the evaluation of its proposal and the SEBC is under no obligation to solicit such information if it is not included with the proposing firm's proposal. Failure of the proposing firm to submit such information in a manner so that it is easily located and understood may have an adverse impact on the evaluation of the proposing firm's proposal.

The proposals shall contain the essential information for which the award will be made. The information required to be submitted in response to this RFP has been determined by the SEBC and the PRC to be essential in the evaluation and award process. Therefore, all instructions contained in this RFP must be met in order to qualify as a responsive contractor and to participate in the PRC's consideration for award. Proposals that do not meet or comply with the instructions of this RFP may be considered non-conforming and deemed non-responsive and subject to disqualification at the sole discretion of the PRC.

3.0 RFP Award Notification

The contract shall be awarded to the vendor(s) whose proposal is determined by the SEBC to be most advantageous, taking into consideration the evaluation criteria set forth in the RFP. The SEBC is not obligated to award the contract to the vendor(s) who submits the lowest bid or the vendor(s) who receives the highest total point score. Rather the contract will be awarded to the vendor(s) whose proposal is determined by the SEBC to be the most

advantageous. The award is subject to the appropriate State of Delaware approvals including the Technology and Data Security Requirements by the Department of Technology and Information (DTI). After a final selection is made, the winning vendor(s) will be invited to negotiate a contract with the State; remaining vendors will be notified in writing of their selection status.

4.0 Award of Contract

The final award of a contract is subject to approval by the SEBC. The SEBC has the sole right to select the successful vendor(s) for award, to reject any proposal as unsatisfactory or non-responsive, to award a contract to other than the lowest priced proposal, to award multiple contracts, or not to award a contract, as a result of this RFP. Notice in writing to a vendor of the acceptance of its proposal by the SEBC and the subsequent full execution of a written contract will constitute a contract and no vendor will acquire any legal or equitable rights or privileges until the occurrence of both such events.

F. Confidentiality of Documents

The OMB is a public agency as defined by State law, and as such, it is subject to the Delaware Freedom of Information Act, 29 Del. C. Ch. 100 (FOIA). Under the law, all the State's records are public records unless otherwise declared by law to be not public and are subject to inspection and copying by any person. Subject to applicable law or the order of a court of competent jurisdiction to the contrary, all documents submitted as part of the vendor's proposal will be treated as confidential during the evaluation process. There shall be no disclosure of any vendor's information to a competing vendor or in fulfillment of a FOIA request during the bidding and contract development process.

Organizations are advised that when the contract has been fully executed or after the effective date of the contract, whichever comes later, the contents of the proposal and terms of the contract, including administrative fees, will become public record and nothing contained in the proposal or contract will be deemed to be confidential except the proprietary information.

The State of Delaware wishes to create a business-friendly environment and procurement process. As such, the State respects the vendor community's desire to protect its intellectual property, trade secrets, and confidential business information. Proposals must contain sufficient information to be evaluated. If a vendor feels that they cannot submit their proposal without including confidential business information, they must adhere to the following procedure or their proposal may be deemed non-responsive, may not be recommended for selection, and any applicable protection for the vendor's confidential business information may be lost.

!! IMPORTANT!! In order to allow the State to assess its ability to protect a vendor's confidential business information, vendors will be permitted to designate appropriate portions of their proposal as confidential business information.

The State has determined that:

- Administrative fee structures are **not** confidential and proprietary information.
- However, discount fees for individual providers and provider networks **are** considered confidential and proprietary information by the State and are excluded from the public records and not subject to FOIA disclosure.

In order to preserve the confidential and proprietary status of the appropriately designated portion of your bid, your bid must be submitted in accordance with the submission requirements stated below.

- Proposing firms must submit one (non-redacted) hard copy of any information the firm is seeking to be treated as confidential in a separate, sealed envelope labeled "Confidential and Proprietary Information" with the RFP name included.
- The envelope must contain a signed letter from the proposing firm's legal counsel describing the documents in the envelope, representing in good faith that the information in each document is not public record as defined by FOIA at 29 Del. C. § 10002(d) and state the reasons that each document meets the said definitions. The letter must list the topic and corresponding requirement or question with a reference to that section, number, question and page number, not just the titles of the appendices, exhibits or question numbers.
- The envelope must also contain a corresponding redacted set of hard copies.
- The attorney's letter, non-redacted set and redacted set must also be provided electronically on a CD.
- **Please see Section II.C., *Submission of Proposal*, for a detailed description of the number, format, and type of copies that are required.**

Upon receipt of a proposal accompanied by such a separate, sealed envelope, the State will open the envelope to determine if the procedure described above has been followed. Such requests will not be binding on the SEBC to prevent such a disclosure but may be evaluated under the provisions of 29 Del.C. Chapter 100. Any final decisions regarding disclosure under FOIA shall be made at the sole discretion of the OMB. The State shall independently determine the validity of any vendor designation as set forth in this section. Any vendor submitting a proposal or using the procedures discussed herein expressly accepts the State's absolute right and duty to independently assess the legal and factual validity of any information designated as confidential business information. Accordingly, vendors assume the risk that confidential business information included within a proposal may enter the public domain.

All documentation submitted in response to this RFP and any subsequent requests for information pertaining to this RFP shall become the property of the State of Delaware, OMB, and shall not be returned to the proposing firm. All proposing firms should be aware that government solicitations and responses are in the public domain. **If your bid contains the phrase "confidential and proprietary" on each page, such status will not be granted.**

II. Terms and Conditions

A. Proposal Response Requirements

1. **Conformity** - Your proposal must conform to the requirements set forth in this RFP. The SEBC reserves the right to deny any and all exceptions taken to the RFP requirements. By submitting a bid, each vendor shall be deemed to acknowledge that it has carefully read all sections of this RFP, including all forms, schedules, appendices, and exhibits hereto, and has fully informed itself as to all existing conditions and limitations. The failure or omission to examine any form, instrument or document shall in no way relieve vendors from any obligation in respect to this RFP.

2. **Concise and Direct** - Please provide complete answers and explain all issues in a concise, direct manner. Unnecessarily elaborate brochures or other promotional materials beyond those sufficient to present a complete and effective proposal are not desired. Please do not refer to another answer if the question appears duplicative, but respond in full to each question. If you cannot provide a direct response for some reason (e.g., your company does not collect or furnish certain information), please indicate the reason rather than providing general information that fails to answer the question. **"Will discuss" and "will consider" are not appropriate answers, nor is a reference to the current contractual terms by an incumbent.** All information requested is considered important. If you have additional information you would like to provide, include it as an exhibit to your proposal. If your organization is an incumbent, please reply with a full explanation to every question since the review committee may not be familiar with the current contract or your services.

3. **Realistic** – It is the expectation of the SEBC that vendors can fully satisfy the obligations of the proposal in the manner and timeframe defined within their proposal. Proposals must be realistic and must represent the best estimate of time, materials, and other costs including the impact of inflation and any economic or other factors that are reasonably predictable. The State of Delaware shall bear no responsibility or increased obligation for a vendor's failure to accurately estimate the costs or resources required to meet the obligations defined in the proposal.

4. **Completeness of Proposal** – The proposal must be complete and comply with all aspects of the specifications. Any missing information could disqualify your proposal. Proposals must contain sufficient information to be evaluated and, therefore, must be complete and responsive. Unless noted to the contrary, we will assume that your proposal conforms to our specifications in every way. The SEBC reserves full discretion to determine the competence and responsibility, professionally, and/or financially, of vendors. Failure to respond to any request for information may result in rejection of the proposal at the sole discretion of the SEBC.

5. **Medicare Supplement and Medicare Advantage Plans** – Vendors that are only bidding on the Medicare Supplement or the Medicare Advantage plan may determine that some of the questions within this RFP are related to a service that does not apply to that plan. This is the only instance where a bidder may answer that a topic is not applicable because the bidder is submitting a proposal for the Medicare Supplement or Medicare Advantage plan only. If a response to the same question differs for the Medicare Supplement and/or Medicare Advantage plan(s), it is your responsibility to make that notation.

   Some of the requirements in the Technical Standards and Security Requirements section (Section VIII) apply only to incumbents or non-incumbents, regardless of the plan design(s) you are proposing. Additionally, there are two different appendices for the mandatory terms and conditions. One is for the medical plans currently offered – i.e., all of the plans except the Medicare Advantage plan – which will include sections to be completed for the bidders to provide both self-funded ASO pricing as well as fully-insured premium rates; the other appendix is for the fully-insured Medicare Advantage plan. For example, if you are proposing both the Medicare Supplement and Medicare Advantage plans, you would complete both appendices. If you are proposing one or more plans, you would only fill out the corresponding plan appendix/form. If you are not providing fully insured premiums for the plans included in your proposal, you must provide a response as to why within Appendix Q: *Fully Insured Medical Premium Quotes*.

B. General Terms and Conditions

General

1. **Intent to Bid** – **!!!IMPORTANT!!!**

   a. **You must indicate your intent to bid via email to Ms. Laurene Eheman at laurene.eheman@state.de.us by Monday, August 29, 2016, no later than 1:00 p.m. ET (local time).**

   b. **Your bid will not be accepted if the State of Delaware does not receive an email or written confirmation of an intent to bid.** Include the following information: company name and address, the name, title, and email address of the primary contact along with the same information for a secondary contact, and the plan(s) for which your organization will be submitting a bid.

   c. **Upon receipt, a Word version of the RFP, along with Appendices S, T, U and V in Excel, and various non-confidential attachments will be provided.**

   d. **Non-Disclosure Agreement - A signed non-disclosure agreement is required by the Intent to Bid deadline of Monday, August 29, 2016, by 1:00 p.m., ET (local time) in order to receive a disc containing the census and claims/utilization data** which are collectively referred to as Attachment 6 throughout the RFP. NOTE: Brokers cannot execute the non-disclosure

agreement on behalf of their client. Subcontractors cannot obtain the confidential census and claims/utilization disc directly from the State and it must be obtained through the contractor they are working with.

e. After signature, scan all the pages and e-mail to Ms. Laurene Eheman at laurene.eheman@state.de.us. The data files will be sent via UPS overnight mail and instructions to access the data file will be included in the reply email confirmation.

f. Certificate of Destruction - After the RFP process is completed and the contract award is made, the Non-Disclosure Agreement requires that the census and claims data be destroyed in a secure manner and a Certificate of Destruction be provided to the State.

2. **No Bid** - To assist us in obtaining competitive bids and analyzing our procurement processes, if you choose not to bid we ask that you let us know the reason. We would appreciate your candor. For example: objections to (specific) terms, do not feel you can be competitive, or cannot provide all the services in the Scope of Services. Please email Ms. Laurene Eheman at laurene.eheman@state.de.us.

3. **Definitions** –

a. The following terms are used interchangeably throughout this RFP:

i. bidder, vendor, contractor, organization, service provider

ii. SEBC, State of Delaware

iii. proposal, bid, vendor's submission

iv. Medicare plans, Medicare Supplement, Medicfill

v. non-payroll group, participating group

b. Customer Service – Services to the members/insured, not the State, SEBC or SBO personnel.

c. Account Management – Services provided to your client - the State, SEBC and SBO personnel.

d. Appendix – Form provided in the RFP that needs to be completed by the bidder.

e. Attachment – Informational document provided in the RFP.

f. Exhibit – Attachment requested to the vendor's bid response. Examples would be the bidder's business license, a resume, or sample mailings.

4. **Mandatory Pre-Bid Meeting – A conference call will take place on Wednesday, August 31, 2016, at 11:00 a.m. ET (local time).** The purpose is to discuss the bid submission requirements, requirements for a claim of confidential and proprietary information, along with the formatting of hard copies and electronic copies. We will also discuss the technology requirements. If additional topics will be discussed and/or additional personnel are required to attend, vendors that submitted an Intent to Bid will be notified.

   The following participants are required to attend:

   - Your organization's primary contact for the RFP or their designee;
   - The administrative person who will be compiling the confidential and proprietary request, if applicable, the redacted copies of the discount fees for individual providers and provider networks, and the hard and electronic copies; and
   - The person who will be responding to the requirements in the Technical Standards and Security Requirements section.

   Your bid will not be accepted if your organization does not participate in the conference call. Meeting minutes will not be taken. However, if new or additional information is provided, an addendum may be released to address information provided during the mandatory pre-bid conference call. Questions regarding other topics will not be entertained and must be submitted in the Questions and Answers process as described in Section II.B.6.

5. **Discrepancies, Revisions and Omissions in the RFP** – 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, Ms. Laurene Eheman, electronically, and only electronically, at laurene.eheman@state.de.us, at least ten (10) business days before the proposal due date by submitting the *RFP Terms and Conditions Exception Tracking*, Appendix F. This will allow for the issuance of any necessary addenda. It will also help prevent the opening of a defective proposal and exposure of the vendor's proposal upon which an award could not be made. All unresolved issues should be addressed in the proposal.

   Protests based on any omission or error, or on the content of the solicitation, will be disallowed if these faults have not been brought to the attention of Ms. Laurene Eheman, electronically, and only electronically, at laurene.eheman@state.de.us, no later than ten (10) business days prior to the time set for opening of the proposals.

If it becomes necessary to revise any part of the RFP, an addendum will be posted on the State of Delaware's website at www.bids.delaware.gov and emailed to all vendors that submitted an Intent to Bid. The State of Delaware or SEBC is not bound by any statement related to this RFP made by any State of Delaware employee, contractor or its agents.

6. **Questions** – The SEBC anticipates this will be an interactive process and will make every reasonable effort to provide sufficient information for vendor responses. Vendors are invited to ask questions during the proposal process and to seek additional information, if needed. However, do not contact any member of the SEBC about this RFP. Communications made to other State of Delaware personnel or attempting to ask questions by phone or in person will not be allowed or recognized as valid and may disqualify the vendor.

   Vendors should only rely on written statements issued by the RFP designated contact, Ms. Laurene Eheman. **All proposing vendors must submit their questions electronically, and only electronically, to Ms. Laurene Eheman at laurene.eheman@state.de.us no later than Wednesday, September 7, 2016, by 1:00 p.m. ET (local time)**

   Required Format: Questions must be submitted in a Word document with a table format. So that we can be sure to respond within the context of the question, if you are referring to a specific question or term, please copy the question or information and reference the section, question number, and/or page number in the first column. In the second column, copy the requirement or question. In the third column, state your question. The SBO will then put all questions received and the responses into one document and send it to all vendors who confirmed their intention to bid. It will also be posted on www.bids.delaware.gov.

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). The vendor must guarantee financial terms through June 30, 2020 for all plans outside of the Medicare Supplement and Medicare Advantage. The State will have the option to renew the contract for two (2) one-year periods; FY21 and FY22.

Contract Termination

The term of the contract between the successful organization and the State will be for three (3) years and may be renewed for two (2) additional one-year extensions at the discretion of the SEBC. The contract may not be terminated for convenience by the successful firm. The contract may be terminated for cause by the vendor with 180 days written notice to the State. In the event the successful firm materially breaches any obligation under this Agreement, the State may terminate this Agreement upon thirty (30) days written notice.

Performance Guarantees

The State expects exceptional client account management and participant customer service from their vendors and is interested in evaluating financial and non-financial performance guarantees. The State reserves the right to negotiate both financial and non-financial performance guarantees. ***If your offer does not receive a clarifying question or any other response from the State, it does not infer acceptance.*** Please refer to Appendix C.

Use of Subcontractors

Subcontractors are subject to all the terms and conditions of the RFP and the companies and their services must be clearly explained in your proposal. The SEBC reserves the right to approve any and all subcontractors.

Required Reporting of Fees and 2nd Tier Spend

Monthly Vendor Usage Report - One of the State's primary goals in administering all its contracts is to keep accurate records regarding actual value/usage. This information is essential in order to update the contents of a contract and to establish proper bonding levels if they are required. The integrity of future contracts revolves around the State's ability to convey accurate and realistic information to all interested parties. For benefit programs, only the administrative fees are reported.

A complete and accurate Usage Report (for illustrative purposes, Attachment 4) shall be furnished in an Excel format and submitted electronically to the 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. *The SBO will submit this report on your behalf.*

2nd Tier Spending Report - In accordance with Executive Order 44, the State of Delaware is committed to supporting its diverse business industry and population. 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) under this awarded contract. The reported data elements shall include but not be limited to: name of state contract/project, the name of the Diversity Supplier, Diversity Supplier contact information (phone, email), type of product or service provided by the Diversity Supplier and any minority, women, veteran, or service disabled veteran certifications for the subcontractor (State OSD certification, Minority Supplier Development Council, Women's Business Enterprise Council, VetBiz.gov). The format used for Subcontracting 2nd Tier report is shown as in Attachment 4.

Accurate 2nd Tier Reports shall be submitted to the Office of Supplier Diversity on the 15th (or next business day) of the month following each quarterly period. For consistency, quarters shall be considered to end the last day of March, June, September and December of each calendar year. Contract spend during the covered periods shall result in a report even if the contract has expired by the report due date. *You will be asked for this information and the SBO will submit this report on your behalf.*

Offshore Vendor Activity

An activity central to the Scope of Services cannot take place at a physical location outside of the United States. 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.

Rights of the PRC

- The PRC reserves the right to:
  - Select for contract or negotiations a proposal other than that with lowest costs.
  - Reject any and all proposals received in response to this RFP.
  - Make no award or issue a new RFP.
  - Waive or modify any information, irregularity, or inconsistency in a proposal received.
  - Request modification to proposals from any or all vendors during the review and negotiation.
  - Negotiate any aspect of the proposals with any organization.
  - Negotiate with more than one organization at the same time.
  - Pursuant to 29 Del. C. § 6986, select more than one contractor/vendor to perform the applicable services.

- Right of Negotiation – Discussions and negotiations regarding price, performance guarantees, and other matters may be conducted with organizations(s) who submit proposals determined to be reasonably acceptable of being selected for award, but proposals may be accepted without such discussions. The PRC reserves the right to further clarify and/or negotiate with the proposing organizations following completion of the evaluation of proposals but prior to contract execution, if deemed necessary by the PRC and/or the SEBC. ***If any portion of a bid response does not receive a clarifying question or any other response from the State, the non-response does not infer acceptance of that portion of the bid response by the State.*** The SEBC also reserves the right to move to other proposing firms if negotiations do not lead to a final contract with the initially selected proposing firm. The PRC and/or the SEBC reserves the right to further clarify and/or negotiate with the proposing firm(s) on any matter submitted.

- Right to Consider Historical Information – The PRC and/or the SEBC reserves the right to consider historical information regarding the proposing firm, whether gained from the proposing firm's proposal, question and answer conferences, references, or any other source during the evaluation process.

- Right to Reject, Cancel and/or Re-Bid – The PRC and/or the SEBC specifically reserve the right to reject any or all proposals received in response to the RFP, cancel the RFP in its entirety, or re-bid the services requested. The State makes no

commitments, expressed or implied, that this process will result in a business transaction with any vendor.

C. Submission of Proposal

1. **Format** - For each requirement or question, retain the numbering/lettering convention, even if there is an error in the numbering sequence, and provide your response in the appropriate response area or box. Please completely answer the question even if you must restate information provided in a different minimum requirement or in another question. Complete instructions have been provided at the beginning of the Minimum Requirements and Questionnaire sections.

2. **Non-Redacted Hard Copies** –

   a. For each section, such as the minimum requirements and questionnaire, and for each attachment/exhibit you reference, separate the materials with tabs. Please include a table of contents.

   b. Please use double-sided copies where it is logical to do so; for example, a section of six or more pages.

   c. Please use locking binders so the rings don't separate in shipping. Do not use spiral binding because we have to add follow-up questions and responses to your bid response.

   d. Please use multiple smaller binders instead of one large 6" binder, for example. A suggestion might be to have the appendices and exhibits in their own binder.

   e. For reports or documents of fifty or more pages, do not include a hard copy. Use a sheet that references the electronic document.

   f. Please submit **seven (7) *complete* hard copies** of your proposal. *Complete* means that it includes all information you may deem proprietary and confidential. In other words, the information deemed proprietary and confidential must not be redacted or separated from the rest of the information. Send to the following address:

      Ms. Laurene Eheman, RFP and Contract Manager
      Office of Management and Budget
      Statewide Benefits Office
      500 W. Loockerman Street, Suite 320
      Dover, DE 19904
      Phone: (302) 739-8331

3. **Non-Redacted Electronic Copies** –

a. Include a *complete* non-redacted electronic copy of your proposal in a PDF format on its own CD. You must scan all the documents; for example, a signed cover letter, the signed Officer's Statement and any exhibits.

b. You must divide your bid into PDFs of manageable sections for easier readability. We will not accept a bid with one PDF of the entire bid response!

   i. The file names of the documents must be short. Include a short version of your company name but do not include, the reference number of this RFP, the words "State of Delaware" or "Delaware". Simply use a title of the document; for example, "ABC Co - Minimum Requirements", "L&C -Appendix A – Performance Guarantees", or "John's Mgt Co - Exhibit 1 – John Doe's Resume".

c. Versions –

   a. All documents must be in PDF format.

   b. The following documents are to ALSO be included in their Word or Excel format as applicable:

      1. Minimum Requirements

      2. Questionnaire

      3. Appendix P: Medical ASO & Discounts

      4. Appendix Q: Fully-Insured Medical Premium Quotes

      5. Appendix R: Supplemental Financial Questions

      6. Appendix V: Provider Disruption

d. Please label the CD with your company name and carefully package it for shipping. Do not use a thumb or flash drive.

4. **Redacted Hard and Electronic Copies –**

Any information you deem confidential and propriety as identified in the attorney's cover letter as explained in Section I.F., *Confidentiality of Documents*, must be redacted. This means the information must be blacked out or substituted with a blank page that references the page or document that is missing. For example:

For all transactions, the following conditions must be met:

- individual section policies are followed;
- verbal price quotes are obtained;
- State Contracts must be utilized;
- purchases over $5,000 have a corresponding purchase order prior to the charge; and fragmentation of purchases is prohibited.

In addition, [redacted] Employees must reimburse the State of Delaware for any expenditure above the allowable amounts.

Any questions on requirements should be directed to staff in OMB Financial Operations.

2. Coordinator/Back-Up Coordinator – Designation, Roles and Responsibilities
The Coordinator or Back-Up Coordinator will be responsible for maintaining a file which shows all applications, signed affidavits, and policies and procedures. Any issue that arises with the employee or [redacted] is to be dealt with first by the Coordinator or Back-up Coordinator. The Coordinator or Back-Up Coordinator is also responsible for ensuring that the purchases comply with the state and federal legislation, regulations, policies and procedures. [redacted] and attached to a weekly log (Exhibit C). Any employee not producing a receipt must complete an affidavit statement certifying that they did in fact purchase the particular item. The affidavit statement must be signed by the employee and the supervisor or section designee.

Reconciler - The Reconciler is responsible for applying the chartfield information in the First State Financial system. The Reconciler is also responsible for ensuring that the purchases comply with the state and federal legislation, regulations, policies and procedures.

Approver – [redacted]

3. Request for an Application
All requests need to be addressed to the employee's supervisor for approval. The supervisor then will request a SuperCard approval from the Coordinator or Back-up Coordinator.

a. You must use a software program that has a redaction feature, such as Adobe. If you simply use a black highlight, the text can still be seen on a hard copy and it may be able to be reversed on a PDF.

b. One *complete* and separate hard copy is needed with the redacted materials. Imagine you are flipping through the hard copy. You would see that section on a page with information blacked out (redacted) that the author considers confidential and proprietary. If an entire document, section or exhibit consisting of multiple pages is considered confidential and proprietary, use a blank page with a reference to the missing information. For example, "Appendix C – Disaster Recovery Plan – is confidential and proprietary and is not public record as defined by FOIA at 29 Del. C. § 10002(d)".

c. One *complete* electronic copy is needed with the redacted materials in a PDF format on a separate CD from the non-redacted copy. We need a separate complete electronic copy to use for FOIA requests. You must scan all the documents as explained above. The same sectioning and naming requirements as described above apply.

Recap of Proposal Copy Formats	Hard Copies	Electronic Copies on Separate CDs
Confidential and Proprietary Information: One set of non-redacted and one set of redacted copies along with the attorney's cover letter in a marked and sealed envelope.	1	1
Complete bid with redacted sections (only PDF versions)	1	
Complete bid without redacted sections (PDFs, Word and Excel versions as listed above).	7	1

The person who is putting together the hard and electronic copies is welcome to, and encouraged to, contact Ms. Laurene Eheman directly by phone at 302-760-7060 to discuss the requirements and ask questions.

5. **Follow-Up Responses and Finalist Presentations –**

a. The same format requirements apply to follow-up responses and presentations.

b. Follow-Ups - Via email, you will be asked for a non-redacted electronic response. SBO will print the required number of hard copies for you (unless they are voluminous and in that event the email will contain a request for the hard copies).

c. Finalist Presentation - You will be asked for a non-redacted electronic copy that includes pdfs of any supplemental materials or handouts.

d. If information in any of the follow-ups and presentation matches the type that was requested for a confidential and proprietary determination, you must submit a redacted electronic version of the document(s). For example, if you asked for your client references to be deemed confidential and in a follow-up we ask for additional references or an alternate contact name and number, we would need an electronic copy with that information redacted. Similarly, if you have a list of clients in your presentation materials, we would also need a redacted copy of your presentation.[15]

e. If there is a new type of information that was not included in your original bid and you deem it confidential and proprietary, you must include the required attorney's letter.

[15] Don't forget, discount fees for individual providers and provider networks have already been granted a confidential and proprietary determination. If a follow-up response or your presentation includes this type of information, a redacted electronic copy is required.

6. **Proposal Submission Date** – Both hard and electronic copies of your complete proposal must be received at the above address no later than **1:00 p.m. ET (local time) on Monday, September 26, 2016**. Electronic copies cannot be transmitted via email by the deadline with hard copies to arrive before, on, or after the due date. If the office is closed on the bid due date due to weather or other emergency, the due date and time cannot be pushed forward one day. Any proposal received after this date and time shall not be considered and will be returned to the proposing firm unopened. The proposing firm bears the risk of delays in delivery. The contents of any proposal shall not be disclosed or made available to competing entities during the negotiation process.

7. **Proposal Opening –** To document compliance with the deadline, the proposals will be date and time stamped upon receipt. Proposals will be opened only in the presence of State of Delaware personnel. There will be no public opening of proposals, but a public log will be kept of the names of all vendor organizations that submitted proposals. The list will be posted on www.bids.delaware.gov. In accordance with Executive Order #31 and Title 29, Delaware Code, Chapter 100, the contents of any proposal will not be disclosed to competing vendors prior to contract execution. Proposals become the property of the State of Delaware at the proposal submission deadline.

8. **Officer Certification** – All vendors participating in this RFP will be required to have a company officer attest to compliance with RFP specifications and the accuracy of all responses provided. Please fill out the *Officer Certification Form*, Appendix E, and include it in your bid package.

9. **Vendor Errors/Omissions** – The SEBC will not be responsible for errors or omissions made in your proposal. You will be permitted to submit only one proposal. You may not revise or withdraw submitted proposals after the applicable deadline.

10. **General Modifications to RFP** – The SEBC reserves the right to issue amendments or change the timelines to this RFP. All firms who submitted an Intent to Bid notice will be notified in writing via e-mail of any modifications made by the SEBC to this RFP. If it becomes necessary to revise any part of the RFP, an addendum will be emailed to all vendors who submitted an Intent to Bid and it will also be posted on the State of Delaware's website at www.bids.delaware.gov.

11. **Modifications to Submitted Proposal** – Changes, amendments or modifications to proposals shall not be accepted or considered after the time and date specified as the deadline for submission of proposals. However, vendors may modify or withdraw its complete proposal by written request, provided that both proposal and request is received by Ms. Laurene Eheman prior to the proposal due date and time. Pages for substitution will not be accepted or allowed. The proposal may be re-submitted in accordance with the proposal due date in order to be considered.

12. **Proposal Clarification** – The SEBC may contact any vendor in order to clarify uncertainties or eliminate confusion concerning the contents of a proposal. Clarifications (known as "Follow-Ups") will be requested in writing and the vendor's responses will become part of the proposal.

13. **References** – The SEBC may contact any customer of the vendor, whether or not included in the vendor's reference list, and use such information in the evaluation process. Additionally, if applicable to the scope of work in this RFP, the State of Delaware may choose to visit existing installations of comparable systems, which may or may not include vendor personnel. If the vendor is involved in such site visits, the State of Delaware will pay travel costs only for the State of Delaware personnel for these visits.

14. **Time for Acceptance of Proposal –** The bidder agrees to be bound by its proposal for a period of at least 180 days, during which time the State may request clarification or corrections of the proposal for the purpose of the evaluation. The State reserves the right to ask for an extension of time if needed.

15. **Incurred Costs** – This RFP does not commit the SEBC to pay any costs incurred in the preparation of a proposal in response to this request and vendor/bidder agrees that all costs incurred in developing its proposal are the vendor/bidder's responsibility. The State shall bear no responsibility or increased obligation for a vendor's failure to accurately estimate the costs or resources required to meet the obligations defined in the proposal.

16. **Basis of Cost Proposal** – Your proposal must be based on your estimated cost of all expenses for the services and funding arrangements requested.

17. **Certification of Independent Price Determination** – By submission of a proposal, the proposing firm certifies that the fees submitted in response to the RFP have been arrived at independently and without – for the purpose of restricting competition – any consultation, communication, or agreement with any other proposing firm or competitor relating to those fees, the intention to submit a proposal, or the methods or factors used to calculate the fees proposed. Please fill out the *State of Delaware Non-Collusion Statement*, Appendix A, and include it in your bid package.

18. **Improper Consideration** – Bidder shall not offer (either directly or through an intermediary) any improper consideration such as, but not limited to, cash, discounts, service, the provision of travel or entertainment, or any items of value to any officer, employee, group of employees, retirees or agent of the SEBC in an attempt to secure favorable treatment or consideration regarding the award of this proposal.

19. **Representation Regarding Contingent Fees** – If it is your business practice to engage services from any person or agency to secure or execute any of the services outlined in this RFP, any commissions and percentage, contingent, brokerage,

service, or finder's fees must be included in your proposed fee. The SEBC will not pay any separate brokerage fees for securing or executing any of the services outlined in this RFP. **Therefore, all proposed fees must be net of commissions and percentage, contingent, brokerage, service or finders' fees.**

20. **Confidentiality** – All information you receive pursuant to this RFP is confidential and you may not use it for any other purpose other than preparation of your proposal. After the RFP process is completed and the contract award is made, the Non-Disclosure Agreement requires that the census and claims data be destroyed in a secure manner and a certificate of destruction be provided to the State.

21. **Solicitation of State Employees** – Until contract award, vendors shall not, directly or indirectly, solicit any employee of the State of Delaware to leave the State's employ in order to accept employment with the vendor, its affiliates, actual or prospective contractors, or any person acting in concert with the vendor, without prior written approval of the State's contracting officer. Solicitation of State of Delaware employees by a vendor may result in rejection of the vendor's proposal.

    This paragraph does not prevent the employment by a vendor of a State of Delaware employee who has initiated contact with the vendor. However, State of Delaware employees may be legally prohibited from accepting employment with the contractor or subcontractor under certain circumstances. Vendors may not knowingly employ a person who cannot legally accept employment under state or federal law. If a vendor discovers that they have done so, they must terminate that employment immediately.

22. **Consultants and Legal Counsel** – The SEBC may retain consultants or legal counsel to assist in the review and evaluation of this RFP and the vendors' responses. Bidders shall not contact the consultant or legal counsel on any matter related to this RFP unless written permission and direction is provided.

23. **Contact with State Employees** – Direct contact with State of Delaware employees regarding this RFP other than the designated contact, Ms. Laurene Eheman, is expressly prohibited without prior consent. Vendors directly contacting State of Delaware employees risk elimination of their proposal from further consideration. Exceptions exist only for organizations currently doing business with the State who require contact in the normal course of doing that business.

24. **Organizations Ineligible to Bid** - Any individual, business, organization, corporation, consortium, partnership, joint venture, or any other entity including subcontractors currently debarred or suspended is ineligible to bid. Any entity ineligible to conduct business in the State of Delaware for any reason is ineligible to respond to the RFP.

25. **Exclusions** - The PRC reserves the right to refuse to consider any proposal from a vendor who:

a. Has been convicted for commission of a criminal offense as an incident to obtaining or attempting to obtain a public or private contract or subcontract, or in the performance of the contract or subcontract;

b. Has been convicted under State or Federal statutes of embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property, or other offense indicating a lack of business integrity or business honesty that currently and seriously affects responsibility as a State contractor;

c. Has been convicted or has had a civil judgment entered for a violation under State or Federal antitrust statutes;

d. Has violated contract provisions such as:

    i. Knowing failure without good cause to perform in accordance with the specifications or within the time limit provided in the contract; or

    ii. Failure to perform or unsatisfactory performance in accordance with terms of one or more contracts;

    iii. Has violated ethical standards set out in law or regulation; and

    iv. Any other cause listed in regulations of the State of Delaware determined to be serious and compelling as to affect responsibility as a State contractor, including suspension or debarment by another governmental entity for a cause listed in the regulations.

III. Minimum Requirements

1. The following minimum requirements are mandatory.
2. Additionally, the Technology and Data Requirements in Section VIII are considered minimum requirements.
3. Failure to meet any of these proposal criteria may result in disqualification of the proposal submitted by your organization.

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

A. **Clear and Succinct** - Whenever applicable, you must clearly and succinctly indicate how your standard procedures would be modified in order to accommodate any specific requirements of the State that deviate from your standard procedures.

B. **Responsiveness** –

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

C. **Respond to Each Question** –

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

D. **Incumbents** - If your organization is the current vendor, you must reply with a full explanation to every question since the review committee may not be familiar with the current contract or your services.

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

appendix (i.e., Appendix P: *Medical ASO & Discounts*, Appendix Q: *Fully-Insured Medical Premium Quotes*, and Appendix R: *Supplemental Financial Questions*).

F. **Exceptions** - If you have an exception, you must copy and paste the term into the *Responses Exceptions Tracking* form, Appendix B, and provide a detailed explanation, or, check the box to acknowledge that you take no exceptions to the specifications, terms or conditions found in the *Minimum Requirements* or *Questionnaire* sections and submit it with your bid package.

G. **Numbering** - Please do not change the numbering of a question, even if there is an error in the sequence or a duplication. Thank you.

H. **Table and Check Box Format** –

- Due to the table format, be sure to respond in the same row instead of adding a row beneath the question.
- If a question asks for a response in a check box format, please bold your selection(s) since the check box feature is not operational.
- If a question asks for a selection (“pick”), please also use a bold formatting for your response.
- For any additional information you provide, either in a response to “other” or as information you feel is required to provide a complete response, please do not add a lengthy explanation that expands the cell beyond a reasonable number of sentences and length. Instead, reference an exhibit and use a table format that includes the section name, item number, copy of the question, and page number. The review committee must be able to easily find your response and refer back to the question!

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As an introduction, please provide the firm’s name, home office address and telephone number, and the address and telephone number of additional offices, if any, that would provide the services requested under this RFP. Include the name and information for the primary contact, including email address, for this RFP. Include your company’s website address.

A. Core Capabilities and Experience

1. The selected vendor must have at least three (3) years’ experience as an organization providing all of the services indicated in the Scope of Services (Section I.C). Please confirm and provide a concise outline of your organization’s experience and qualifications.

2. Of your company's current clients, using the list of information below, provide three (3) or more references with at least one being a public sector client. Additionally, provide references for three (3) terminated clients and note the date of termination and reason.
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Your company must have proven ability to perform the services described in this RFP, therefore, you must provide the references at this time in order to show your ability to serve clients of a similar size. If requested in your bid response, the SEBC will agree to notify you before contacting your references during the initial bid analysis process. Then, if selected as a finalist, you will be asked to arrange for your current client references to contact the State or its designated representative. Specific instructions will be provided at that time.

Include the following information:

a. Client name

b. Client principal location

c. Location servicing account, if different

d. Client contact including name, title address, email and phone number

e. Name of Account Manager

f. Total number of employees

g. Number of employees that are participants, if different

h. Number of covered lives

i. Effective date of contract

j. (Date and reason for termination, if applicable)

3. For the plan(s) that the selected vendor bids on, the selected vendor must be able to duplicate the current plan designs without deviation – for further details on the current plan designs, see http://ben.omb.delaware.gov/medical/index.shtml. Please confirm. If you cannot duplicate the current plan designs without deviation, please explain.

4. The selected vendor must have either have in place or a plan to implement one or more value-based contracting models within all three counties in Delaware by the third year of the contract (July 1, 2019 – June 30, 2020). Please describe your program or your plan to implement one or more of these models within all three counties in Delaware by July 1, 2019.

B. Account Support

5. The individual who will act as the SEBC's primary contact shall be, at a minimum, a senior level manager and shall have at least five (5) years' experience providing medical TPA account management, of which three (3) years' experience must have been in providing medical TPA account management services to clients of similar size and complexity. As an exhibit, please provide a statement detailing such experience and a resume.

6. Please confirm that the primary contact will respond promptly (within the same business day) to all State administrative staff requests and questions within normal business hours and will have broad and extensive expertise in at least the following areas: plan design set-up/management, claims processing, enrollment, billing, and member service. Indicate the

percent of their time that will be spent on the State's account. Also, indicate whether the primary contact can be dedicated 100% to the State's account and, if so, whether this would entail additional cost/fees. Additional costs/fees must be stated on the *Medical ASO & Discounts* form, Appendix P.

7. Please confirm that the primary contact and/or lead personnel assigned to a transition team (implementation manager), account executive, account manager, clinical manager, along with the director of your network contracting area will be part of any finalist interview team. Additionally, confirm that during the presentation the vendor will provide a demonstration of the on-line member portal and any account management on-line tools that can be used by SBO's account management team to manage the Plan.

8. Do you anticipate any mergers, transfer of company ownership, sales management reorganizations, or departure of key personnel within the next three (3) years that might affect your ability to carry out your proposal if it results in a contract with the State? If yes, please explain.

9. Please confirm that you will provide designated clinical manager to the State, who will have full knowledge of all clinical programs in effect under the Plan as well as all clinical programs offered by your organization. What percent of their time would be spent on the State's account? As an exhibit, please provide a statement detailing such experience and a resume.

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.

11. Please confirm that your company will provide regular information concerning industry developments or new services and will provide articles and other communications at a frequency determined by the State for inclusion in newsletters and websites.

12. At no cost to the State, please confirm that you will meet with the State on-site on a quarterly basis, noting your company performance according to the performance guarantees in place and to review plan participation.

13. At no cost to the State, please confirm that your organization will provide on-site representation throughout Delaware for two (2) days of benefit representatives' meetings in April each year as well as approximately five (5) days of Health Fairs and educational sessions in May at various locations in all three counties.

14. Please confirm that you will provide a toll-free telephone number for Statewide Benefit Office account management personnel and HR benefit representatives who require assistance with operational or administrative functions of the Plan.

15. Please confirm that your member services representatives will be trained and the toll-free line will be operational by May 1, 2017 for annual enrollment calls and at no additional cost to the State of Delaware. This requirement also applies to the Open Enrollment period each year.

C. Benefit Administration

16. Please confirm that member Welcome Kits and ID cards will be mailed to the homes of newly enrolled employees within fourteen (14) calendar days upon receipt of the enrollment file from the State.

17. 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 with the State of Delaware concerning the open enrollment period.

18. Please confirm that the State maintains flexibility to edit/approve all communication materials.

19. Please confirm your organization will conduct customer service surveys and report on a quarterly basis. (This is a requirement in the Performance Guarantees.) If you have a sample of a customer service survey, please provide a copy as an exhibit.

20. Please confirm that you will provide a toll-free telephone nurse line 24 hours a day, 7 days a week (which does include major holidays).

21. Please confirm that your system is able to handle multiple coverage termination rules depending on the type of Qualifying Event (QE). The State requires that coverage terminates at the end of the month for all QEs <u>except</u>:

    a. Coverage terminates the day after the effective date of a divorce; and

    b. Coverage for the ex-spouse of a retiree covered by a Medicare Supplement plan will terminate on the last day of the month in which the divorce is final.

22. On a monthly basis and at no cost to the State, please confirm that you agree to provide the State's data mining vendor, currently Truven Health Analytics, with claims data. The vendor may, at the direction of the State, be required to provide claims data to other parties and/or business partners of the State, including, but not necessarily limited to, the State's healthcare consultant as determined necessary for the administration of the State's Group Health Insurance Program. Such requests shall be fulfilled at no cost to the State. Please refer to the file layouts referred to as Attachment 3. Additionally, the State may require that disease management data be sent to the data mining vendor in the future. The State acknowledges that the release of claims data must be done in compliance with HIPAA Privacy rules and regulations.

23. Please confirm that services will extend nationwide to all eligible employees and retirees.

24. Please confirm that your organization will run a GeoAccess analysis and provider disruption on an annual basis to compare the prior year's information with the current year's census, Attachment 6.

25. Please confirm that you will provide member support services for selecting and/or locating network providers.

26. Reporting – Please confirm that at no cost to the State:

    a. Your organization can provide the reports listed in the *Master Report List*, Attachment 1, at no cost to the State. Which reports are available on-line? As an exhibit, please provide a sample of these types of reports and include samples of any reports that are available but not listed.

    b. That your organization can accept electronic files from the State containing the data elements of completed Spousal Coordination of Benefits (S-COB) forms required by employees and pensioners who cover a spouse on their health plan and read those files to interpret (preferably through an automated process) compliance with the S-COB policy. In addition, confirm that your organization will also be able to accept a small number of paper S-COB forms. Production of an initial annual report is required no later than June 20th and which provides the status of S-COB compliance based on forms completed during annual Open Enrollment. Thereafter, weekly reporting will be required by the State which will list all employees who are not compliant with the S-COB policy.

    c. That your 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.)

    d. 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.

27. Please confirm that your organization can provide *ad hoc* reports as requested. Is there a fee for such reports? If so, please indicate in Section VI.2. Financial Assumptions. As an exhibit, please provide a sample of a type of *ad hoc* report that was produced for a client.

28. Please confirm your ability to accept Plan Eligibility File effective dates that may be up to 120 days in the future.

29. Please confirm your ability to receive the entire Plan Eligibility Files and only process those fields in which the resident information has been added, deleted, or changed.

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.

31. Please confirm your ability to support retroactive enrollments and terminations of up to one year for members in situations allowable under the Patient Protection and Affordable Care Act.

32. Please confirm your ability to accept alternative sequence numbers in lieu of actual Social Security Numbers for newborns and foreign nationals.

33. Please confirm your ability to maintain member records so that you can categorize members in the following employer types: Merit Agency, Public Education, Higher Education, State of Delaware Retirees, Non State Participating Groups as well as by Plan type and actives, non-Medicare retirees and Medicare retirees.

34. Please confirm your ability to participate in Voluntary Data Sharing Agreement (VDSA) with the Center for Medicare and Medicaid and accept electronically-transmitted Medicare claims and coordinate those claims with the Plan.

35. Please confirm that the existence of concurrent review and discharge services will be transparent to the member.

36. Please confirm your ability to inquire of the member whether a third party may be liable for the cost of the care received, and, if so, request that the identity of the third party be provided for the purposes of instituting subrogation.

37. Please confirm your ability to actively pursue the State's right of subrogation to recover claim payments from third parties, including pursuing payments made when there is a work related accident or illness.

38. Please confirm your acceptance of the State's electronic Spousal Coordination of Benefits (S-COB) file (see Attachments 3 and 8) as well as paper forms where applicable (retirees). Acceptance of this file including all testing must be completed prior to the start of Open Enrollment which begins on May 8, 2017. Production of an annual report is required after Open Enrollment (May 8, 2017 through May 25, 2017) and then weekly thereafter to the SBO which reports the members who are noncompliant with the State's Coordination of Benefits policy. The vendor must make a determination, either manually or by an automated system, for the non-compliance status which is defined as State members who have not completed and returned the State's S-COB form. The S-COB policy and S-COB form are available at http://ben.omb.delaware.gov/documents/cob. Additionally, describe your process for determining non-compliance, i.e., do you have data processing capabilities currently or would need to develop the programming? If the latter, would the programming hours be at no-cost to the State or be applied to an implementation allowance?

39. Please refer to the State's appeal process for members when coverage for a specific service is denied – Attachment 7. Please confirm your ability to customize appeal responses to reflect the State's processes, as necessary.

40. Please confirm your ability to monitor eligibility for Medicare coverage and notify the State and members when a member is first eligible and of any changes in eligibility.

41. Please confirm your ability to inquire as to the existence of other group medical or Medicare coverage and coordinate payment of claims with other payers.

42. Please confirm your ability to provide designated staff to proactively monitor claims that qualify for other medical coverage due to any reason, including ESRD.

43. Please confirm your ability to provide, at no cost to the State, written notice via U.S. mail to eligible members that enrollment in Medicare Parts A and B is mandatory (for any reason that they qualify for Medicare, e.g., attained age, disability, ESRD), within a specific timeframe that is mutually agreeable to you and to the State that also complies with regulatory requirements related to the timeframe for this notification. Please confirm that you will also provide this notification to the Statewide Benefits Office. Bidders that do not have procedures in place to accurately enforce this requirement shall accept liability for any overpayments that cannot be recovered in a timely manner.

44. Under the Employee Assistance Program (EAP), currently administered by HMS/Health Advocate, eligible participants may receive up to five (5) counseling sessions before being transferred to their medical plan. Please confirm your ability to fully cooperate with the EAP in their assistance to all eligible enrollees.

45. Please confirm your ability to support the State in compliance with all requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

46. Please confirm your ability to comply with the following three pieces of legislation[16] that were just passed in the 148th General Assembly (in June 2016):
    - HB 381 – pre authorizations
    - HB 439 – OON disclosure and transparency
    - HB 238 – All Payers Claim Database

    Please also provide a brief description of how you would comply with these pieces of legislation, including any implementation processes necessary if your operational processes as they exist today would not allow you to comply with the legislation. **Please be specific and comment separately on each of the three pieces of legislation.**

47. Please confirm your ability to comply with any other legislation passed at the State or Federal level that applies to the GHIP.

D. Financial

48. Please confirm that all fees or costs to administer the program are included in your pricing terms quoted in the Financial Proposal (Section VI) and on Appendices P, Q and R - *Medical ASO & Discounts, Fully-Insured Medical Premium Quotes* and *Supplemental Financial Questions*. **Fees or costs that are not included in your bid on those forms will not be considered by the State.**

49. Please confirm that the State will receive a 90-day notice, when possible, of any event or negotiation that may cause a disruption to the provider network access.

[16] For further details about each piece of legislation, please access the following website which provides the status of all bills introduced in the legislature: http://legis.delaware.gov/.

50. Please confirm that your organization will not bill the State for any uncollected participant's copays.

51. Please confirm that your organization will reimburse the State for any claim payments that were incurred as a result of incorrect benefit plan programming.

52. Please confirm that your organization will reimburse the State for any claim payments that were incurred as a result of incorrect information provided by a customer service representative.

53. Please confirm that the State or its designee will have the right to audit on an annual basis with an auditor of its choice and with full cooperation of your organization, the services and pricing provided in order to verify compliance with all program requirements and contractual guarantees. The State's right to audit shall survive the termination of the agreement between the parties for a period of three (3) years.

54. Please confirm your acceptance that your organization must make a reasonable effort to recover claim amounts overpaid or paid in error and refund the recoveries to the State or credit these recoveries against any amounts payable by the State. The Bidder may pursue the overpayment with the provider and/or member.

55. Please confirm that your organization must make all reasonable efforts to recover claims paid in error when the member has been involved in a workplace accident. Reasonable efforts include: asserting liens, appearing in workers' compensation court to recover liens and all correspondence with member's attorney.

56. With regard to recovery of overpayment to members, please confirm that your organization must never pursue legal remedies such as placing liens for overpayment without first advising the State. After reasonable attempts are made to recover the overpayment, the Bidder may deduct the overpayment from future payments to the member. If the overpayment was the result of an error of the Bidder, the overpayment will be immediately absorbed by Bidder and will not be charged to the State or to the member.

57. Please confirm that monies recovered such as subrogation outside of Delaware of a claim or lien must be fully disclosed and accounted for and credited to the State's claims account. Reports to be provided quarterly.

58. Please confirm that your organization must assign a dedicated account manager for the State to call concerning claims paid.

59. At minimum, guarantee proposed fees and provider network discounts for three (3) contract years: July 1, 2017 to June 30, 2020 with two (2) one-year extensions, each at the discretion of the SEBC and with rate caps not to exceed 3% per year. Minimum network discount guarantees must be provided for each of the two (2) one-year extensions; please include this in your response to Appendix P: *Medical ASO & Discounts*.

60. Please confirm that payment by your organization of any amount payable under the Plan must be made by checks drawn by Bidder payable through a bank (referred to in this Contract(s) as "the Bank selected by Bidder") or via electronic fund transfers to providers.

61. Please confirm that your organization must request reimbursement for claim checks that have cleared their bank account and for electronic fund transfers Bidder has paid to providers. The Bidder will be reimbursed for claim checks and electronic fund transfers to providers that have cleared the Bidder's bank account by the Bidder transmitting the total amount cleared via electronic mail or facsimile machine to the State by 11:00 a.m., EST each Friday. To determine the total amount that will be funded by Automated Clearing House (ACH) transfers to the Bidder's designated bank by noon Wednesday of the following week or by noon of the third business day due to a State closing. The transmission must include a breakdown by health plan.

62. Please confirm that your organization agrees that if in the normal course of business, it, or any other organization with which the Bidder has a working arrangement, chooses to advance any funds that are due, to any provider, subsidiary or subcontractor, the cost of such advance must not be charged back to the State except the State must reimburse Bidder within the confines of the provisions of a contract.

63. Please confirm that your organization must disclose, fully account for, and remit to the State any and all funds received by it as the result of a recovery of an overpayment or incorrect payment, rebates, or subrogation of a claim or lien. Reports to be provided quarterly. Any discounted or negotiated rates or payment arrangements, any price adjustment, or refunds, and any retroactive or supplemental payments or credits negotiated with regard to covered services received by State members must be remitted to the State. Administrative Services Only (ASO) fees must take into consideration this provision.

64. Please confirm that your organization will never charge the State for a claim payment that is greater than the actual amount paid by Bidder.

65. Please confirm that your organization must submit to the State on its invoice an itemization of the charges and fees (other than claim payments) and credit for services provided in the administration of the Plan.

66. Please confirm that your organization must provide the State with an estimate of incurred unpaid claims, administrative fees and amounts of outstanding checks no later than 45 days following the close of each fiscal quarter.

67. Please confirm that your organization must provide financial reporting 45 days (under no circumstances to exceed 60 days) following the end of each quarter.

E. Implementation

68. As an exhibit, provide a detailed implementation schedule including dates/tasks/roles (for both State and vendor resources) assuming an Open Enrollment of May, 2017, and a July 1, 2017 effective date, for all plans except Medicare Supplement and Medicare Advantage.

The Open Enrollment period would require telephone customer service support and therefore training by May 1, 2017, by the customer service representatives of the State's plan design. On-site support is required at open enrollment meetings.

69. For any bidder that is submitting a proposal on either the Medicare Supplement or Medicare Advantage plan, as an exhibit, provide a detailed implementation schedule including dates/tasks/roles (for both State and vendor resources) assuming an Open Enrollment of October, 2017, and a January 1, 2018 effective date for Medicare Supplement and Medicare Advantage plans. The Open Enrollment period would require telephone customer service support and therefore training by October 1, 2017, by the customer service representatives of the State's plan design for either the Medicare Supplement or Medicare Advantage. On-site support is required at open enrollment meetings.

70. Please confirm that your organization will lead the implementation process taking direction from the State of Delaware, including but not limited to providing support at employee Open Enrollment meetings.

71. Confirm that you conduct a pre-implementation testing process to ensure accuracy of plan administration prior to the effective date and that you will share the results of the testing process with the plan sponsor.

72. The vendor agrees not to appoint any agent, general agent, or broker, nor authorize payment of any kind to a party not approved in writing by the State.

F. Legal

73. Please confirm that your organization will not use the names, home addresses or any other information obtained about participants of the medical program for offering for sale any property or services that are not directly related to services negotiated in the RFP without the express written consent of the State.

74. Please confirm that commission percentages, brokerage or contingent fees are not payable to any agent or broker by the State of Delaware.

75. Please confirm your acceptance that an activity central to the Scope of Services cannot take place at a physical location outside of the United States. Only support activities may be performed at satellite facilities such as a foreign office or division. Subcontractors are also subject to this provision.

76. Please confirm that within the past five (5) years the firm or any officer, controlling stockholder, partner, principal, or other person substantially involved in the contracting activities of the business is not currently suspended or debarred and is not a successor, subsidiary, or affiliate of a suspended or debarred business.

77. Please confirm your company is appropriately licensed to do business in the State of Delaware and provide a copy of the license.

78. Please confirm that your organization is operating as an independent contractor and that it is liable for any and all losses, penalties, damages, expenses, attorney's fees, judgments, and/or settlements incurred by reason of injury to or death of any and all persons, or injury to any and all property, of any nature, arising out of the vendor's negligent performance under this contract, and particularly without limiting the foregoing, caused by, resulting from, or arising out of any act of omission on the part of the vendor in their negligent performance under this contract.

79. Please confirm that your organization and any subcontractors, agents or employees employed by you shall not, under any circumstances, be considered employees of the State and they shall be entitled to any of the benefits or rights afforded employees of the State.

80. Please confirm that your organization is operating as an independent contractor and shall maintain insurance that will protect against claims under Worker's Compensation Act and from any other claims for damages for personal injury, including death, which may arise from operations under this contract. The vendor is an independent contractor and is not an employee of the State of Delaware.

81. During the term of this contract, the vendor shall, at its own expense, carry insurance minimum limits as follows:

a.	Comprehensive General Liability	$1,000,000 per person and $3,000,000 per occurrence
b.	Medical or Professional Liability	$1,000,000 per occurrence and $3,000,000 aggregate
c.	Misc. Errors and Omissions	$1,000,000 per occurrence and $3,000,000 aggregate

The successful vendor must carry (a) and (b) and/or (c), above, depending on the type of service being delivered. If you believe that a type of coverage would not apply to your service, please explain.

If awarded the contract, the State of Delaware shall **not** be named as an additional assured.

As an exhibit, please provide a copy of your certificate of insurance with the appropriate types and coverage levels. At this time, you must provide a copy of your certificate of insurance with the appropriate types and coverage levels, and, if awarded the contract, please confirm your understanding that the vendor <u>must</u> provide a copy of your certificate of insurance before any work is done pursuant to the terms in the RFP and resulting contract.

82. The effective date of the contract awarded under this RFP will be July 1, 2017 for non-Medicare plans and January 1, 2018 for a Medicare plan (either Supplement or Advantage). It is anticipated that the award will be made in mid-November, 2016. Please confirm that

if you are awarded the contract no later than December 15, 2016, you would be able to successfully implement your program or plan for non-Medicare plans with a May open enrollment period and a July 1, 2017, effective date and for a Medicare plan with an October open enrollment period (May 8, 2017 through May 25, 2017) and a January 1, 2017, effective date.

83. If awarded the contract, please confirm your organization's willingness to enter into performance guarantees. Please follow the instructions in Appendix C and include the completed *Performance Guarantees* form in your bid package. ***If your offer does not receive a clarifying question or any other response from the State, it does not infer acceptance.***

84. Please confirm that upon termination of a contract your organization will not solicit any SEBC member or retiree for any services or products without the explicit written permission of the State.

85. Please confirm your understanding that any of the functions to be performed under a contract, if awarded, shall not be assigned by either party to another party, absent advance notice to the other party, and written consent to said assignment, which consent shall not be unreasonably withheld. In the event either party shall not agree to an assignment by the other party, then the contract shall terminate upon the effective date of said assignment.

86. **Please confirm your organization's acceptance of the following indemnity paragraphs. For your response, if you do not accept this indemnity paragraph as written, you must provide a redline of suggested changes. Be advised that the State cannot agree to major changes.**

Vendor shall indemnify and hold harmless the State, its agents and employees, from any and all liability, suits, actions or claims, together with all reasonable costs and expenses (including attorneys' fees) directly arising out of (A) the negligence or other wrongful conduct of the vendor, its agents or employees, or (B) vendor's breach of any material provision of this Agreement not cured after due notice and opportunity to cure, provided as to (A) or (B) that (i) vendor shall have been notified in writing by the State of any notice of such claim; and (ii) vendor shall have the sole control of the defense of any action on such claim and all negotiations for its settlement or compromise.

The State shall not indemnify the Vendor in the contact awarded under this RFP or any related contract. Vendor shall not request the State to indemnify or provide quasi-indemnification under any contract. An example of an unacceptable quasi-indemnification provision is:

> The State asserting it is without legal authority to agree to such indemnification, acknowledge that Vendor, on behalf of itself and any affiliate, reserves such rights as it may have to obtain reasonable compensation from the State, against any loss, damage, costs of suit or other expenses resulting from the improper use or disclosure of data or any breach of this Agreement by State.

87. Please confirm your organization's agreement that:

a. Only the State may terminate the contract for convenience.

b. The vendor can terminate the contract for cause with written notice to the State of no less than 180 days.

c. The State can terminate the contract for cause with written notice to the vendor of no less than thirty (30) days. The State anticipates the vendor will be given the opportunity to cure any default in performance well in advance of a notice of termination.

88. Please confirm your organization's agreement that it is the State's right to modify the benefit design during the contract period with reasonable notice.

89. The State requires your organization to confirm that all services identified in your proposal are provided solely by your organization and identify <u>any</u> services that may be provided by a subcontractor. This includes graphics, mailing, and printing services, for example. Subcontractors are subject to all the terms and conditions of the RFP and the SEBC reserves the right to approve any and all subcontractors. If a subcontractor(s) is involved, note in your response to this question and complete Appendix G, *Subcontractor Information Form*, included herein for <u>each</u> subcontractor. The company OSD classification information is for self-identification only.

90. If your company is awarded the contract, please confirm your agreement that performing the services subject to this RFP, as set forth in 19 Del. C. § 710, you will not discriminate against any employee or applicant with respect to compensation, terms, conditions or privileges of employment because of such individual's race, marital status, genetic information, color, age, religion, sex, sexual orientation, gender identity, or national origin. The successful vendor shall comply with all federal and state laws, regulations and policies pertaining to the prevention of discriminatory employment practice. Failure to perform under this provision constitutes a material breach of contract.

91. Please confirm your organization's acceptance: The RFP and the executed Contract between the State and the successful organization will constitute the Contract between the State and the organization. In the event there is any discrepancy between any of these contract documents, the following order of documents governs so that the former prevails over the latter: contract, State of Delaware's RFP. No other documents, <u>including your bid response</u>, will be considered. These documents contain the entire agreement between the State and the organization.

92. Please confirm your organization's acceptance: The payment of an invoice by the SEBC shall not prejudice the SEBC's right to object or question any invoice or matter in relation thereto. Such payment by the SEBC shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any costs invoiced therein. Vendor's invoice or payment shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the SEBC, based on audits, to not

constitute allowable costs. Any payment shall be reduced for overpayment, or increased for underpayment on subsequent invoices.

93. Please confirm your organization's acceptance: The SEBC reserves the right to deduct from administrative fees, not claims or premiums, that are or shall become due and payable to the vendor under this contract between the parties any amounts which are or shall become due and payable to the SEBC by the vendor.

94. Please confirm your organization's acceptance that any payments made by the State of Delaware will be by Automated Clearing House (ACH) as per its ACH processing procedures.

95. Please confirm that your organization will not use the State's name, either express or implied, in any of its advertising or sales materials without the State's express written consent.

96. If your company is awarded the contract, please confirm your understanding that pursuant to 29 Del. C. § 6909B and effective November 4, 2014, the State does not consider the criminal record, criminal history or credit score of an applicant for state employment during the initial application process unless otherwise required by state and/or federal law. Vendors doing business with the State are encouraged to adopt fair background check provisions. Vendors can refer to 19 Del. C. § 711(g) for applicable established provisions.

97. Please confirm your acceptance that in the event of any dispute under a contract, you consent to jurisdiction and venue in the State of Delaware and that the laws of the State of Delaware shall apply to the contract except where Federal law has precedence.

98. Please confirm your acceptance that the State of Delaware reserves the right to pre-approve any news or broadcast advertising releases concerning this solicitation, the resulting contract, if awarded, the work performed, or any reference to the State of Delaware with regard to any project or contract performance. Any such news or advertising releases pertaining to this solicitation or resulting contract shall require the prior express written permission of the State of Delaware.

99. The State acknowledges that a contractor has the right to exercise full control over the employment direction, compensation and discharge of all persons employed by the contractor in the performance of services for their clients. However, please confirm that, if awarded the contract, your organization will attempt to honor the State's request for specific individuals to be assigned to managerial roles in all areas of account management.

100. Please confirm that, if awarded the contract, your organization ("vendor") will provide on an annual basis Service Organization Control ("SOC") Reports 1 and 2 that address the internal control over financial reporting of vendor's services and other criteria that are applicable to non-financial reporting subject matter for vendor's services. SOC 1 and 2 reports may include multiple reports to reflect all processes and locations utilized by vendor in performing the Services. All SOC reports will be prepared by external auditors selected by the vendor with appropriate credentials. Upon the State's request, the vendor will confirm directly with the State's auditors to confirm separately any SOC report or Bridge

Letters. Vendor will cause the SOC reports to be delivered to State promptly after such reports are delivered to vendor by the vendor's auditors. Upon the request of the State, vendor will deliver to the State a Bridge Letter or report to address any time gap between the date of the SOC reports delivered by vendor and the date of the State's audit that relies on such reports. SOC reports are prepared under the American Institute of Certified Public Accountants (AICPA) Statements on Standards for Attestation Engagements (SSAE) 16.

101. Please confirm that, if awarded the contract, your organization will provide a written report no later than forty-five (45) days following the close of each quarter which shall describe any judgment or settlement or pending litigation involving Contractor that could result in judgments or settlements in excess of One Hundred Thousand Dollars ($100,000).

102. Please confirm that your company complies with all federal, state and local laws applicable to its activities and obligations including:

    a. the laws of the State of Delaware;

    b. the applicable portion of the Federal Civil Rights Act of 1964;

    c. the Equal Employment Opportunity Act and the regulations issued there under by the federal government;

    d. a condition that the proposal submitted was independently arrived at, without collusion, under penalty of perjury; and

    e. that programs, services, and activities provided to the general public under resulting contract conform with the Americans with Disabilities Act of 1990, and the regulations issued there under by the federal government.

    If awarded the contract, your organization will keep itself fully informed of and shall observe and comply with all applicable existing Federal and State laws during its performance of the work. If your organization fails to comply with (a) through (e) of this paragraph, the State reserves the right to terminate the contract or consider the Contractor in default.

103. Please confirm your acceptance that your organization, if awarded a contract, shall furnish to the State's designated representative copies of all correspondence to regulatory agencies that apply to services or products of a contract.

104. Please confirm your full HIPAA, EDI and Privacy compliance and that all State member data will be maintained in accordance with applicable federal, state and local regulations to ensure protection and confidentiality.

105. Please confirm the existence of strict policies and procedures for the protection of client and member Personal Health Information (PHI) and avoidance of security breaches under HIPAA and HITECH. Confirm the existence of breach notification procedures in the event of a release of PHI.

106. Please confirm your ability and inclusion of services required to assist the State in any and all reporting and compliance efforts related to local, state and federal legislation, such as New York HCRA, Massachusetts creditable coverage requirements, and so forth.

107. Please confirm you have filled out the *State of Delaware Non-Collusion Statement* form, Appendix A, and included it in your bid package.

108. Please confirm you have filled out the *Officer Certification Form*, Appendix E, and included it in your bid package.

109. Please confirm you have filled out the *Employing Delawareans Report*, Appendix H, and included it in your bid package. (The number of Delawareans employed by your organization are not taken into consideration during the evaluation or scoring of your bid.)

110. Please confirm you have filled out the *Financial Ratings Form*, Appendix I, and included it in your bid package.

111. Please confirm your acceptance that if a contract is awarded to an incumbent, the current Business Associate Agreement in effect will be incorporated by reference in a contract and not re-negotiated.

112. **For Non-Incumbents Only:** Please confirm your commitment to execute a contract at least ninety (90) days prior to the date employee services will commence under the contract, as follows:

    a. Begin the contract development and review process in December, 2016;

    b. Execute final contract by April 1, 2017 (non-Medicare plans only) and/or by October 1, 2017 (Medicare plans only);

    c. With a contract effective date of April 1, 2017 (non-Medicare plans only) and/or October 1, 2017 (Medicare plans only), for all implementation services and technology and data security requirements;

    d. All implementation services - including but not necessarily limited to, communications, test file exchanges, enrollment file processing, and on-site meetings - for Open Enrollment in May, 2017, through July 1, 2017 (non-Medicare plans only) and/or Open Enrollment in October, 2017, through January 1, 2018 (Medicare plans only), will be at no cost to the State; and

    e. Payment for contract services rendered on or after July 1, 2017 (non- Medicare plans only) and/or January 1, 2018 (Medicare plans only), will not be remitted by the State until after July 1, 2017.

113. **For Non-Incumbents Only:** Please confirm that, if awarded the contract, your organization will accept the terms in the *Business Associate Agreement*, see Attachment 5. If you do not accept the terms as written, you must provide a redline of suggested changes. **Be advised that the State cannot agree to major changes.** You cannot provide a copy

of your organization's form for comparison by the State. If awarded a contract, the Business Associate Agreement must also be signed by April 1st (if contract includes non-Medicare plans) or by October 1st (if contract is only for Medicare plans).

IV. Questionnaire

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

A. **Responsiveness** –

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

B. **Respond to Each Question** –

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

C. **Incumbents** - If your organization is the current vendor, you must reply with a full explanation to every question since the review committee may not be familiar with the current contract or your services.

D. **Fees or Costs** - Fees or costs that are not included in your bid and stated on the appropriate appendices (forms) will not be considered by the State. A fee only stated in a response to a question, whether or not we remind you to include a fee on the appropriate appendix or form, will not be considered! You must document ALL fees and costs on the appropriate appendix (i.e., Appendix P: *Medical ASO & Discounts*, Appendix Q: *Fully-Insured Medical Premium Quotes*, and Appendix R: *Supplemental Financial Questions*).

E. **Exceptions** - If you have an exception, you must copy and paste the term into the *Responses Exceptions Tracking* form, Appendix B, and provide a detailed explanation, or, check the box to acknowledge that you take no exceptions to the specifications, terms or conditions found in the *Minimum Requirements* or *Questionnaire* sections and submit it with your bid package.

F. **Numbering** - Please do not change the numbering of a question, even if there is an error in the sequence or a duplication. Thank you.

G. **Table and Check Box Format – !!! IMPORTANT !!!**

- Due to the table format, be sure to respond in the same row instead of adding a row beneath the question.
- If a question asks for a response in a check box format, please bold your selection(s) since the check box feature is not operational.
- If a question asks for a selection ("pick"), please also use a bold formatting for your response.
- For any additional information you provide, either in a response to "other" or as information you feel is required to provide a complete response, please do not add a lengthy explanation that expands the cell beyond a reasonable number of sentences and length. Instead, reference an exhibit and use a table format that includes the section name, item number, copy of the question, and page number. The review committee must be able to easily find your response and refer back to the question!

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A. Bidder Profile

#	Question	Response
A.1	Please provide a brief history of your company. Include a summary of your status with respect to any past (within the last five (5) years), current, or prospective mergers and acquisitions. In addition, please describe your strategy towards growth and any immediate plans for expansion both nationally and in the State of Delaware's markets (if applicable).	
A.2	Have you or any of your subsidiary or affiliated corporations ever been indicted or otherwise accused of any criminal misconduct within the past 10 years? If so, please explain and indicate the outcome as well as any actions and preventive measures now in place to prevent any repetition in the future.	
A.3	What is the size of your current book of business (by number of covered lives) for each of the medical plans your organization is bidding on? (i.e., PPO, HMO, CDHP)	
A.4	What percent of your book of business (by number of covered lives) would the State of Delaware represent among your other customers with the same type of medical plan?	
~~~~~~

#	Question	Response
A.5	Please describe your organization's experience, including the number of years of experience, with providing medical TPA services for plan sponsors with at least 50,000 covered lives.	
A.6	What are your plans to expand your book of business in Delaware over the next three (3) years?	
A.7	Please provide the contact name, title, phone number, email and brief biography for the following positions who will be assigned to the State of Delaware's account. If available, please provide a resume as an exhibit.	
	Executive Sponsor	
	Contact Name	
	Title	
	Phone number	
	Email Address	
	Fax number	
	Current Client Load	
	Percent of Time Dedicated to the State of Delaware	
	Account Executive	
	Contact Name	
	Title	
	Phone number	
	Email Address	
	Fax number	
	Current Client Load	
	Percent of Time Dedicated to the State of Delaware	
	Account Manager	
	Contact Name	
	Title	
	Phone number	
	Email Address	
	Fax number	
	Current Client Load	
	Would this person be designated or dedicated to the State's account? If designated, what percentage of their time would be dedicated to the State of Delaware?	
	Clinical Manager	
	Contact Name	
	Title	
	Phone number	
	Email Address	

#	Question	Response
	Fax number	
	Current Client Load	
	Percent of Time Dedicated to the State of Delaware	
	Implementation Manager	
	Contact Name	
	Title	
	Phone number	
	Email Address	
	Fax number	
	Current Client Load	
	Would this person be designated or dedicated to the State's account? If designated, what percentage of their time would be dedicated to the State of Delaware during implementation?	
	Day-to-Day Contact	
	Contact Name	
	Title	
	Phone number	
	Email Address	
	Fax number	
	Current Client Load	
	Percent of Time Dedicated to the State of Delaware	
	Eligibility/Enrollment	
	Contact Name	
	Title	
	Phone number	
	Email Address	
	Fax number	
	Current Client Load	
	Percent of Time Dedicated to the State of Delaware	
	Claims Supervisor	
	Contact Name	
	Title	
	Phone number	
	Email Address	
	Fax number	
	Current Client Load	
	Percent of Time Dedicated to the State of Delaware	
	Member Services Supervisor	
	Contact Name	
	Title	
	Phone number	
	Email Address	

#	Question	Response
	Fax number	
	Current Client Load	
	Percent of Time Dedicated to the State of Delaware	
	Operations Manager	
	Contact Name	
	Title	
	Phone number	
	Email Address	
	Fax number	
	Current Client Load	
	Percent of Time Dedicated to the State of Delaware	
	Medical Director	
	Contact Name	
	Title	
	Phone number	
	Email Address	
	Fax number	
	Current Client Load	
	Percent of Time Dedicated to the State of Delaware	
	Other Important Roles	
	Contact Name	
	Title	
	Phone number	
	Email Address	
	Fax number	
	Current Client Load	
	Percent of Time Dedicated to the State of Delaware	
A.8	For the account contacts below, provide the following:	
	Account Executive	
	Number of years with organization	
	Number of years in current position	
	Total number of accounts	
	If not already provided in the references section, please provide two accounts (company name, city and state, contact name and phone number and/or email address) for which this person served in a similar capacity	
	Account Manager	
	Number of years with organization	
	Number of years in current position	
	Total number of accounts	

#	Question	Response
	If not already provided in the references section, please provide two accounts (company name, city and state, contact name and phone number and/or email address) for which this person served in a similar capacity	
	Clinical Manager	
	Number of years with organization	
	Number of years in current position	
	Total number of accounts	
	If not already provided in the references section, please provide two accounts (company name, city and state, contact name and phone number and/or email address) for which this person served in a similar capacity	
A.9	Based on your experience with similar clients/programs, describe the resources that will be needed from the State of Delaware on an ongoing basis to manage the program. What level and frequency of interaction with the State of Delaware would you prefer to ensure program success?	
A.10	Do you use a sub-contractor for subrogation collections? If so, what is the fee? (Please be sure to fill out the *Sub-Contractor* form, Appendix G.)	
	This section applies to ACOs only.	
A.11	Please describe your ACO organization, including names and types of major contracted/business associates or community partners.	
A.12	What criteria did your organization use to create networks/select partners? How do you assure network adequacy?	
A.13	What are your organization's previous experiences with bearing financial and clinical risk and contracting capability for care outside your organization or structure's walls to assure appropriateness of care and total cost of care accountability?	

#	Question	Response
A.14	How do you handle members who receive care outside of your service area?	*(Check all that apply)* ☐ Member must contact member services before receiving care (except in emergency) ☐ Member may receive any necessary care from any provider ☐ Member must pre-certify treatment ☐ Level of payment is determined by employer ☐ Member must receive care from plan-specified provider (except in emergency) ☐ Member must pay for care and then submit bill to plan for payment ☐ Member may submit provider bill directly to plan for payment to provider
A.15	Does your ACO have a governorship system?	*(Pick one of the following)* ☐ Board ☐ Mix of Hospital, professional ☐ Plan ☐ Employer ☐ Other _____
A.16	Who are your current ACO customers (please list names, address, contacts and member number served)?	
A.17	Please describe your care coordination philosophy, integration and other strategies to obtain the Triple Aim (e.g., partners, vendors, TPA, etc.)	
A.18	Please describe your risk and gain sharing philosophy. (e.g., provider/facility/administer compensation volume/value, expected gain sharing, strategies to assume more risk, etc.)	
A.19	Please describe your experience in value-based contracting, including number of years, outcomes, experience, risk and gain sharing arrangements, for the following value-based contracting models.	*(Pick one of the following)* ☐ MSSP ☐ Medicare ACO ☐ Medicaid PCCM ☐ Employer direct contracting ☐ Plan based ACO – PCP – Specialist – Facility

B. Medical Plan Administration

1.0 Medical Plan Implementation

#	Question	Response
1.1	Indicate the ideal notification date to achieve a successful implementation for the State of Delaware's effective date of July 1, 2017 (non-Medicare plans only) and/or January 1, 2018 (Medicare plans only).	
This section applies to ACOs only.		
1.2	Please attach your proposed implementation schedule including dates/tasks/roles.	
1.3	Indicate the ideal notification date to achieve a successful implementation for the State of Delaware's effective date.	
1.4	Confirm that you conduct a pre-implementation testing process to ensure accuracy of plan administration prior to the effective date and that you will share the results of the testing process with the plan sponsor	

2.0 Eligibility Data Processing

#	Question	Response
2.1	Confirm that you are able to update eligibility on the following frequencies:	*(Check all that apply)* ☐ Real-time ☐ Multiple times per day (but not real-time) ☐ Daily ☐ Weekly ☐ Less frequently than weekly
2.2	What functionality is available to employers for enrollment processing?	*(Check all that apply)* ☐ Web-based ☐ Telephonic ☐ Paper-based
	Add enrollees	
	Change enrollees	
	Terminate enrollees	
	View enrollment status by individual member	

#	Question	Response
2.3	What cost management services are available to employers through your client self-service portal?	*(Check all that apply)* ☐ Automated premium billing reconciliation ☐ Automated retroactive eligibility reporting ☐ Automated bank reconciliation reports ☐ Aggregate medical cost management reports ☐ Ad hoc cost management reports ☐ Services listed are not available through the internet or intranet system
2.4	What is your turn-around time for loading electronic eligibility files?	*(Pick one of the following)* ☐ 24 hours or less ☐ 24-48 hours ☐ 48-96 hours ☐ 5 days or more
2.5	What is your turn-around time for handling eligibility records that error out of the general load process?	*(Pick one of the following)* ☐ 24 hours or less ☐ 24-48 hours ☐ 48-96 hours ☐ 5 days or more
2.6	Does your eligibility system have the ability to load and/or track a COBRA paid-through date (other than notation)? Under the State's current process for COBRA participants, updates and enrollments to COBRA coverage are sent by the State's COBRA vendor to the SBO, and the SBO notifies vendors of changes and enrollments manually. Please confirm that you have the ability to accept COBRA enrollment elections manually in lieu of receiving a COBRA participant file.	
2.7	If your organization is not also the HSA bank or trustee, describe how eligibility and funding is coordinated between your organization and the HSA bank or trustee. Please discuss frequency and timeliness of data coordination between your organization and the following organizations.	
	PBM	
	HSA administrator	
	Bank or Trustee	

#	Question	Response
2.8	Do you collect single/family enrollment status from the employer (or its administrator) in order to validate the permissible funding levels and limits?	*(Pick one of the following)* ☐ Yes ☐ No
2.9	Describe how the maximum contribution to the HSA will be affected by mid-year family status changes (e.g., from single to family coverage). Describe any enrollment requirements or limitations associated with family status changes that occur mid-year and explain how you assist the member in understanding the impact of family status changes to their HSA.	
2.10	With which HSA banks do you currently have electronic exchange capabilities for eligibility and claims?	

3.0 Medical Plan Claims Administration

#	Question	Response
3.1	What is the claims processing system platform(s) you have proposed for the State of Delaware? Indicate the name, length of time the platform has been in use, and the products it supports.	
3.2	If you are proposing to have more than one claim processing platform for one or more sub-groups within the State of Delaware's covered population, do you plan to consolidate to a single platform? If so, when?	*(Pick one of the following)* ☐ Yes, within 12 months ☐ Yes, within 24 months ☐ Yes, within 36 months ☐ No plans to consolidate platforms ☐ N/A
3.3	Are you planning any major upgrades to your claim system that will be used to process the State of Delaware's claims within the next 36 months?	
3.4	Provide the following information (for the most recent calendar year) for your proposed claim office that would process claims from the State of Delaware:	
	Proposed office name	
	Location	
	Years in operation	
	Number of claims processed	

#	Question	Response
	Average number of claims per processor per day	
	Percentage of all claims submitted electronically	
	Number of member lives handled by this office	
	Average ratio of claims examiners to member lives in this office	
	Rate of claims processor turnover	
	Percentage of total claims submitted electronically for professional (non-facility) services	
	Percentage of total claims converted to electronic medical data by scanning, Optical Character Recognition (OCR) or Intelligent Character Recognition (ICR) method	
	Percentage of total claims automatically adjudicated (no manual intervention of any kind)	
	Percentage of claims adjusted after initial payment	
	Percentage of all claims processed that underwent random internal audit	
3.5	For the proposed claim office, provide the following claims performance information for the two (2) latest calendar years: plan standard, actual - most recent calendar year, actual – prior full calendar year	
	Claims Accuracy, Financial: Percentage of claim dollars paid accurately	
	Claim Turnaround Time: Percentage of clean claims processed in 14 business days	
	Claim Turnaround Time: Percentage of clean claims processed in 30 calendar days	
	Claims Processing Accuracy, Non-Financial: Percentage of claims processed without a non-financial error	
	Claim Payment Accuracy: Percentage of claims processed without a financial error	

#	Question	Response
3.6	Indicate which of the following data systems are housed on the same platform as your medical claims system:	*(Check all that apply)* ☐ Eligibility ☐ Provider pricing ☐ Utilization review program ☐ Customer service member call notes ☐ Large Case Management program ☐ HRA claims processing ☐ HSA claims processing ☐ FSA claims processing ☐ None ☐ Other: specify
3.7	If the following data systems are not housed on the same platform as the medical claims system, is there an electronic link between your claims system and any of the following:	*(Check all that apply)* ☐ Eligibility ☐ Provider pricing ☐ Utilization review program ☐ Customer service member call notes ☐ Large Case Management program ☐ HRA claims processing ☐ HSA claims processing ☐ FSA claims processing ☐ None ☐ Other: specify
3.8	If the HRA or HSA data systems are not housed on the same platform as the medical claims system, how do you support integrated reporting of account based claims?	
3.9	How often do you back up claims system data?	*(Pick one of the following)* ☐ Real time ☐ Daily ☐ Weekly ☐ Monthly
3.10	Check all of the internal audits, logic, and controls that currently exist in your medical claim system	
	Patient's gender or age is inconsistent with the procedure code	
	Diagnosis code and procedure code are inconsistent	
	Appropriateness of assigned DRGs	
	Patient's gender or age is inconsistent with the diagnosis code	
	Valid date of service	
	Valid procedure code	
	Valid diagnosis code	
	Determination of fraudulent claims	

#	Question	Response
	Precertification is necessary for claim payment	
	Appropriateness review is necessary for procedure	
3.11	Do you apply COB on a pay and pursue, or pursue and pay, basis?	
3.12	Based on the State of Delaware's plan designs, included as an attachment, in what manner does your claims system handle the following?	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	Eligibility of employee	
	Eligibility of dependent	
	Benefit plan exclusions	
	Frequency limits	
	Calculate payment amount	
	Accumulation of deductible	
	Co-insurance	
	Copay	
	Out-of-pocket maximum	
	Lifetime maximum	
	Coordination of benefits including Medicare	
	Spousal coordination of benefits determination according to the State's existing process	
	Workers' compensation	
	Subrogation	
	Check issuance	
	EOB issuance	
	Utilization review coordination	
	Duplicate claims	
	In-network/out-of-network determination	
	Automatic rollover to flexible spending account	
	Automatic rollover to personal health care account (HSA/HRA)	

#	Question	Response
3.13	Please describe how you will administer the embedded individual OOPM for employees with individual and family coverage. Please discuss your administration for all plan design types, including qualified High Deductible Health Plans that include Health Savings Accounts. Comment on any financial impact the embedded individual OOPM will have on plan claim or administrative costs.	
3.14	Confirm that all required programming is in place to correctly administer ACA required Preventive Care with no cost sharing.	
3.15	Does your system have the ability to accommodate a retroactive benefit change? If yes, is there a time limit?	
3.16	The State currently utilizes a Spousal Coordination of Benefits Policy form – please see Attachment 8. Please confirm that you will reconcile receipt of this required form with the State at each open enrollment period, assuring claims are processed at a secondary level of 20% for applicable subscribers' dependents until an updated form has been secured. The forms are received electronically and in hard copy. The State also requires weekly updates/reports for changes and new enrollments.	
3.17	Please refer to the State's appeal process for members when coverage for a specific service is denied – Attachment 7. As an exhibit, please provide a complete description of your internal claims and appeals process along with your external review processes. Please confirm the State has the right to override the appeal.	
3.18	Confirm your ability to track IVF participant expenses (both medical and prescription) for both grandfathered and non-grandfathered participants to ensure members do not exceed limits. For grandfathered members, this includes coordination or experience with the State's PBM.	

#	Question	Response
3.19	What sampling procedures do you use for internal audits?	*(Pick one of the following)* ☐ Random sample ☐ Processor specific ☐ Client specific ☐ Claim office specific ☐ Percentage of claim transactions ☐ Percentage of claim dollar ☐ Do not perform internal audits ☐ Other: specify
3.20	Please describe the process your organization has undertaken to support the use of ICD-10 coding, including training, communication and reporting.	
3.21	Is your system currently able to accept ICD-10 codes?	
3.22	Please confirm your ability to proactively monitor claims for "disabled" members.	
3.23	Please confirm your ability to provide written notice to "disabled" members or members with ESRD that enrollment in Medicare Parts A and B is mandatory. The bidder will provide notice to the Pension Office and the Statewide Benefits office.	
3.24	Participants who are eligible for Medicare Part A or B (for whatever reason they qualify) must enroll. Please confirm that if a subscriber who is not actively employed full-time has Medicare Part A and failed to enroll in Part B, related claims should be denied and the State should be contacted in writing and the status maintained. Vendors who do not have procedures in place to accurately enforce this requirement shall accept liability for any overpayments that cannot be recovered in a timely manner.	
3.25	The Medicare Supplement plan is currently administered with Medicare "crossover" (i.e., a voluntary data sharing agreement, or VDSA) under which claims are automatically sent from Medicare to the secondary carrier for processing. Describe your Medicare crossover program process and confirm that this is included in your fees.	

#	Question	Response
3.26	Please confirm that your organization is able to administer all potential methods of coordination of benefits (COB) with Medicare, including but not limited to standard COB, non-duplication of benefits, and government exclusion at no additional cost and with no charge to your proposed administrative fees.	
3.27	Confirm that you have HICN tracking capabilities.	
3.28	If your proposal includes a group Medicare Advantage plan, your organization will be required to process a group default enrollment for all individuals to be covered under the group Medicare Advantage plan. Please confirm that you have filed with CMS to process group enrollments and dis-enrollments.	
3.29	Please confirm that you will notify CMS that GHIP members are covered under your Medicare Advantage plan for the upcoming plan year or are no longer covered and should be placed back into Original Medicare effective 1/1/2018 as appropriate.	
3.30	If your proposal includes a group Medicare Advantage plan, please confirm that you can administer the plan as a national passive PPO that mirrors the design of the existing Medicare Supplemental plan.	
3.31	Are there any states, counties or other areas that are not included in your national Medicare Advantage PPO network? If so, please list these areas. If any GHIP retirees reside in the excluded areas, do you offer any alternative solutions for these individuals?	

4.0 Health Reimbursement Account (HRA) Administration

#	Question	Response
4.1	What is the Health Reimbursement Account (HRA) administration platform you have proposed for the State of Delaware? Indicate the name, length of time the platform has been in use, and the products it supports.	

#	Question	Response
4.2	Do you plan to migrate the HRA administration platform proposed for the State of Delaware within the next 24 months? If yes, when?	*(Pick one of the following)* ☐ Yes, explain ☐ No
4.3	How long have you offered HRA administration services?	
4.4	Can your organization currently administer HRA deposits/incentives based on the completion of wellness programs offered by other vendors?	*(Pick one of the following)* ☐ Yes ☐ No
4.5	Does the member receive one or two EOBs for a transaction that is first adjudicated with the medical plan and then applied to the HRA account?	*(Pick one of the following)* ☐ One ☐ Two ☐ Other, explain
4.6	Describe how the account balances will be adjusted for claim errors (especially for a member liability that is later determined to be less than what was withdrawn).	
4.7	If a participant's distribution exceeds the account balance due to problems synchronizing accounts, how will your organization handle this situation, including participant communication?	
4.8	Confirm that your organization is responsible for all adjustments and reconciliations for the account if an overpayment or underpayment is made.	*(Pick one of the following)* ☐ Yes ☐ No, explain
4.9	What is the process for member appeals of account balance errors?	
4.10	Once employer deposit or incentive participation data is received by your organization, how many days does it take for your organization to reflect the amounts in individual HRAs?	*(Pick one of the following)* ☐ 1-3 days ☐ 4-6 days ☐ 7-10 days ☐ More than 10 days
4.11	Once deposits are credited to individual accounts, are the funds immediately available for use?	*(Pick one of the following)* ☐ Yes ☐ No, explain
4.12	Is there a minimum and/or maximum dollar amount your organization will reimburse a member for in one transaction? If so, what are those amounts?	
4.13	Can you administer the HRA regardless of the definition that the employer uses for reimbursable claims?	*(Pick one of the following)* ☐ Yes ☐ No, explain

#	Question	Response
4.14	If the HRA is administered on a separate platform from the medical claims, are you able to integrate the paid claim data into a single file before sending it to a data warehouse?	
4.15	Mid-year new hires, reinstatements, and status changes can create complexities for the pro-ration of HRA and deductible balances. Briefly describe your approach and capabilities for this administration. (For example, can you calculate monthly pro-ration of HRA and deductible balances?) Please confirm that you can administer the HRA carryover and proration schedule for mid-year enrollments as described in Section I.A.2 Background Information. Please be sure to indicate if you can administer monthly or quarterly pro-ration of HRA roll-over amounts for mid-year new hires.	
4.16	What is your normal process for handling COBRA plan participants? Please specify your normal processes for allocating balances to plan participants when they move to COBRA from active plan enrollment.	
4.17	Are you able to administer the following plan design features, including:	
	Primary deductible levels required before access to the HRA	
	Coinsurance/copayment components within the HRA	
	Roll-over (unused dollars flow into next year's HRA balance) or partial roll-over	
4.18	Please confirm you will invoice the State of Delaware for HRA funds like you would for any other medical claim.	

5.0 Health Savings Account (HSA) Administration

As you respond to the following section, please keep in mind that the State of Delaware does not currently offer a High Deductible Health Plan with a Health Savings Account (HSA), but may opt to do so in the near future (i.e., within the next five (5) years) and is interested in understanding your organization's capabilities with respect to HSA administration.

#	Question	Response
5.1	How long have you offered administration services for HSAs?	*(Pick one of the following)* ☐ < 1 year ☐ 1 to 5 years ☐ 5 to 10 years ☐ Greater than 10 years
5.2	Do you administer the HSA directly or through a banking partner? If you administer directly, is the HSA FDIC insured? If you use a partner, please provide the following:	
	Legal name and address	
	Type of contractual relationship	
	Number of years using this partner	
	Duration of existing contract	
	Confirm that accounts are FDIC insured	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed
5.3	If you use a banking partner to administer HSAs, please confirm that your responses to this section reflect your joint administrative capabilities.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
5.4	Confirm that your organization is able to administer a HDHP that is coordinated with a third party HSA administrator if the State chooses an HSA custodian outside of your organization.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed
5.5	Confirm that your organization is able to administer HSAs in conjunction with a HDHP.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed
5.6	List the number of clients and employee lives for which your organization administers accounts as of July 1, 2016.	
	2016 number of HSA clients	
	2016 number of HSA employee accounts	
	2016 number of HSA funds managed	
	2017 projected number of HSA clients	
	2017 projected number of employee HSA accounts	
	2017 projected number of HSA funds managed	
5.7	Provide, for your banking partner, the most recent financial ratings received from the following rating organizations and indicate the date of the rating:	

#	Question	Response
	Best's Bank Deposit Rating	
	Moody's	
	Standard & Poor's	
	Duff & Phelps/Fitch	
5.8	Is it permissible for the state to choose a different HSA bank or trustee? If so, will you agree to coordinate with the selected bank or trustee?	
5.9	Please describe in detail the processes/flows used to synchronize data between systems, including HSA administration, trust, debit cards, and claim adjudication.	
5.10	Please describe the data elements you require on an eligibility file feed. For example, in addition to employee demographic detail, do you collect single/family plan election status? Please provide a sample of your preferred eligibility data layout. Please note that there is no file layout for HSA provided in Attachment 3 since the State does not offer an HSA today.	
5.11	If data for administration of the accounts is transferred between vendors (e.g., your organization as the HSA administrator and an external bank trustee), please describe the flow and timing of each transfer. In addition, please describe the security measures in place to ensure the data is not compromised during the transfers.	
5.12	Do you plan to modify/migrate any key HSA administration platforms within the next 24 months? If yes, which systems and when?	*(Pick one of the following)* ☐ Yes, explain ☐ No
5.13	Can your organization currently administer HSA deposits/incentives based on the completion of wellness type programs offered by other vendors? How long will it take for you to credit the individual accounts and how soon will this be updated on the website?	*(Pick one of the following)* ☐ Yes, explain ☐ No
5.14	How frequently is interest credited to HSA balances?	*(Pick one of the following)* ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other

#	Question	Response
5.15	Can you administer automatic claim submission from the HDHP to the HSA?	*(Pick one of the following)* ☐ Yes, explain ☐ No
5.16	If not using a debit card, can the member have control of auto-payment/approval to release funds to providers and/or pharmacies?	*(Pick one of the following)* ☐ Annually elected ☐ Elected/changed at any time ☐ May not be changed monthly ☐ Not available
5.17	Describe how the account balances will be adjusted for claim/distribution errors (especially if the member liability that is later determined to be less than originally withdrawn)?	
5.18	Confirm that your organization is responsible for all adjustments and reconciliations for the account if an overpayment or underpayment is made.	*(Pick one of the following)* ☐ Yes ☐ No
5.19	Confirm that your organization will be responsible for identifying and reporting (to the employee) non-qualified withdrawals from the HSA.	*(Pick one of the following)* ☐ Yes, explain ☐ No
5.20	Are you willing to perform outreach to those participants who enroll in the HDHP but have not opened an account? If yes, please explain.	*(Pick one of the following)* ☐ Yes, explain ☐ No
5.21	Will you and your banking partner accept employer contributions for accounts which are "unopened" (e.g., employee enrolls in HDHP but does not complete account enrollment before employer contributions are sent), in order to establish the account?	*(Pick one of the following)* ☐ Yes, please explain how contributions will be held while unopened accounts are pending ☐ No
5.22	What is the process for member appeals of account balance errors?	
5.23	Do you require a minimum number of participants to provide the requested services?	*(Pick one of the following)* ☐ Yes, explain ☐ No
5.24	Indicate the methods available for members to access HSA funds.	*(Check all that apply)* ☐ Debit card ☐ ATM ☐ Online banking ☐ Checks ☐ Other, explain
5.25	If sufficient HSA funds are not available when the member requests reimbursement:	

#	Question	Response
	Will you allow the member to setup an auto payback feature that completes reimbursement when HSA funds become available? (For example, the member submits a $100 HSA claim but only has $25 available.)	*(Pick one of the following)* ☐ Yes, explain ☐ No
	Can the member elect to have the account "sweep" its balances as funds are deposited until the claim is satisfied?	*(Pick one of the following)* ☐ Yes, explain ☐ No
5.26	Is there a minimum and/or maximum dollar amount your organization will reimburse a member for in one transaction? If so, what are the amounts?	
5.27	How many debit cards are provided to each family at no additional cost?	
5.28	Describe the method of HSA and debit card synchronizations and how frequently they occur.	
5.29	Describe the flow of an HSA claim in each of the following situations:	
	Rx claim - Debit Card - HSA has adequate funds	
	Rx claim - No Debit Card - HSA has adequate funds	
	Rx claim - Debit Card - HSA does not have adequate funds	
	Rx claim - No Debit Card - HSA does not have adequate funds	
	Medical claim - Debit Card - HSA has adequate funds	
	Medical claim - No Debit Card - HSA has adequate funds	
	Medical claim - Debit Card - HSA does not have adequate funds	
	Medical claim - No Debit Card - HSA does not have adequate funds	
5.30	Is there a merchant code or other limit applied to debit card purchases to prevent use of card for non-health care expenses?	*(Pick one of the following)* ☐ Yes, explain ☐ No
5.31	Are members able to submit manual claims and receive reimbursement through check or direct deposit as an alternative to the debit card?	*(Pick one of the following)* ☐ Yes ☐ No

#	Question	Response
5.32	How is interest credited when amounts were withdrawn in error?	
5.33	How are employer deposits handled?	
5.34	Are there any minimum deposit requirements?	*(Pick one of the following)* ☐ Yes, indicate amount ☐ No
5.35	Are there any minimum deposit amounts that would result in a fee to the participant if not met?	*(Pick one of the following)* ☐ Yes, describe: – Requirements: – Fee: ☐ No
5.36	How do you monitor the performance of the investment funds offered to participants to assure they are high quality, low fee investments?	
5.37	What are the investment options available to participants?	*(Check all that apply)* ☐ Checking/Savings account (indicate interest rate) ☐ Money market account (indicate interest rate) ☐ Preset mutual fund(s) (provide number) ☐ Mutual fund options (provide number) ☐ Unlimited stock/mutual fund options ☐ Other, describe
5.38	Do the investment options vary by account balance (such as a mutual fund option if balance exceeds $1,000)?	*(Pick one of the following)* ☐ Yes, explain ☐ No
5.39	Will you report earnings on investments in a participant's HSA separately for amounts that may have exceeded the annual maximum?	*(Pick one of the following)* ☐ Yes, explain ☐ No
5.40	After an employee deposits funds into an HSA, how quickly are they posted to their account?	

6.0 Behavioral Health Benefit Administration

Behavioral health (BH) benefits administered by a group health plan have many of the same plan administration requirements as the health plan. Plan administration features that are unique to behavioral health are listed below. Use yes/no answers to indicate your ability and willingness to deliver each feature to an employer-sponsored plan.

#	Question	Response
6.1	Utilization and Care Management	
	Care Management: Licensed clinicians conduct all medical necessity reviews.	*(Pick one of the following)* ☐ Yes ☐ No
	Access to psychiatrists for consultation: Care management clinicians have ready access to psychiatrists for consultation.	*(Pick one of the following)* ☐ Yes ☐ No
	Medical necessity denials of BH treatment rendered by psychiatrists: Psychiatrists review and approve all medical necessity denials involving treatment by psychiatrists.	*(Pick one of the following)* ☐ Yes ☐ No
	Care management triggers for selected outpatient BH treatment: Outpatient BH visit claims and/or treatment plans are screened for characteristics triggering a care management intervention (e.g., an eating disorder diagnosis).	*(Pick one of the following)* ☐ Yes ☐ No
	Prescription drug data is incorporated into BH care management: Psychotropic prescription drug data is used to trigger intervention and to monitor BH treatment, e.g., adequate dosage, medications recommended for certain diagnoses, medications that pose a danger for those with certain diagnoses, polypharmacy (e.g., ≥ 5 psychotropic drugs), patient adherence, adverse drug interactions, multiple prescribers, therapeutic duplication, drug abuse.	*(Pick one of the following)* ☐ Yes ☐ No
	Medical Director for BH treatment: Board-certified in psychiatry, licensed, experienced in both psychiatric and addictive disorders.	*(Pick one of the following)* ☐ Yes ☐ No
6.2	Network	
	All levels of care: Contracted network providers include inpatient, residential treatment centers, partial hospitalization programs and intensive outpatient programs.	*(Pick one of the following)* ☐ Yes ☐ No

#	Question	Response
	Credentialed network: All network clinicians are credentialed (i.e., Master's degree minimum, state license to practice independently and malpractice insurance ($1M/$3M for prescribers; $1M/$1M for non-prescribers), with licensure and malpractice insurance verified at the primary source.	*(Pick one of the following)* ☐ Yes ☐ No
	Contracted: All network providers are under contract.	*(Pick one of the following)* ☐ Yes ☐ No
	Availability of network benefits: Network benefits are available in all 50 states, even if single case agreements must be negotiated with out-of-network (OON) providers where network providers are either not available within the access standards listed above or lack the qualifications needed.	*(Pick one of the following)* ☐ Yes ☐ No
6.3	How often is the provider fee network updated? When was the last update? What was the percentage of increase/decrease?	
6.4	BH Web Resources: Behavioral health web site resources can be accessed via the medical plan administrator's web site and include the following content:	
	Information about mental illness and addictive disorders	*(Pick one of the following)* ☐ Yes ☐ No
	Self-assessment tools for depression and alcohol abuse	*(Pick one of the following)* ☐ Yes ☐ No
	Self-development programs (e.g., anger management)	*(Pick one of the following)* ☐ Yes ☐ No
	Psychotherapeutic medication information	*(Pick one of the following)* ☐ Yes ☐ No

#	Question	Response
6.5	Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance: Indicate whether each of the following non-quantitative treatment limitations (NQTLs) are administered such that processes, strategies, evidentiary standards and other factors are applied to BH benefits in a manner that is comparable to and applied no more stringently than those applied to medical/surgical benefits. This question applies only to carriers administering both medical and BH benefits.	
	Utilization management timing, criteria and sanctions for inpatient as well as outpatient services	*(Pick one of the following)* ☐ Yes ☐ No
	Precertification for services in both the inpatient and outpatient classifications	*(Pick one of the following)* ☐ Yes ☐ No
	Triggers for initiating outpatient treatment review (e.g., number of outpatient visits for treatment of depression without a medication evaluation)	*(Pick one of the following)* ☐ Yes ☐ No
	Network admission requirements for practitioners (i.e., criteria required for practitioners to become network providers)	*(Pick one of the following)* ☐ Yes ☐ No
	Network fee schedules for practitioners	*(Pick one of the following)* ☐ Yes ☐ No
6.6	List the BH services in the outpatient classification that you believe should be pre-certified.	
6.7	List and describe the initiatives you have undertaken to improve the quality and outcomes of substance use disorder treatment. Examples include: individualized treatment planning and individual (rather than exclusively group) treatment; use of Medication-Assisted Treatment, dual diagnosis treatment for those with comorbid mental and addictive disorders. Provide any data you have available documenting the success of these efforts.	

#	Question	Response
6.8	What is your ratio of clinical utilization and care managers to covered members? If the ratio is different for the two, provide the ratio for each.	
6.9	List your triggers for utilization management reviews of outpatient treatment (e.g., eight sessions for treatment of depression without a medication evaluation). Do not include triggers for reviewing partial hospitalization or intensive outpatient treatment programs.	
6.10	Are any of these triggers supported by quantitative data (e.g., variability in length of stay, among top ten drivers of cost increases)? If so, indicate which triggers are supported by quantitative data and describe the data.	
6.11	Do you use psychotropic prescription drug data to trigger outpatient BH treatment case management? If so, provide examples of your psychotropic medication outpatient review triggers.	
6.12	Do you use psychotropic prescription drug data to inform your medical care management program?	
6.13	Do you identify members who may benefit from Medication Assisted Treatment for SUD?	
6.14	For what percentage of outpatient cases (excluding partial hospitalization and intensive outpatient treatment programs) is some form of utilization and/or care management action initiated (e.g., requesting clinical information from treating provider, contact between a case manager and the treating provider)?	
Using the questions below, describe your observations about and targeted BH care management initiatives specifically designed for the Adult Dependent population (i.e., the 18 – 26 year olds that became eligible for coverage in 2011, under the Affordable Care Act).		
6.15	List the BH-related characteristics of the Adult Dependent population that distinguish this population from the rest of the commercial covered population.	

#	Question	Response
6.16	Provide any data you have gathered that supports the observations you made above regarding this population (e.g., SUD admissions/1,000 to inpatient facilities; use of out-of-network SUD treatment).	
6.17	Describe any care management or related initiatives you have implemented specifically to serve the needs and issues of this population.	
6.18	Describe the mechanisms/criteria to identify cases that are high-risk and/or have comorbid features? How are these cases handled for clinical and ongoing management of care?	
6.19	What are you doing to increase access to network providers?	
6.20	What percentage of outpatient visits with Primary Care Physicians in your self-funded health plans (with network and OON benefits) is with a network physician?	
6.21	What is your employer BOB percentage increase in plan costs if Applied Behavior Analysis (ABA) is covered?	
6.22	For your self-funded health plan customers, what was the range and average per member per month (PMPM) cost of covering ABA in 2015?	
6.23	For your self-funded health plan customers, what is the range and average percentage of a covered population receiving an ABA benefit?	
6.24	In 2015, what was the average ABA cost per year per person receiving ABA benefits?	
6.25	How many of your self-funded customers are covering ABA?	
6.26	What percentage of your self-funded customers is covering ABA?	
6.27	Describe your company's views about the medical necessity of ABA, both today and in terms of changes you expect in the next 12 to 18 months.	

#	Question	Response
6.28	When a self-funded customer decides to begin covering ABA, what language do you suggest for inclusion in the Summary Plan Description? Comment on any expectations you believe should be communicated regarding the services that will or will not be covered and the treatment reviews that will be conducted. Also comment on any exclusion(s) you believe should be added, such as an exclusion for services covered under the Individuals with Disabilities in Education Act (IDEA).	
6.29	HEDIS BH indicators: Using the NCQA's definitions of the eight BH quality indicators (published annually in NCQA's State of Health Care Quality report), provide the most recent data available for your PPO plans.	
6.30	If applicable, provide your HEDIS results on follow-up after hospitalization for mental illness that showcases your best performance on this indicator. Sometimes results are lowered by customers that do not purchase outpatient BH utilization/care management.	
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.	
	Mental Health	
	Inpatient	
	Intermediate levels of care (PHP, Residential)	
	Outpatient (IOP included)	
	Substance Abuse	
	Inpatient	
	Intermediate levels of care (PHP, Residential)	
	Outpatient (IOP included)	
6.32	Please provide your mental health/substance use expense per employee per month for your employer book of business in 2015 and 2016 YTD.	

#	Question	Response
6.33	Indicate whether Medicare has maximum allowable charges available for each of the levels of care below, either through Medicare's Prospective Payment System or through Medicare Allowable Charges.	
	Inpatient psychiatric treatment	*(Pick one of the following)* ☐ Yes, maximum charge is: ☐ No
	Inpatient substance use disorder treatment	*(Pick one of the following)* ☐ Yes, maximum charge is: ☐ No
	Residential Treatment Centers for psychiatric treatment	*(Pick one of the following)* ☐ Yes, maximum charge is: ☐ No
	Residential Treatment Centers for substance use disorder treatment	*(Pick one of the following)* ☐ Yes, maximum charge is: ☐ No
	Partial hospitalization for psychiatric treatment	*(Pick one of the following)* ☐ Yes, maximum charge is: ☐ No
	Partial hospitalization for substance use disorder treatment	*(Pick one of the following)* ☐ Yes, maximum charge is: ☐ No
	Intensive outpatient programs for psychiatric treatment	*(Pick one of the following)* ☐ Yes, maximum charge is: ☐ No
	Intensive outpatient programs for substance use disorder treatment	*(Pick one of the following)* ☐ Yes, maximum charge is: ☐ No
6.34	Have you implemented reimbursement methodologies (other than paying billed charges) for any of the levels of care listed above for which Medicare has no maximum allowable charge available? If applicable, describe your approach by level of care, including any distinction between mental and substances use disorder conditions.	
6.35	Comment on the steps you have taken to prevail in the event of a challenge based on the Mental Health Parity and Addiction Equity Act (i.e., the comparability between out-of-network reimbursements for medical/surgical treatment versus MH/SUD treatment).	

7.0 Affordable Care Act (ACA)

#	Question	Response
7.1	Describe your planned investment in technology, telecommunications and other resources over the next 2 years to support ACA changes.	
7.2	Please respond to the following table regarding ACA. When further description or explanation is required, please include your comments within the Response column.	
	Confirm your compliance with requirements of ACA.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain:
	Confirm your ability to generate ACA compliant SBCs, including the integration of plan data for carve-out vendors (e.g., pharmacy).	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain:
	Confirm that you will distribute SBCs to plan members.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain:
	How are you supporting plan sponsor reporting requirements as a result of ACA?	
	Confirm you are providing written communication regarding health plan loss ratio information to plan sponsors and members.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain:
	Confirm your ability to administer the comprehensive out of pocket maximum, including any carve-out benefits (e.g., pharmacy), including the embedded out of pocket maximum for an individual member.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain:
7.3	Confirm that you will support employer plan sponsors in their required Form 1095C reporting, if requested, including member information and confirmation of minimum value. Advise of any charges that may apply.	

8.0 Provider Support: Administrative and Clinical Efficiencies

#	Question	Response
8.1	Indicate which of the following plan documents or features are available to providers through your web-based system.	*(Check all that apply)* ☐ Plan policies for coverage ☐ Plan policies for medical necessity criteria ☐ Plan policies are searchable by key words ☐ Not applicable
8.2	What claim and enrollment information is available to providers?	
	Claim level detail	*(Pick one of the following)* ☐ Web-based ☐ Automated telephonic ☐ Telephonic by contacting member services ☐ Paper-based
	Denied claims	*(Pick one of the following)* ☐ Web-based ☐ Automated telephonic ☐ Telephonic by contacting member services ☐ Paper-based
	Amount of member financial responsibilities (copay, coinsurance, etc.)	*(Pick one of the following)* ☐ Web-based ☐ Automated telephonic ☐ Telephonic by contacting member services ☐ Paper-based
	Claim payment cycle (paid, awaiting check issue, etc.)	*(Pick one of the following)* ☐ Web-based ☐ Automated telephonic ☐ Telephonic by contacting member services ☐ Paper-based
	Twelve (12) or more months paid claim history	*(Pick one of the following)* ☐ Web-based ☐ Automated telephonic ☐ Telephonic by contacting member services ☐ Paper-based

#	Question	Response
	Eligibility Inquiry	*(Pick one of the following)* ☐ Web-based ☐ Automated telephonic ☐ Telephonic by contacting member services ☐ Paper-based
	Gaps in care	*(Pick one of the following)* ☐ Web-based ☐ Automated telephonic ☐ Telephonic by contacting member services ☐ Paper-based
	Names of other providers utilized in past 12 months	*(Pick one of the following)* ☐ Web-based ☐ Automated telephonic ☐ Telephonic by contacting member services ☐ Paper-based
	Filled prescription history (based on paid claims)	*(Pick one of the following)* ☐ Web-based ☐ Automated telephonic ☐ Telephonic by contacting member services ☐ Paper-based
8.3	If not currently available, what are your future plans to add availability for the features above? As of what date?	
8.4	How are provider support services changing in light of the emerging value based provider contracting arrangements?	

9.0 Provider Network

#	Question	Response
9.1	Identify all services and products you provide in or through the provider networks that you are proposing for the State of Delaware. Any service/product that you offer in any region covered by your proposal must be included. For each product, if even one network location is part of a leased or subcontracted arrangement, you must select "Combination of 1st and 2nd bullet" and specify what network location(s) fall into that category. Please specify for both PPO/POS and HMO/EPO networks (provided that your proposal includes both types of products; if you are proposing on only one of those networks, please only include the information relative to your proposal to the State).	
	Provider Contracting/Network	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Physician Credentialing	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Hospital Credentialing	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Provider Services	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet

#	Question	Response
	Claims Adjudication	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Eligibility/Enrollment	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Repricing Services	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Draft Summary Plan Description Services	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	ID Card Production	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Network Provider Quality Improvement Program: Clinical	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet

#	Question	Response
	Health Risk Appraisals	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Language service to assist non-English speaking members	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Quality Improvement Program: Administrative	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Information Systems/Reporting	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Member Services Website Development	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Member Services Website Technical Support	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet

#	Question	Response
	Precertification/ Concurrent Utilization Review and Discharge Planning: MEDICAL	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Precertification/ Concurrent Utilization Review and Discharge Planning: BEHAVIORAL HEALTH	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Subrogation	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Retrospective Utilization Review	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Disease Management	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Case Management: MEDICAL	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet

#	Question	Response
	Case Management: BEHAVIORAL HEALTH	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	24-Hour Nurse Line	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
	Quality Improvement Program (clinical/health management and wellness)	*(Pick one of the following)* ☐ Service is provided internally or through an outside Plan-owned entity or affiliate ☐ Service is leased, subcontracted or delegated ☐ Service is not offered ☐ Combination of 1st and 2nd bullet
9.2	**PPO/POS**	
	How many network locations are being offered to the State of Delaware?	
	Provide the following information for each of your proposed PPO/POS network locations:	
	Location Name	
	Owned/Leased	
	Number of individual physicians	
	Number of hospitals	
	Predominant reimbursement arrangement for primary care physicians	
	Predominant reimbursement arrangement for specialists	
	Predominant reimbursement arrangement for hospitals	
9.3	**HMO/EPO**	
	How many network locations are being offered to the State of Delaware?	
	Provide the following information for each of your proposed PPO/POS network locations:	
	Location Name	

#	Question	Response
	Owned/Leased	
	Number of individual physicians	
	Number of hospitals	
	Predominant reimbursement arrangement for primary care physicians	
	Predominant reimbursement arrangement for specialists	
	Predominant reimbursement arrangement for hospitals	
9.4	Do you supplement your proprietary provider network through third-party network management companies? If so, please describe where these third party networks apply to the State of Delaware.	
9.5	If you supplement your proprietary provider network, who are your preferred network vendors? Please list all of the vendors and locations.	
9.6	What percentage of the network providers likely to be utilized by the State of Delaware's employees will be part of a leased network?	
9.7	What is your process for providing notification to a plan sponsor and its members regarding provider additions, terminations, or insolvencies?	*(Check all that apply)* ☐ Electronic provider directory updated ☐ Notice placed on the State of Delaware's customized website ☐ Letters sent to all affected employees
9.8	How and when will plan sponsors be informed of potential terminations?	
9.9	Please provide your provider turnover rate in 2015 for the following provider types:	
	Primary Care Physicians	
	Specialists	
	Behavioral Health Clinicians excluding MDs	
	Psychiatrists (MDs)	
	Outpatient Facilities	
	Hospitals	
	Labs	
	Urgent Care Centers	
	DME Providers	
	Radiology Providers	

#	Question	Response
9.10	What is your approach, other than provider satisfaction surveys, to measuring participating provider satisfaction? What action steps have you taken or do you plan to take as a result of these recent activities?	
9.11	What measures do you take on an ongoing basis to make certain that the network physicians (and other providers) do not require payment in full for office visits, do not practice balance billing and do not charge patients extra "malpractice" or "administrative" fees?	

10.0 Network Financial Information

#	Question	Response
10.1	What is the source of your Usual, Customary and Reasonable (UCR) table used to determine out-of-network payment levels?	*(Pick one of the following)* ☐ Fair Health ☐ Internal fee schedules ☐ Medicare RBRVS ☐ Other, specify:
10.2	How often do you update your UCR tables?	*(Pick one of the following)* ☐ Monthly ☐ Quarterly ☐ Biannually ☐ Annually ☐ Less frequently than annually
10.3	How is the allowable amount determined in circumstances in which a participant receives services from a non-network provider at a network hospital facility?	*(Pick one of the following)* ☐ Automatically treated as in-network ☐ Paid at in-network level via manual override ☐ Paid at in-network level only upon appeal ☐ Always treated as out-of-network ☐ Other, describe
	Hospital-based physicians	
	Hospital-based surgeons	
	Assistant surgeons	
	Anesthesiologists	
	Pathologists/Radiologists	

#	Question	Response
10.4	Do you have a pre-determined dollar threshold and/or types of claims for which you will conduct negotiations for a discounted payment to non-participating providers? If so, list the amount.	*(Pick one of the following)* ☐ Yes, specify amount: ☐ We conduct negotiations for out of network claims, but no formal policy or procedure exists to identify specific claims (identify approximate percentage of non-network claims that are negotiated) ☐ We do not typically conduct negotiations for out of network claims
10.5	What is the fee charged to the plan sponsor for negotiating discounted payments from non-participating providers? (i.e., for out-of-network non-contracted and Emergency Medicine, Radiology, Anesthesiology and Pathology (ERAP) providers) How and when is this fee paid by the employer?	
10.6	How are savings calculated in these situations?	
10.7	Regarding services provided by a non-network provider where you are able to negotiate a discount on charges, what protection do members have against balance billing by the provider up to the original billed amount?	*(Pick one of the following)* ☐ Provider agrees to refrain from balance billing ☐ Other, describe:
10.8	Can the employer opt out of this program? If yes, what impact, if any, is there to the quoted ASO fee?	
10.9	Confirm that the full provider discounts are passed onto plan sponsors and participating members for all eligible non-network shared savings plans. If a fee is applied, please note the percentage of savings retained by the vendor.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain:
10.10	Provide your overall book of business trend rates (Hospital med/surg) including utilization changes, cost increases, etc. used to calculate cost projections for:	

#	Question	Response
	2015	*(Please provide rates for the following)* ☐ PPO/POS ☐ HMO/EPO ☐ CDHP/HRA ☐ HPHP/HSA ☐ ACO ☐ HPN ☐ Medicare ☐ Non-Medicare retiree
	2016 YTD	*(Please provide rates for the following)* ☐ PPO/POS ☐ HMO/EPO ☐ CDHP/HRA ☐ HPHP/HSA ☐ ACO ☐ HPN ☐ Medicare ☐ Non-Medicare retiree
	2017 Projected	*(Please provide rates for the following)* ☐ PPO/POS ☐ HMO/EPO ☐ CDHP/HRA ☐ HPHP/HSA ☐ ACO ☐ HPN ☐ Medicare ☐ Non-Medicare retiree
10.11	Provide the following utilization statistics for your plan-wide commercial enrollment for the most recent calendar year based upon results reported in HEDIS outcomes. If you do not report on HEDIS outcomes, please provide as a reference document an explanation of how you arrived at your response. Exclude mental health/substance abuse from your response.	
	Input the date of the most recent calendar year	*(Please provide)* ☐ Response ☐ Results ☐ % change vs. prior year
	Outpatient physician encounters/1,000 members (excluding MH/SA)	*(Please provide)* ☐ Response ☐ Results ☐ % change vs. prior year

#	Question	Response
	Inpatient admits/1,000 members (excluding MH/SA)	*(Please provide)* ☐ Response ☐ Results ☐ % change vs. prior year
10.12	Non-physician outpatient services: Complete the following table indicating your commercial business for the most recent full calendar year. "Allowed cost" means the charges eligible for payment under the plan after applying discounts but before the application of plan design provisions such as uncovered expenses, copayments, deductibles, coinsurance and coordination of benefits. "Visit" means each complete encounter or requisition (for lab services) consisting of the collection of procedures (excluding physician professional activity) performed as part of the encounter or requisition.	
	Emergency Room	*(Please provide for 2015 Calendar Year)* ☐ Visits/1,000 members ☐ Average # procedures/visit ☐ Average charge/visit ☐ Average allowed cost/visit
	Surgery	*(Please provide for 2015 Calendar Year)* ☐ Visits/1,000 members ☐ Average # procedures/visit ☐ Average charge/visit ☐ Average allowed cost/visit
	Radiology	*(Please provide for 2015 Calendar Year)* ☐ Visits/1,000 members ☐ Average # procedures/visit ☐ Average charge/visit ☐ Average allowed cost/visit
	Laboratory	*(Please provide for 2015 Calendar Year)* ☐ Visits/1,000 members ☐ Average # procedures/visit ☐ Average charge/visit ☐ Average allowed cost/visit
	All other (including ambulance, PT/OT, DME)	*(Please provide for 2015 Calendar Year)* ☐ Visits/1,000 members ☐ Average # procedures/visit ☐ Average charge/visit ☐ Average allowed cost/visit

#	Question	Response
10.13	Physician/Non-facility utilization and cost: Complete the following table indicating the commercial business for the most recent full calendar year. "Allowed cost" means the charges eligible for payment under the plan after applying discounts but before the application of plan design provisions such as uncovered expenses, copayments, deductibles, coinsurance and coordination of benefits. "Procedure" means each incidence of the listed CPT code.	
	CPT 29873: Knee arthroscopy/surgery	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 33512: Coronary artery bypass	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 36415: Drawing of blood	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 44950: Appendectomy	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 45378: Diagnostic colonoscopy	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 49505: Repair inguinal hernia	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 55845: Extensive prostate surgery	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 58150: Total hysterectomy	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure

#	Question	Response
	CPT 59400: Obstetrical care	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 59510: Cesarean delivery	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 70460-26: CAT, head or brain, w contrast	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 73610-26: X-Ray exam, ankle complete	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 73721-26: MRI, any joint of lower extremity	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 93000: Electrocardiogram, complete	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 93015: Cardiovascular stress test	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 98941: CMT; spinal, three to four regions	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 99213: Office/outpatient visit	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 27446: Knee replacement	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure

#	Question	Response
	CPT 33534: CABG/Bypass	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
10.14	Facility utilization and cost: Complete the following table indicating the commercial business for the most recent full calendar year. "Allowed cost" means the charges eligible for payment under the plan after applying discounts but before the application of plan design provisions such as uncovered expenses, copayments, deductibles, coinsurance and coordination of benefits. "Procedure" means each incidence of the listed DRG code.	
	DRG 470: Knee/Hip	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	DRG 455: Spine	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	DRG 373: Vaginal Delivery	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	DRG 371: C-section Delivery	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	DRG 743: Hysterectomy	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	DRG 343: Appendectomy	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	DRG 667: Prostate	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure

#	Question	Response
	DRG 234: CABG/Bypass	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 73721-26: MRI, any joint of lower extremity	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure
	CPT 70460-26: CAT, head or brain, w contrast	*(Please provide for 2015 Calendar Year)* ☐ Procedures/1,000 members ☐ Average charge/procedure ☐ Average allowed cost/procedure

11.0 Network Accreditation and Plan Performance Reporting

#	Question	Response
11.1	Identify the internal certifications and accreditations achieved by the following network products. Indicate if the PPO is accredited and if 100% of PPO Providers are also HMO Providers. If the function is outsourced to a vendor, accreditation and certification information will be captured in a subsequent question below.	
	PPO Accreditation (Commercial)	*(Please provide the following)* ☐ PPO accreditation and/or certification awarded ☐ Yes ☐ Do not have accreditation or certification in this area ☐ HMO accredited and 100% of PPO providers are HMO providers ☐ Yes ☐ Do not have accreditation or certification in this area ☐ Review organization (NCQA, JCAHO, URAC): ☐ Current status (level awarded): ☐ Effective date of current status (MM/YYYY): ☐ Date of next scheduled full review (MM/YYYY):

#	Question	Response
	Credentialing Certification	*(Please provide the following)* ☐ PPO accreditation and/or certification awarded ☐ Yes ☐ Do not have accreditation or certification in this area ☐ HMO accredited and 100% of PPO providers are HMO providers ☐ Yes ☐ Do not have accreditation or certification in this area ☐ Review organization (NCQA, JCAHO, URAC): ☐ Current status (level awarded): ☐ Effective date of current status (MM/YYYY): ☐ Date of next scheduled full review (MM/YYYY):
	Utilization Management Certification	*(Please provide the following)* ☐ PPO accreditation and/or certification awarded ☐ Yes ☐ Do not have accreditation or certification in this area ☐ HMO accredited and 100% of PPO providers are HMO providers ☐ Yes ☐ Do not have accreditation or certification in this area ☐ Review organization (NCQA, JCAHO, URAC): ☐ Current status (level awarded): ☐ Effective date of current status (MM/YYYY): ☐ Date of next scheduled full review (MM/YYYY):

#	Question	Response
	Claims Administration Certification	*(Please provide the following)* ☐ PPO accreditation and/or certification awarded ☐ Yes ☐ Do not have accreditation or certification in this area ☐ HMO accredited and 100% of PPO providers are HMO providers ☐ Yes ☐ Do not have accreditation or certification in this area ☐ Review organization (NCQA, JCAHO, URAC): ☐ Current status (level awarded): ☐ Effective date of current status (MM/YYYY): ☐ Date of next scheduled full review (MM/YYYY):
	Network Management Certification	*(Please provide the following)* ☐ PPO accreditation and/or certification awarded ☐ Yes ☐ Do not have accreditation or certification in this area ☐ HMO accredited and 100% of PPO providers are HMO providers ☐ Yes ☐ Do not have accreditation or certification in this area ☐ Review organization (NCQA, JCAHO, URAC): ☐ Current status (level awarded): ☐ Effective date of current status (MM/YYYY): ☐ Date of next scheduled full review (MM/YYYY):
11.2	Have you voluntarily sought distinction from NCQA for the member Connections and/or Care Management and Health Improvement (HMO & POS plans only) components of Quality Plus?	
11.3	Please indicate for the types of covered lives that you submitted HEDIS and CAHPS data last year.	*(Pick one of the following)* ☐ HMO covered lives ☐ PPO covered lives ☐ Both HMO and PPO covered lives ☐ Neither

#	Question	Response
11.4	Did you allow public reporting of CAPHS and HEDIS results?	
11.5	Do you promote or sponsor participation in NCQA Physician Recognition Program for your network physicians?	

12.0 Access to Care/Providers

#	Question	Response
12.1	If you are willing to expand your service area where the State of Delaware has members, indicate where (city and/or county) and the expected date service will be available utilizing the format below. Enter N/A if you are not planning to expand your service area.	
	New Castle County	*(Please provide the following)* ☐ Estimate date available ☐ Willing to expand based on client specific needs
	Kent County	*(Please provide the following)* ☐ Estimate date available ☐ Willing to expand based on client specific needs
	Sussex County	*(Please provide the following)* ☐ Estimate date available ☐ Willing to expand based on client specific needs
	Other Area	*(Please provide the following)* ☐ Estimate date available ☐ Willing to expand based on client specific needs
12.2	Do you have specialty contracts, such as manufacturer direct contracts for durable medical equipment (wheelchairs, infusion pumps, etc.), that can be applied as additional discounts to member claims?	

#	Question	Response
12.3	How do you handle members who receive care outside of your service area?	*(Check all that apply)* ☐ Member must contact member services before receiving care (except in emergency) ☐ Member may receive any necessary care from any provider ☐ Member must pre-certify treatment ☐ Level of payment is determined by employer ☐ Member must receive care from plan-specified provider (except in emergency) ☐ Member must pay for care and then submit bill to plan for payment ☐ Member may submit provider bill directly to plan for payment to provider
12.4	What percentage of total utilization for the State of Delaware for the quoted product is represented by networks you lease?	
	Total membership percentage	
	Total claim dollar percentage	
12.5	What percent of participating providers in the proposed the State of Delaware networks are currently closed to new patients? The term "closed" refers to an office that cannot currently accept new patients regardless of network affiliation. In other words, the doctor is not accepting new patients to his/her practice.	
	Primary Care Physicians	
	Specialists	
12.6	With the increased insurance plan enrollment that has come as a result of PPACA, how have you measured, monitored, and ensured timely and appropriate access for your members to providers in your networks?	
12.7	Using HEDIS' technical specifications identify the percentage of contracted Providers who are board certified in your network. If board certification is not tracked, enter 0.	
	PCPs (including OB/GYNs)	*(Please provide for the Calendar Year specified)* ☐ 2015: ☐ 2016:

#	Question	Response
	Specialists (including allergists, cardiologists, dermatologists, gastroenterologists, general surgeons, ophthalmologists, orthopedic surgeons, and otolaryngologists)	*(Please provide for the Calendar Year specified)* ☐ 2015: ☐ 2016:

13.0 Provider Credentialing

#	Question	Response
13.1	Confirm that your in-network providers are subjected to a credentialing process prior to contracting.	
	Hospitals	*(Pick one of the following)* ☐ Yes, internally ☐ Yes, by a Credentialing Verification Organization (CVO) for full delivery system ☐ Yes, hybrid internal and CVO process ☐ No
	Physicians	*(Pick one of the following)* ☐ Yes, internally ☐ Yes, by a Credentialing Verification Organization (CVO) for full delivery system ☐ Yes, hybrid internal and CVO process ☐ No
13.2	Which of the following is included in your policies and procedures for credentialing and re-credentialing?	
	Identification of all providers that are credentialed, e.g., MD, DO, PA, NP, etc.	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	Credentialing criteria used and the primary source verification of information used to meet the criteria	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either

#	Question	Response
	Process used to make credentialing decisions	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	The right of a provider to review all information submitted	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	The process of notification to a provider of conflicting information and correct erroneous information	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	The right of a provider to appeal denials	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	The process to ensure confidentiality of information	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	On-site visits to providers	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
13.3	What percent of providers (PCPs and Specialists) in your network are currently credentialed?	
13.4	How often are providers re-credentialed?	

#	Question	Response
	Hospitals	*(Pick one of the following)* ☐ Annually ☐ Once every two years ☐ Once every three years ☐ Less than every three years ☐ Other
	Physicians	*(Pick one of the following)* ☐ Annually ☐ Once every two years ☐ Once every three years ☐ Less than every three years ☐ Other
13.5	Indicate which of the following are included in the credentialing and re-credentialing applications:	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	Current attestation by the provider regarding ability to perform the essential function of the position	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	Current attestation by the provider and external confirmation regarding Valid Drug Enforcement Agency license	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	Board certification	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	Current attestation by the provider regarding illegal drug use	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either

#	Question	Response
	Current attestation by the provider and external confirmation regarding history of loss of license or felony convictions	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	Current attestation by the provider and external confirmation regarding loss or limitation of hospital privileges	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	Current attestation by the provider and external confirmation regarding malpractice insurance coverage	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
	Current attestation by the provider regarding the correctness and completeness of the application	*(Pick one of the following)* ☐ Included in credentialing and re-credentialing ☐ Included in credentialing only ☐ Included in re-credentialing only ☐ Not included in either
13.6	Do you profile individual providers, group providers or hospitals on the parameters listed below?	
	Clinical performance indicators	*(Check all that apply)* ☐ Individual Providers ☐ Yes ☐ No ☐ Do not profile ☐ Group Providers ☐ Yes ☐ No ☐ Do not profile ☐ Hospitals ☐ Yes ☐ No ☐ Do not profile

#	Question	Response
	Utilization	*(Check all that apply)* ☐ Individual Providers ☐ Yes ☐ No ☐ Do not profile ☐ Group Providers ☐ Yes ☐ No ☐ Do not profile ☐ Hospitals ☐ Yes ☐ No ☐ Do not profile
	Mortality or complication rates	*(Check all that apply)* ☐ Individual Providers ☐ Yes ☐ No ☐ Do not profile ☐ Group Providers ☐ Yes ☐ No ☐ Do not profile ☐ Hospitals ☐ Yes ☐ No ☐ Do not profile
	Cost measures	*(Check all that apply)* ☐ Individual Providers ☐ Yes ☐ No ☐ Do not profile ☐ Group Providers ☐ Yes ☐ No ☐ Do not profile ☐ Hospitals ☐ Yes ☐ No ☐ Do not profile

#	Question	Response
	Comparison with peers	*(Check all that apply)* ☐ Individual Providers ☐ Yes ☐ No ☐ Do not profile ☐ Group Providers ☐ Yes ☐ No ☐ Do not profile ☐ Hospitals ☐ Yes ☐ No ☐ Do not profile
	Comparison with benchmarks	*(Check all that apply)* ☐ Individual Providers ☐ Yes ☐ No ☐ Do not profile ☐ Group Providers ☐ Yes ☐ No ☐ Do not profile ☐ Hospitals ☐ Yes ☐ No ☐ Do not profile
	Satisfaction surveys	*(Check all that apply)* ☐ Individual Providers ☐ Yes ☐ No ☐ Do not profile ☐ Group Providers ☐ Yes ☐ No ☐ Do not profile ☐ Hospitals ☐ Yes ☐ No ☐ Do not profile
13.7	How is this information used to improve provider performance?	

14.0 Provider Management

#	Question	Response
14.1	Indicate the conditions or terms that are included in your contracts with in-network providers.	
	Continuation of care if there is an involuntary termination (by employer, provider, or Plan) of the provider's contract when undergoing treatment for a chronic/disabling condition (other than pregnancy)	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	Continuation of care through completion of postpartum care when in the 2nd or 3rd trimester of pregnancy if provider's contract is terminated (by employer, provider or Plan).	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	Balance billing policy - member held harmless	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	Allowance for use of "passive" blind networks (no differentiation between in- and out-of-network benefits)	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	Credentialing	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	Compliance with UM	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	Claims submissions	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required

#	Question	Response
	Complaints/Grievances	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	Electronic capabilities for member services/communications	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	Disclosure of reimbursement rates for the use in member transparency tools	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
14.2	Are network physicians contractually obligated to admit to in-network hospitals only?	*(Pick one of the following)* ☐ Yes ☐ No, describe procedures to ensure neither the member nor the State of Delaware is penalized for physicians admitting practices
14.3	Did you terminate any hospital contracts during the current year (or did any hospitals terminate their relationship with you)? If yes, indicate the approximate percentage of admissions in the prior year attributed to the terminated hospital(s). The percentage should be calculated by taking the number of admissions to the terminated hospital(s) last year and, dividing by the total number of admissions for the plan last year.	
14.4	Indicate whether clinical performance is measured, benchmarked, or reported for any of the following:	

#	Question	Response
	Immunization Rate	*(Please provide the following)* ☐ Indicate if HEDIS or other (define) ☐ Measurement ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results to providers ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results with benchmarking ☐ Yes ☐ No ☐ Not tracked ☐ Public reporting ☐ Yes ☐ No ☐ Not tracked
	Diabetes Process (testing)	*(Please provide the following)* ☐ Indicate if HEDIS or other (define) ☐ Measurement ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results to providers ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results with benchmarking ☐ Yes ☐ No ☐ Not tracked ☐ Public reporting ☐ Yes ☐ No ☐ Not tracked

#	Question	Response
	Diabetes Outcomes (comprehensive diabetes care for HBA1C control)	*(Please provide the following)* ☐ Indicate if HEDIS or other (define) ☐ Measurement ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results to providers ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results with benchmarking ☐ Yes ☐ No ☐ Not tracked ☐ Public reporting ☐ Yes ☐ No ☐ Not tracked
	Beta Blockers for Heart Failure	*(Please provide the following)* ☐ Indicate if HEDIS or other (define) ☐ Measurement ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results to providers ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results with benchmarking ☐ Yes ☐ No ☐ Not tracked ☐ Public reporting ☐ Yes ☐ No ☐ Not tracked

#	Question	Response
	Cholesterol Control	*(Please provide the following)* ☐ Indicate if HEDIS or other (define) ☐ Measurement ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results to providers ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results with benchmarking ☐ Yes ☐ No ☐ Not tracked ☐ Public reporting ☐ Yes ☐ No ☐ Not tracked
	Asthma Medication Management	*(Please provide the following)* ☐ Indicate if HEDIS or other (define) ☐ Measurement ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results to providers ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results with benchmarking ☐ Yes ☐ No ☐ Not tracked ☐ Public reporting ☐ Yes ☐ No ☐ Not tracked

#	Question	Response
	Breast Cancer Screening	*(Please provide the following)* ☐ Indicate if HEDIS or other (define) ☐ Measurement ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results to providers ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results with benchmarking ☐ Yes ☐ No ☐ Not tracked ☐ Public reporting ☐ Yes ☐ No ☐ Not tracked
	Cervical Cancer Screening	*(Please provide the following)* ☐ Indicate if HEDIS or other (define) ☐ Measurement ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results to providers ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results with benchmarking ☐ Yes ☐ No ☐ Not tracked ☐ Public reporting ☐ Yes ☐ No ☐ Not tracked

#	Question	Response
	Colorectal Screening	*(Please provide the following)* ☐ Indicate if HEDIS or other (define) ☐ Measurement ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results to providers ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results with benchmarking ☐ Yes ☐ No ☐ Not tracked ☐ Public reporting ☐ Yes ☐ No ☐ Not tracked
	Prostate Cancer Screenings	*(Please provide the following)* ☐ Indicate if HEDIS or other (define) ☐ Measurement ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results to providers ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results with benchmarking ☐ Yes ☐ No ☐ Not tracked ☐ Public reporting ☐ Yes ☐ No ☐ Not tracked

#	Question	Response
	Depression-medication management	*(Please provide the following)* ☐ Indicate if HEDIS or other (define) ☐ Measurement ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results to providers ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results with benchmarking ☐ Yes ☐ No ☐ Not tracked ☐ Public reporting ☐ Yes ☐ No ☐ Not tracked
	Other HEDIS metric(s)	*(Please provide the following)* ☐ Indicate if HEDIS or other (define) ☐ Measurement ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results to providers ☐ Yes ☐ No ☐ Not tracked ☐ Reporting results with benchmarking ☐ Yes ☐ No ☐ Not tracked ☐ Public reporting ☐ Yes ☐ No ☐ Not tracked
14.5	Indicate whether performance is measured, benchmarked, or reported for any of the following:	
	Patient Experience	*(Please provide)* ☐ Yes ☐ No ☐ Not tracked
	Specialty referral rate	*(Please provide)* ☐ Yes ☐ No ☐ Not tracked

#	Question	Response
	Inpatient Admission Rate	*(Please provide)* ☐ Yes ☐ No ☐ Not tracked
	Average Length of Stay	*(Please provide)* ☐ Yes ☐ No ☐ Not tracked
	Emergency Room Visits (non-urgent care)	*(Please provide)* ☐ Yes ☐ No ☐ Not tracked
	Medical Claims Costs	*(Please provide)* ☐ Yes ☐ No ☐ Not tracked
	Financial Results	*(Please provide)* ☐ Yes ☐ No ☐ Not tracked
	Longitudinal Efficiency (episode of care)	*(Please provide)* ☐ Yes ☐ No ☐ Not tracked
	IT Capacity (use of e-health visits, etc.)	*(Please provide)* ☐ Yes ☐ No ☐ Not tracked
	Other, describe in comments	
14.6	Based on your most recent physician satisfaction survey, what percentage of physicians are "satisfied" or "more than satisfied" with your plan? Do NOT report on "somewhat satisfied".	
	Satisfaction survey conducted	
	What is the date of the most recent survey? (mm/dd/yyyy)	
	% combined response "satisfied or more than satisfied"	

15.0 Medical Plan Performance Auditing

#	Question	Response
15.1	Confirm that your organization will allow the State of Delaware or a third party audit your claim administration and member services performance under the contract, annually if requested.	
15.2	Are there any limitations or restrictions regarding the audit? (e.g., limit on the number of calls/transactions audited per year, number of audits) If yes, please describe all limitations and restrictions.	
15.3	How long will you retain member service records relating to the contract for auditing purposes?	*(Pick one of the following)* ☐ Less than 1 year ☐ 1 to 2 years ☐ 2 to 5 years ☐ More than 5 years
15.4	Indicate your contractual stipulations to submit to external audits that verify the accuracy of your member services, claims repricing and/or adjudication functions when requested by your clients.	*(Check all that apply)* ☐ Notice requirement (provide number of days) ☐ Confidentiality agreement is required ☐ Sample limited to __ of years prior to current year ☐ Plan is not responsible for any costs of audit ☐ Extrapolation is permitted ☐ Extrapolation is NOT permitted ☐ Reserve right to rebut information in audit report ☐ Signed contract required ☐ Claim sample size limit ☐ Other, specify ☐ Not applicable

16.0 Medical Plan Reporting

#	Question	Response
16.1	Please indicate which of the following reports you provide to your self-funded plan sponsors.	

#	Question	Response
	Customer service - phone and claim statistics	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
	Financial management - enrollment, claims, fees	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
	Banking summary - payment summary, account balance, interest credit, fees	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability

#	Question	Response
	Claims lag	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
	Paid claim summary - category of service, single/family, ETG, DRG, COB/TPL	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
	Patient status by age, gender, relationship (e.g., employee, spouse)	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability

#	Question	Response
	Claim utilization	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
	High claimant reports - all members exceeding a specific dollar amount in a given period	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
	HRA/HSA usage – covered services (i.e., categories of spending), account reconciliation reports, error reporting	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability

#	Question	Response
	Top provider report - including charges, allowable amount, and payment	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
	Cost savings report - charges, covered services, deductible, copay, COB, savings, provider savings, etc.	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
	Hospital utilization - DRG, number of admissions, average length of stay, number of days, cost/DRG, etc.	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability

#	Question	Response
	Hospitalization utilization by provider	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
	Annual utilization analysis	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
	Customer service call reason report	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability

#	Question	Response
	Case management activity report	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
	Utilization management activity report	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
	Disease management activity report	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability

#	Question	Response
	Gaps in care activity report	*(Check all that apply)* ☐ Provided frequency ☐ Yes, monthly ☐ Yes, quarterly ☐ Yes, annually ☐ Not provided ☐ Preferred media ☐ Online ☐ Email delivery ☐ Paper ☐ Not provided ☐ Minimum membership for report availability
16.2	Describe the analytic support you provide to plan sponsors for both standard and ad hoc reports.	
	Who performs the data analysis?	
	How frequently is this person available for discussions by phone? Face to face meetings?	
	Is there an additional charge for this support? If so, provide detail.	
16.3	Please confirm that you can accommodate sending the following fields to Truven: • Whether particular members are attributed to a particular ACO • Which ACO is the member attributed to • An indicator within the claims data for whether a provider is associated with an ACO • An indicator that a provider submitted a payment for a bundled payment	

17.0 Medical Plan Banking Arrangements

#	Question	Response
17.1	Include a description of your preferred banking arrangement.	
17.2	Who sets up the bank account and pays the bank charges?	

#	Question	Response
17.3	How do you assess banking charges if your own bank is not used to writing checks?	
17.4	As noted in the Background section, the State does not prefund a bank account for payment of medical claims. Instead, the vendor(s) must pay claims first and then invoice the State for reimbursement of those payments. Please confirm your ability to administer and pay claims in this manner.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain:
17.5	What is the frequency of bank account funding?	*(Pick one of the following)* ☐ Daily ☐ Multiple times per week ☐ Weekly ☐ Other, specify:
17.6	What is the timing on claim funding?	*(Pick one of the following)* ☐ Daily ☐ Multiple times per week ☐ Weekly ☐ Other, specify:
17.7	What are the reconciliation services that are included in your standard fees?	
17.8	Will you allow a plan sponsor the flexibility to use its own bank account?	
17.9	Are any alternative bank arrangements available? If so, briefly describe them.	
17.10	On what basis are banking reports produced?	*(Pick one of the following)* ☐ Processed claims ☐ Checks cleared ☐ Checks issued ☐ Other, specify:
17.11	What type of financial reports will be generated in conjunction with the bank reconciliation and auditing procedures?	
17.12	What reconciliation services do you provide for banking reports compared to claim reports?	
17.13	What escheatment services do you provide for checks that have been mailed but never cashed? Is this service included in your standard fee?	

18.0 HIPAA Compliance

#	Question	Response
18.1	As an exhibit, please provide the name, e-mail address, certification designation (e.g., CHC, CISSP, CIPP, CHP, or CHPSE) and date certified of the individual responsible for HIPAA Compliance. If this designated position does not exist, provide the name and title of the employee who handles HIPAA privacy and security issues within your company or organization.	
18.2	If this person is not certified, provide detailed information regarding training undertaken by the person responsible for HIPAA compliance. (e.g., date last received training, name of company or person that provided training, etc.)	
18.3	Do all employees receive comprehensive training that covers the privacy and security of Protected Health Information (PHI), both physical and technical?	
18.4	Are HIPAA privacy policies and procedures in place for employees to follow?	
18.5	Are employees trained on the policies and procedures?	
18.6	Are employees required to sign an agreement stating they have read and understand the privacy policies and procedures?	
18.7	Provide details of the methods the company utilizes for securing and rendering PHI unusable, unreadable, or indecipherable to unauthorized individuals.	
18.8	Describe security procedures – physical, technical and administrative - currently in place to ensure confidentiality of protected health information within systems and when transmitting data to the State's PBM(s) or vendors designated by the State.	
18.9	Has your organization conducted a risk assessment and gap analysis to address any findings?	
18.10	Has your organization conducted an application and data criticality analysis? If yes, provide the date it was last performed.	

#	Question	Response
18.11	Please describe or attach a copy as an exhibit of your company's disaster recovery plan for data backup, data recovery, and system testing should a disaster occur (e.g., flood, fire, or system failure). If that plan has been invoked in the last two (2) years, please provide the details of that incident.	
18.12	Please describe or attach a copy of your company's business continuity plan in the event of a disaster (e.g., flood, fire, power failure, system failure). If the plan has been invoked in the last two (2) years, please provide the details of that incident.	
18.13	Has your organization received any certifications to become "HIPAA Compliant"? If yes, please provide copies and the date when the certification was awarded.	
18.14	When was the last time you conducted a review to determine HIPAA Compliance status? As an exhibit, please provide the date the review was performed and the name of the company who performed it. (You may be asked to provide copies of the review findings at a later date.)	
18.15	Do you outsource work to subcontractors who would have access to Plan data and PHI? (If yes, please provide the names of the companies you outsource work to and where they are located. (You would have completed a Subcontractor Information form as a requirement in the Minimum Qualifications section.)	
18.16	Have you entered into business associate agreements with all vendors who may qualify as subcontractors to the Plan for this work? (If so, you may be asked to provide signature pages of BAAs at a later date.)	
18.17	Have you had occasion to review any subcontractors and can you provide information as to whether they are HIPAA compliant at this time? (You would have completed a Subcontractor Information form as a requirement in the Minimum Qualifications section. Additionally, and if so, you may be asked to provide this information at a later date.)	

#	Question	Response
18.18	As an exhibit, please provide the number of HIPAA violations reported to the Office of Civil Rights (OCR) in the last five (5) years and include a description of the incident(s) and the amount of the fine incurred (if any).	

C. Health Care Delivery

For the following section, the following "value-based contracting models" have been defined as follows:

Value-Based Contracting Model	Definition
1) Advanced Primary Care (APC)	Advanced Primary Care broadly encompasses the capabilities required to deliver convenient, effective, well-coordinated care throughout the health care system. This may include multiple models already being adopted by Delaware PCPs, including Patient-Centered Medical Homes, and models that collocate primary care and specialists. The SEBC supports models that include the nine capabilities described in the DCHI consensus paper on primary care practice transformation (see http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Primary-Care-Practice-Transformation.pdf).
2) Accountable Care Organizations (ACOs)	An organized delivery system comprised of facility and professional providers for an attributed/selected population. Accountability for overall performance, cost and quality reside with the provider and the delivery system, including shared risk. Population health management provided across all levels of care. Responsible for all of the health care and related expenditures for a defined population of patients.
3) Narrow Network	A smaller panel of providers structured to deliver reduced unit cost through plan design steerage and contract improvements.
4) High Performance Network (HPN)	A subset of the broad provider panel identified through the evaluation of cost and quality metrics, may or may not include separate contract arrangements. Plan design steerage is optional.
5) Centers of Excellence (COE)	Providers that have been identified as delivering high quality services and superior outcomes for specific procedures or conditions. May incorporate separate contracting arrangements for a predetermined set of services (e.g., bundled payments).
6) Other	Other alternative methods of contracting with medical providers outside of traditional fee-for-service pricing, including percentage of billed charges, DRGs and APCs.

1.0 Onsite Health Centers

#	Question	Response
1.1	Do you offer onsite health center services located at or near employer work locations?	
1.2	If you answered yes to the previous question, what types of services do you offer?	
	Wellness and Prevention (e.g., preventive screenings, biometrics, wellness exams, coaching)	
	Acute Care (e.g., minor eye conditions, respiratory infections, sprains and strains, symptom management etc.)	
	Ancillary Support Services (e.g., immunizations, diagnostic testing, lab draw, radiology, etc.)	
	Minor Medical/Surgical (e.g., nail removal, incision and drainage of a cyst, etc.)	
	Occupational Health (e.g., travel medicine, ergonomics, injury reports, restrictions, leave of absence, audio and vision screening, etc.)	
	Physical Therapy Services	
	Pharmacy	
	Behavioral Health (e.g., screenings, specialty counseling)	
	Other, describe:	
1.3	Do you own the onsite/near-site health centers that you operate?	
1.4	Describe your approach to staffing the onsite health center. Do you:	*(Pick one of the following)* ☐ Directly employ all personnel ☐ Lease employees from a third party ☐ Combination of both ☐ Other, describe:
1.5	Describe the types of data that health center staff can access from your system while onsite:	*(Check all that apply)* ☐ Eligibility data ☐ Claims data ☐ EMR ☐ PHR ☐ Clinical data from health management programs ☐ Clinical data i.e., lab value results, radiology reports etc., ☐ Other, describe

#	Question	Response
1.6	Please describe your capacity to exchange data with the following types of providers and systems in support of onsite health center operations. For each, indicate the following:	
	External laboratories	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Pharmacies	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	External radiology systems	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Community-based doctors	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Hospitals (admissions and discharges)	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No

#	Question	Response
	Health Information Exchanges	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Regional Health Information Organizations	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Health plans and insurers	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Claims clearinghouses	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Disease/Health management vendors	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Workers compensation vendors	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No

#	Question	Response
	EAPs	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Disability vendors	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Personal health records	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Health risk assessments	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Telemedicine	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Accountable Care Organizations	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No

#	Question	Response
	Emergency Department (admissions and discharges)	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
	Others, describe:	*(Check all that apply)* ☐ Send data to ☐ Yes ☐ No ☐ Receive data from ☐ Yes ☐ No
1.7	Do you allow personnel from the employer's other healthcare partners to be co-located with your onsite/near-site health center? (e.g., wellness, EAP)	
1.8	What data can be shared with these co-located partners? For example, assuming all HIPAA requirements are met, can partner vendor staff (e.g., wellness, EAP) have access to your systems to support patient treatment?	
1.9	How many clients do you have for which you adjudicate claims from an onsite health center for members in a high deductible health plan?	
1.10	For those clients, how is the onsite health center fee schedule set?	
	Average allowed by CPT	
	% average allowed by CPT	
	Average allowed by category (rolling up multiple CPT codes)	
	% average allowed by category (rolling up multiple CPT codes)	
	Average of Medicare by CPT	
	% of Medicare by CPT	
	Average of Medicare by category (rolling up multiple CPT codes)	
	% average of Medicare by category (rolling up multiple CPT codes)	
1.11	Do you offer health kiosks at employer worksites? If yes, please describe your capabilities.	

#	Question	Response
1.12	Do you provide onsite nursing and/or coaching services that are not linked to an on-site health center? If yes, please describe your capabilities, including pricing for those services. Please ensure that pricing for those services is included in your response to Appendix P and Q.	

2.0 Telehealth – Partnering with an External Vendor

#	Question	Response
2.1	Does your organization currently work with a preferred telehealth provider? If so, which organizations?	*(Check all that apply)* ☐ Teladoc ☐ MDLIVE ☐ American Well ☐ Doctor On Demand ☐ Other, specify ☐ Do not currently work with a preferred telemedicine provider
2.2	Is your organization able to seamlessly integrate with a telehealth provider of the State of Delaware's choosing?	
2.3	Is your claims system able to receive electronic claim submissions from a telehealth provider, adjudicate the claim against the State of Delaware's benefit plan, and remit payment to the telehealth provider?	
2.4	Are you able to send eligibility data to the telehealth vendor recurrently using a standard 834 eligibility file?	
2.5	Are you willing to consider the telehealth vendor's proprietary file format? If so, is there any additional cost for doing so?	
2.6	Are you able to build a direct 837 claims submission capability to receive the telehealth vendor's claims? If so, is there any additional cost for doing so?	
2.7	What are your capabilities to pass and receive clinical data (e.g., electronic health record, personal health record, health risk assessment, etc.) with a telehealth vendor?	

#	Question	Response
2.8	What steps need to be undertaken to include the telehealth vendor as an in-network provider?	

3.0 Value-based Contracting Models

#	Question	Response
3.1	Please describe your strategy to evolve from fee-for-service to fee-for-value within your provider contracting arrangements.	
3.2	Provide a general description of provider dynamics and your strategic direction for the specific markets in which State of Delaware participants reside.	

3.3	TPAs will be considered to offer a stronger value proposition to the SEBC if they include contractual guarantees to migrate provider payments to value-based payment arrangements which promise or have the potential to reduce trend (or the growth rate in trend) for the SEBC and GHIP members while also maintaining or improving the quality of care. Below are examples of such arrangements, beginning with those that would be considered most favorably: a. Existing contractual commitments or letter of intent between the TPA and network providers which include <u>downside risk</u> sharing for managing the quality and total cost of care: for all GHIP medical spending for all GHIP members of the TPA within Delaware. <u>Note:</u> If you select this option, will the upside and downside risk be separated? In your response, please discuss the following: 1. Risk and gain are related to reductions in total cost of care, trend guaranties, capitation 2. Risk and gain share are related to members who select the ACO product and/or attributed are to an ACO provider 3. Upside and downside risk with fiscal and quality upside only 4. Fiscal targets need to be reached before gain sharing 5. Gain sharing requires quality targets to be reached before sharing fiscal sharing 6. Gain sharing targets escalate over time	

#	Question	Response
	7. Gain sharing related to only PCP attribution (not hospital or specialists) b. [Existing downside risk arrangement, as described above]: for a portion of GHIP spending, based on either select episodes of care or a subset of GHIP members of the TPA, based, for example based on attribution to select primary care providers in the network. c. Commitment to introduce downside risk sharing arrangements for some or all GHIP medical spending, including willingness of TPA to offer performance guarantees relative to adoption. d. Existing contractual commitments between the TPA and network providers which include upside shared savings for managing the quality and total cost of care: for all GHIP members of the TPA within Delaware. e. [Existing upside shared savings arrangement, as described above]: for a portion of GHIP members that may be attributed to primary care providers participating in an Accountable Care Organization (ACO) or Clinically Integrated Network for purposes of clinical integration and adoption of value-based payment. Note: In your response, please indicate the number of PCPs and estimate the proportion of GHIP members attributable to those PCPs. f. Commitment to introduce upside shared savings arrangements for some or all SEBC medical spending, including willingness of TPA to offer performance guarantees relative to adoption.	

<table>
<tr><th>#</th><th>Question</th><th>Response</th></tr>
<tr><td>3.4</td><td>Please indicate which of the above levels of commitment (or alternative level of commitment) you are prepared to make, effective 7/1/2017 and each successive anniversary of the proposed contract. Please also indicate the Penetration Rate associated with your commitment at each interval, where the Penetration Rate is the estimated percentage of GHIP total medical spending that will be paid to providers under the proposed arrangements. Use the chart provided to structure your response.

Please also provide details concerning the financial risk sharing arrangements of any existing or proposed value-based payment arrangements meant to support your performance relative to this criteria, including but not limited to:

a. definition of member attribution criteria, if applicable;

b. categories of medical or other spending included in measures of spending;

c. definition of benchmark trend or cost against which savings are calculated (whether a prospectively defined benchmark, an external benchmark, or a formula based on historical trend for the GHIP population);

d. percentage upside shared savings and/or downside risk for which providers are eligible;

e. any minimum savings rate (MSR) or minimum loss rate that must be achieved to trigger shared savings or losses;

f. any cap on savings or losses shared by providers under such arrangements; and

g. any risk adjustors, risk corridors, share risk insurance for high cost claimants (stop loss and/or provider excess).</td><td>
<table>
<tr><th rowspan="2">Percent of Medical Spending</th><th colspan="3">Effective Date</th></tr>
<tr><th>7/1/17</th><th>7/1/18</th><th>7/1/19</th></tr>
<tr><td>Existing downside risk arrangements</td><td></td><td></td><td></td></tr>
<tr><td>Commitment to downside risk</td><td></td><td></td><td></td></tr>
<tr><td>Existing upside shared savings arrangements</td><td></td><td></td><td></td></tr>
<tr><td>Commitment to upside shared savings</td><td></td><td></td><td></td></tr>
<tr><td>Estimated total penetration</td><td></td><td></td><td></td></tr>
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#	Question	Response
3.5	Section I.E.1 outlines specific cost containment strategies that promise to deliver savings to the SEBC and GHIP members, e.g., performance guarantees that include downside risk, provider acceptance of downside risk arrangements, etc. Please describe which of these strategies are included within your proposal, and provide an estimate of the financial savings (expressed as percent reduction in total allowable claims costs for members selecting your TPA for plan options for which such strategies apply), including the build-up of your savings estimate, e.g., plan options affected, percent of members affected, percent of spend affected for those members affected, savings as percent of addressed spend, etc. Please confirm your willingness to support annual evaluation of savings relative to these goals, and negotiation of contractual guarantees relative to savings actually achieved.	
3.6	Please describe contracting models you are pursuing in the specific markets where State of Delaware GHIP participants reside, where provider payments are tied to specific quality, efficiency or financial results. In your response, please include: • How value-based contracting aligns with your overall network strategy • The criteria you use for provider participation • The expected prevalence of such models, e.g., types of providers, percentage of total reimbursement impacted • The general timeline for the introduction of value-based contracting models in Delaware by July 1, 2019.	

#	Question	Response
3.7	The SEBC will consider more favorably TPA proposals that include cost containment strategies that promise to deliver savings to the SEBC and GHIP members, which may be prospectively forecasted by bidders, subject to actuarial review by the SEBC's benefits consultants, and which may be evaluated for performance on an annual basis. Following are examples of such strategies. a. Performance guarantees from TPAs that include downside risk for increases in total cost of care above historical trends b. Provider acceptance of downside risk arrangements that promise reductions in total cost of care or reduced rate of increase in total cost of care c. Introduction of a narrow network for primary care, specialty care, hospital care, or care in one or more geographic regions, with projected reductions in total cost of care d. Introduction of a high-performance network for primary care, specialty care, hospital care, or other care in one or more geographic regions, with reduced out-of-pocket cost sharing at the point of care to for members who seek care from providers within the high-performance network Please describe which of these strategies are included within your proposal, and provide an estimate of the financial savings (expressed as percent reduction in total allowable claims costs for members selecting your TPA for plan options for which such strategies apply), including the build-up of your savings estimate, e.g., plan options affected, percent of members affected, percent of spend affected for those members affected, savings as percent of addressed spend, etc. Please confirm your willingness to support annual evaluation of savings relative to these goals, and negotiation of contractual guarantees relative to savings actually achieved.	

#	Question	Response
3.8	What percentage of revenue is under value-based contracts currently? What is your target by 2018? Provide responses for your national book of business, and the specific to the markets pertinent to the State of Delaware GHIP.	
3.9	What percentage of commercial membership is under value-based contracts currently? What is your target by 2018? Provide responses for your national book of business, and the specific to the markets pertinent to the State of Delaware GHIP.	
3.10	What percentage of provider and net revenue are covered under value-based contracts (with payment terms as follows)? Provide responses for your national book of business, and the specific to the markets pertinent to the State of Delaware GHIP.	
	Discount from charges	
	Discount FFS with P4P or other incentives	
	Shared risk / shared savings	
	Downside risk	
	Quality bonuses	
	Partial capitation	
	Global capitation	
	Episode of care / bundled payments	
	Other, describe:	
3.11	Percent of providers and percent of net revenue with value-based performance incentives as follows by contract type. Provide responses for your national book of business, and the specific to the markets pertinent to the State of Delaware GHIP.	
	Health system level (primary care, specialty care, facility (IP/OP), ancillary)	
	Facility only (IP/OP)	
	Primary care	
	Primary care & specialty care	
	Specialty care	
	Other (please describe)	

#	Question	Response
3.12	Please describe how your value-based contracting strategy will impact plan costs for self-insured clients. Please answer separately for both the initiatives you currently have in place, as well as those expected in future years.	
3.13	Please list the specific metrics that are and/or will be used to evaluate provider cost and/or quality performance in value-based contracts.	
3.14	Please describe other physician extender capabilities you currently offer or are pursuing. Please include how these capabilities are integrated with your overall network strategy, are linked to ACO, APC or other initiatives, and the potential benefit to employers and plan participants.	
3.15	Please describe how your bundled payment approaches align with your network strategy.	
3.16	Please provide a list of conditions to which your bundled payment arrangements apply.	
3.17	Please describe your bundled payment arrangement for your top three conditions. For example, how do your bundled payment levels vary by severity of the specific conditions? How are bundled payment arrangements communicated to the patients before procedures, and how do you manage patients' expectations should the severity levels change during the course of treatment?	
3.18	Please describe how you are supporting providers as they assume risk. Please include the greatest challenges you see for providers. Explain how your role as a health plan might differ for a large and sophisticated provider practice. Please describe how you inform providers about their on-going financial and clinical performance.	

#	Question	Response
3.19	How are new provider reimbursement arrangements (e.g., quality bonus payments, additional capitation to cover care coordination) to support these delivery models fully disclosed to affected self-funded clients? Will you disclose market-specific impacts? At what time will disclosures be provided, relative to implementation?	
3.20	Will you allow self-funded employers to opt-out of some or all these arrangements?	*(Pick one of the following)* ☐ Yes. If yes, what criteria will be used to allow opt-out, and will the criteria vary by location? Will membership size (for a specific employer) impact their ability to opt out? ☐ No
3.21	Please describe how new reimbursement models will impact any performance guarantees for financial outcomes (claim targets, discounts, trend mitigation), clinical/quality outcomes, and program engagement.	
3.22	What internal models are used to assess financial impact and outcomes, for both estimated prospective savings and for retrospective program evaluation?	*Please indicate the following in your response:* a. If you have conducted internal or external reviews for program evaluation to estimate savings or ROI b. What is measured to assess financial impact c. What is measured to assess clinical and quality outcomes d. What your efficiency and quality metrics of success are for these emerging models
3.23	How you do you administer account-based plan designs (HRA or HSA) when these delivery models are in place?	
3.24	How do carve-outs (e.g., pharmacy) impact the delivery models efficacy and feasibility? Are there specific restrictions?	
3.25	Will employers be allowed to customize deployment of these models on a market-by-market basis?	
3.26	Does your Master Services Agreement include language that outlines the employer's rights or obligations related to these specific models?	

#	Question	Response
3.27	Please describe the type and frequency of reporting on these emerging health care delivery models that will be available, including employer-specific reporting, and whether reporting will be provided on a market-specific basis. Is there a threshold (number of attributed members) above which this reporting is standardly available?	
3.28	Please offer your ideas on how you propose to work with providers in Delaware to provide assistance with:	
	Practice transformation support	
	Care coordination funding (fee types and whether the fees are at risk based on performance guarantees)	

#	Question	Response
	Outcomes-based payments that for both primary care and specialist care, for example: • Shift emergency room care to PCPs and urgent care • Where possible, shift facility-based care to non-facility-based care and services • More integration of professional and facility electronic medical record systems (e.g., real time information on emergency room visits, admissions, labs, X-rays and facility discharge data) • Moving from process to outcomes metrics (preferably those approved by the National Quality Forum) over time (e.g., diabetes HbA1C done to <10% of diabetic population with HbA1C >9%, or ratio of depressed members on antidepressants to percent of members with depression remissions at 6 and 12 months) • Reduction of high cost claimants (target <1% of members and <30% of total costs) contained in the Delaware Blue Print for Change[17] • Increase use of lower cost mid-level providers with associated increases in PCP access (Advanced Registered Nurse Practitioner, Physician's Assistant, Midwives)	

4.0 Accountable Care Organizations (ACOs)

An **ACO** is defined as an organized delivery system comprised of facility and professional providers for an attributed/selected population. Accountability for overall performance, cost and quality reside with the provider and the delivery system, including shared risk. Population health management is provided across all levels of care. The ACO is responsible for all of the health care and related expenditures for a defined population of patients.

[17] For more information, see http://www.dehealthinnovation.org/Content/Documents/DCHI/DCHI-Practice-Transformation-FAQs.pdf.

#	Question	Response
4.1	Please describe your ACO strategy. Please include the product lines you expect to make ACOs available to (i.e., self-funded employer sponsored plans and commercial), how ACOs align with your network strategy in general, and the implications for delivery of health management services by the ACO and/or your health plan.	
4.2	Do you have an ACO offering in the State of Delaware's pertinent markets that will be available to commercial, self-insured clients on July 1, 2017?	*(Pick one of the following)* ☐ There is no offering for commercial, self-insured clients ☐ Yes. Please complete the questions below
4.3	How many ACOs are currently offered across these markets?	*(Pick one of the following)* ☐ 1 ☐ 2 ☐ 3 or more
4.4	Are you willing to support direct contracts for employer based ACO products?	*(Pick one of the following)* ☐ No ☐ Yes, if administered by the health plan ☐ Perhaps, for the right condition
4.5	Describe your approach to ACO contracting. Do you focus on integrated systems or large physician groups? Do you include all physicians in the system, or do you narrow it based on high performing providers?	
4.6	Please complete the following:	*(Membership should be as of January 1, 2016)*
	ACO name	
	ACO location / market	
	Number of members	
	Network structure and steerage	*(Pick one of the following)* ☐ Closed 2 tier network (narrow network providers and OON) ☐ 3 tier network, with benefit steerage to narrow network providers required ☐ 3 tier network, with benefit steerage to narrow network providers optional ☐ In-network only
	Additional product fee required (Y/N)	
	Gate-keeper required (Y/N)	
	Percent of providers in the broad-based PPO in this market that are also in the ACO	

#	Question	Response
	% of PCPs	
	% of SPCs	
	% of Hospitals	
	Please express your response as a range: __% to __%	
	Average medical cost savings compared to your broad-access PPO network in this market based on allowed claim cost only and not plan design cost shift.	
	Physician participation based on:	*(Pick one of the following)* ☐ Cost only ☐ Quality only ☐ Both cost and quality ☐ N/A
	Hospital participation based on:	*(Pick one of the following)* ☐ Cost only ☐ Quality only ☐ Both cost and quality ☐ N/A
	Major hospital/health systems considered in-network (tier 1) of the ACO product (list up to 5)	
	1	
	2	
	3	
	4	
	5	
	Major hospital/health systems considered out-of-network (tier 2 or 3) of the ACO product (list up to 5)	
	1	
	2	
	3	
	4	
	5	
	How are tier 2 hospitals (considered in-network in the PPO, but not tier 1 narrow network providers) reimbursed under the narrow network arrangement?	*(Pick one of the following)* ☐ N/A, hospitals are not included in the narrow network ☐ PPO contract ☐ OON wrap discount ☐ Medicare fee schedule, specify % ☐ R&C, specify % ☐ Other, describe

#	Question	Response
	Describe reimbursement for hospital based Emergency Medicine, Radiology, Anesthesiology and Pathology (ERAP) providers within your narrow network offering	
	Major physician groups considered in-network of the ACO product offering (list up to 5)	
	1	
	2	
	3	
	4	
	5	
	Major physician groups considered out-of-network (tiers 2 or 3, or not covered) of the ACO product offering (list up to 5)	
	1	
	2	
	3	
	4	
	5	
	How are tier 2 physicians (considered in-network in the PPO, but not tier 1 narrow network providers) reimbursed under the ACO arrangement?	
	Describe reimbursement for physician based ERAP providers within your ACO offering.	
	Outline the benefit differential requirements associated with this ACO offering.	
	Does the arrangement include better access to care?	*(Check all that apply)* ☐ No ☐ Same day PCP ☐ Next day PCP ☐ Accelerated specialist access ☐ Urgent care referrals ☐ 24/7 telephonic care assistance ☐ Other, describe

#	Question	Response
	Does the arrangement track call center activity?	*(Check all that apply)* ☐ No ☐ Call wait ☐ Call abandonment ☐ First call resolution of question ☐ Care manager calls ☐ Urgent/non-urgent calls ☐ Warm transfers
	Does the arrangement assign a member to a provider?	*(Check all that apply)* ☐ No ☐ PCP ☐ Care team ☐ Clinic ☐ Care manager
	Does the arrangement measure clinical quality process?	*(Check all that apply)* ☐ No ☐ Diabetes (e.g., % of DM with a HbA1C) ☐ Lipids (e.g., % of high risk on a statin ☐ Hypertension (e.g., % of high risk on a medication) ☐ Depression (% of members on a medication) ☐ BMI (screened for BMI) ☐ Cervical cancer screening ☐ Colon cancer screening ☐ Breast Cancer Screening ☐ Prostate cancer screening ☐ Others (please add other metrics to the next question)
	Does the arrangement measure clinical quality outcomes?	*(Check all that apply)* ☐ No ☐ Diabetes (e.g., % with HbA1C levels >9mg) ☐ Lipids (e.g., % with good medication adherence) ☐ Hypertension (e.g., % of high risk with good BP control) ☐ Depression (% in remission at 6 months) ☐ BMI (% with a BMI over 30 referred for care) ☐ Others (please add others metrics to the next question)

#	Question	Response
	Does the arrangement measure customer service?	*(Check all that apply)* ☐ No ☐ Getting care quickly ☐ Getting care needed ☐ Communication of staff ☐ Communication of provider ☐ Rate my provider 9/10 ☐ NCQA other ☐ Press Ganey other ☐ Others (please add others metrics to the next question)
	Does the arrangement have systems that integrate data management?	*(Check all that apply)* ☐ No ☐ Hospital admissions shared (within 24 hours of admission) ☐ Hospital discharge notification (within 24 hours of discharge) ☐ Discharge summary available to the PCP within 48 hours ☐ PCP appointments made before discharge ☐ Emergency department use (ED use notification) ☐ PBM pharmacy data (prescriber specific prescribing) ☐ Wellness vendors (biometrics, second opinions, etc.) ☐ Laboratory results ☐ Radiology results
	Does the arrangement attribute care to a provider?	*(Check all that apply)* ☐ No ☐ PCP (MD, ARNP, PA) by percent of visits ☐ PCP (MD, ARNP, PA) by cost of care ☐ Specialist ☐ Other (describe)
4.7	Please describe how you will use patient attribution models to measure results, i.e., how the attribution methodology works, how quality and efficiency outcomes will be attributed to providers, and if risk-adjusted measurement will be used.	
4.8	Can your ACO accommodate an attribution model that holds primary care, specialists and hospitals accountable for outcomes?	*(Pick one of the following)* ☐ Yes, please describe ☐ No

#	Question	Response
4.9	Does your ACO accommodate an attribution model that holds only the primary care providers accountable for outcomes?	*(Pick one of the following)* ☐ Yes, please describe ☐ No
4.10	Does your ACO have attribution terms and or conditions to engage members beyond an ACO attribution model?	*(Pick one of the following)* ☐ Yes, please describe ☐ No
4.11	Can your ACO accommodate a contract with interim and final attribution reports?	*(Pick one of the following)* ☐ Yes, please describe ☐ No
4.12	Do your Medical Home/Intensive Outpatient Care Program (IOCP)/Office based Care/Case management have attribution models for assigned care and accountability?	*(Pick one of the following)* ☐ Yes, please describe ☐ No
4.13	Indicate the typical type of provider attributed for Primary Care.	*(Pick one of the following)* ☐ General practice ☐ Family practice ☐ Internal medicine ☐ Obstetrics/Gynecology ☐ Pediatric medicine ☐ Geriatric medicine ☐ Nurse practitioner ☐ Preventive medicine ☐ Certified clinical nurse specialist ☐ Physician assistant ☐ Nurse, non-practitioner ☐ Other, describe:
4.14	Indicate the typical type of provider attributed for Specialist Care.	*(Pick one of the following)* ☐ Oncology ☐ Cardiology ☐ Pulmonary medicine ☐ Endocrinology ☐ Rheumatology ☐ Naturopathic medicine ☐ Neurology ☐ Other, describe:

#	Question	Response
4.15	Indicate wrap-around providers are typically needed in your ACO(s).	*(Check all that apply)* ☐ PT/OT ☐ Audiologist ☐ Chiropractor ☐ DME provider ☐ Rheumatology ☐ Alternative and complimentary ☐ Substance abuse ☐ Psychology ☐ Psychiatry ☐ Other, describe:
4.16	How does your organization proactively monitor patients — within and outside your organization or facilities — to ensure primary care, preventive services, and screenings are appropriate, evidence-based, and delivered in ways that are culturally appropriate for the patient?	
4.17	How do you identify barriers patients are facing in obtaining those services, and how does your organization overcome those barriers?	
4.18	How is primary care used to manage and meet the needs of patients (including social needs) with chronic and complex care needs and conditions?	
4.19	What specific tools, systems, and approaches have you found effective and/or ineffective to help reach and provide primary care/preventive care/screening/ chronic disease management for hard to reach populations?	
4.20	What types of non-traditional or community-based care delivery approaches does your organization use to provide effective and efficient care? (e.g., telehealth, group visits, peer counseling, community health workers/navigators, email)	
4.21	How does your ACO integrate with an onsite health center? How will onsite/near-site health center encounter data be received by physicians in the ACO?	
4.22	How do you integrate a client's telehealth services with your ACO, APC and other care delivery models?	

#	Question	Response		
4.23	Please describe your ability to support benefit design steerage and tiered benefit structures, and indicate your best practice recommendations related to plan design steerage for ACOs.			
4.24	Please provide an example of a successful ACO implementation. What have you learned and how have you modified your implementation process over time?			
4.25	How does your organization measure and assess the impact and effectiveness of patient engagement activities? (e.g., improved use of preventive services, reduction in unnecessary treatments or services, patient activation levels and self-management)			
4.26	Does your organization have a website for consumers/members that includes (but is not limited to) a cost calculator, cost information linked to members' benefit design; medical costs searchable by procedures, drugs, and episodes of care, cost comparisons for alternative treatments linked to shared decision making tools, and cost comparisons for physicians, hospitals, ambulatory surgery centers and diagnostic centers linked to quality data?			
4.27	Does your ACO have member services goals? (e.g., call center stats)	*(Check all that apply)* ☐ Call wait times ☐ Call adornment ☐ Resolution on first call ☐ Other, describe		
4.28	Does your ACO monitor nationally recognized member services?	*(Check all that apply)* ☐ CAHPS ☐ Press Ganey ☐ Other		
4.29	Does your ACO have access criteria that you use for ACO provider adequacy? If yes, please fill in the appropriate cell in the table below.			
	General Medical	**Urban**	**Suburban**	**Rural**
	PCPs and acute care hospitals (compound)			
	PCPs			

#	Question	Response		
	OB/GYNs			
	Pediatricians			
	All other specialists			
	Acute care hospitals			
	Behavioral Health	**Urban**	**Suburban**	**Rural**
	Masters level practitioners			
	MDs			
	Psychiatric hospitals			
	Detox/Chemical dependency facilities			
4.30	What is your ACO's capacity and experience with leveraging claims and clinical data for measure collection and reporting?	*(Check all that apply)* ☐ Health status ☐ Clinical outcomes ☐ Functional status/productivity ☐ Appropriateness ☐ Patient/caregiver experience ☐ Preventive health ☐ Care coordination/patient safety/care transitions ☐ At risk populations ☐ Cost ☐ Utilization and resource use ☐ Provider feedback (e.g., peer to peer comparisons) ☐ Other		
4.31	Does your ACO employ utilization benchmarking? (e.g., if your organization sets targets and how)	*(Pick one of the following)* ☐ Yes, describe ☐ No		
4.32	Does your ACO use a specific data systems reporting platform?	*(Pick one of the following)* ☐ Cerner ☐ Epic ☐ MyChart ☐ Other		

#	Question	Response
4.33	Does your ACO/Medical Home/IOCP/Office based Care/Case management provide real time EMR access clinical data?	*(Check all that apply)* ☐ Lab ☐ Radiology ☐ Pharmacy ☐ Inpatient care ☐ Outpatient care ☐ DME ☐ Integrated problem list ☐ Red flag reporting for Lab, Rx, other ☐ Other
4.34	Does your ACO/Medical Home/IOCP/Office based Care/Case management provide an EMR that functions as a portal for the member?	*(Pick one of the following)* ☐ Yes, describe ☐ No
4.35	Does your ACO Medical Home/IOCP/Office based Care/Case management ensure participation in a patient registry (e.g., the CMS PQRS program)?	*(Check all that apply)* ☐ Diabetes ☐ Hypertension ☐ Lipids ☐ Cancer ☐ Orthopedics (total joint, back surgery) ☐ Cardiac surgery and PCI ☐ Inflammatory disorders (RA) ☐ Multiple sclerosis ☐ Other
4.36	Does your ACO have real time data sharing agreements for the following?	*(Check all that apply)* ☐ Real time hospitalizations and discharges reporting ☐ Real time ED use (EDIE) reporting ☐ Case management ☐ Lab ☐ Radiology ☐ Other
4.37	Does your ACO have a governance structure and processes for data sharing that is clearly stated and balances (clinical fiscal) terms, conditions and processes for decision making and data review?	*(Pick one of the following)* ☐ Yes ☐ No

#	Question	Response
4.38	Does your ACO support reporting of encounter data and diagnostic information into the EMR that feeds into management reports that include the following?	*(Check all that apply)* ☐ Claims extract (medical and MH) ☐ Claims extract (Rx) ☐ Enrollment file ☐ Inpatient admission file ☐ High cost claimant ☐ High cost drugs ☐ DUR and generic fill rates by provider ☐ Definitive attribution reports ☐ Interim attribution reports ☐ Designated ACO member list ☐ Utilization report ☐ Wellness (biometric and HRA) ☐ Inpatient admission discharge (real time) ☐ Please provide a copy of a management report ☐ Other
4.39	How does your organization use clinical, experience, and other patient data (e.g., from Electronic Health Record (EHR), chronic disease registry, etc.) at the point of care for individual patients and population health management?	
4.40	How does your ACO use data to continually improve quality and patient care over time? (e.g., never events, adverse events, malpractice claims)	
4.41	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)?	
4.42	Based on your aggregated ACO experience, please fill out requested information in the Appendices M, N and O: *CMS-Approved ACO Metrics*, *Updated CMS-Approved ACO Metrics*, and *ACO Domestic Medical Care*.	

#	Question	Response
4.43	Does your ACO link the pharmacy and EMR systems to provide feedback to prescribers for retail and specialty drugs in the inpatient and outpatient settings?	*(Check all that apply)* ☐ Costs and utilizations ☐ Generic prescribing ☐ Aggregated DUR edits ☐ Formulary compliance ☐ Other
4.44	Does your ACO have requirements for pharmacies to be accredited (retail, mail and specialty)?	*(Pick one of the following)* ☐ Yes, describe ☐ No
4.45	Does your ACO allow for data sharing with the payer PBM?	*(Pick one of the following)* ☐ Yes, fully integrated Rx and medical data ☐ Yes, partially integrated Rx and medical data ☐ No
4.46	Does your ACO support Sure Script transactions from the inpatient and outpatient settings for retail and specialty drugs?	*(Pick one of the following)* ☐ Yes, describe ☐ No
4.47	Does your ACO have processes for pharmacists, working with the Rx and EMR systems, conduct medication reviews for high risk members?	*(Check all that apply)* ☐ High dose opiates, >10-15 drug/year ☐ >5-10 prescriber/year ☐ Poor adherence in the inpatient and outpatient settings (MDA <80%) ☐ High cost retail and specialty drugs ☐ Other
4.48	Does your ACO offer prescriber Rx feedback?	*(Check all that apply)* ☐ Generic fill rates ☐ Specialty drugs (use and costs) ☐ Medication adherence/alerts ☐ DUR edits ☐ Other
4.49	Does your ACO offer access to 340B pricing for members and the State?	*(Check all that apply)* ☐ Retail ☐ Specialty drugs ☐ Mail ☐ Other, describe

5.0 Network Financial Information

This section applies to ACOs only. If your proposal does not include an ACO, please move on to the next section.

#	Question	Response
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?	
5.2	Does your ACO offer risk?	*(Check all that apply)* ☐ Full capitation ☐ Trend guaranties ☐ PMPM goals ☐ Other
5.3	Does your ACO contracts require the PMPM risk/gain sharing to be reset?	*(Check all that apply)* ☐ At a certain year of the ACO ☐ If there is a change in benefits ☐ If there is an unforeseen issue (HINI Flu season) ☐ At a particular % of total expenditure ☐ Other
5.4	Does your ACO require a particular risk adjustor for risk and gain sharing arrangements?	*(Check all that apply)* ☐ Age/gender ☐ Chronic conditions (e.g., DXCG) ☐ Other
5.5	Does your ACO currently include gain sharing?	*(Check all that apply)* ☐ Yes, gain sharing requires a fiscal target to be met ☐ Yes, gain sharing requires a fiscal target to be exceeded before gain sharing ☐ Gain sharing is separate from risk sharing ☐ If yes, what have been the outcomes and is the typical percentage of gain sharing?
5.6	Does your ACO have any excluded services that require wrap-around programs prior to implementation? (e.g., transplants, pediatric surgery, etc.)	*(Pick one of the following)* ☐ Yes, describe ☐ No
5.7	Will your ACO accept terms and conditions for monitoring COE outcomes (services, morbidity mortality)?	*(Pick one of the following)* ☐ Yes, describe ☐ No

#	Question	Response
5.8	Does your ACO have systems to monitor for plan demographic and population health changes?	*(Pick one of the following)* ☐ Yes, describe ☐ No
5.9	Does your ACO have processes to engage hospitals, providers and affiliates in defined goals?	*(Pick one of the following)* ☐ Yes, describe ☐ No
5.10	Does your ACO governance structure allow for fiscal, quality and provider service audits?	*(Pick one of the following)* ☐ Yes, describe ☐ No
5.11	Does the ACO have clear member service transformation goals?	*(Pick one of the following)* ☐ Getting care quickly ☐ Getting needed care ☐ Good communication by staff and providers ☐ Better member ratings of providers ☐ Other
5.12	Does the ACO have provisions to address member return to work and lower disability rate for an employer/payer?	*(Pick one of the following)* ☐ Yes, describe ☐ No
5.13	Does the ACO have a contractual requirement to reduce the risk for high cost claims?	*(Pick one of the following)* ☐ Self-insure required ☐ Employer reinsurance or stop loss ☐ ACO reinsurance, stop loss or provider excess ☐ Risk corridors ☐ Other
5.14	Does your ACO have processes to address access, capacity, and out of network services?	*(Pick one of the following)* ☐ Yes, describe ☐ No
5.15	Does the ACO address differential population needs and wants (e.g., market segmentation to attract and retain selected membership)?	*(Pick one of the following)* ☐ Yes, describe ☐ No
5.16	Does the ACO have requirements to report real-time hospitalization and discharge reporting for both in network and out of network facilities?	*(Pick one of the following)* ☐ Yes, describe ☐ No
5.17	Does the ACO have processes for additions and deletions of network providers and or delegations or payers?	*(Pick one of the following)* ☐ Yes, describe ☐ No

6.0 Advanced Primary Care (APCs)

#	Question	Response
6.1	Please describe your APC strategy. Please include the product lines you expect to make APC available to (self-funded employer sponsored plans, commercial), how it aligns with your network strategy in general, and the implications for delivery of health management services by the APC and/or your health plan.	
6.2	Please provide the criteria you use to evaluate providers for their participation in your APC.	
6.3	For your APC, are Primary Care Physicians (PCPs) required to be "gatekeepers?"	
6.4	Do you have a mechanism in place to designate onsite/near-site health centers as APC centers?	
6.5	How do your APC centers integrate with onsite/near-site health centers? How will encounter data be received by physicians in the APC center?	
6.6	Describe any APC arrangements you have in markets pertinent to the State of Delaware GHIP, including composition of the APC, estimated financial impacts and summary of outcomes to date.	

7.0 Centers of Excellence

#	Question	Response
7.1	Do you have or are you developing Centers of Excellence (COEs) for the following conditions?	
	Cancer treatment	*(Pick one of the following)* ☐ In place ☐ Being developed ☐ No plans to develop
	Cardiac surgical procedures	*(Pick one of the following)* ☐ In place ☐ Being developed ☐ No plans to develop

#	Question	Response
	Spinal surgery	*(Pick one of the following)* ☐ In place ☐ Being developed ☐ No plans to develop
	Transplants	*(Pick one of the following)* ☐ In place ☐ Being developed ☐ No plans to develop
	Bariatric surgery	*(Pick one of the following)* ☐ In place ☐ Being developed ☐ No plans to develop
	Infertility	*(Pick one of the following)* ☐ In place ☐ Being developed ☐ No plans to develop
	Joint replacement	*(Pick one of the following)* ☐ In place ☐ Being developed ☐ No plans to develop
	Other, describe:	*(Pick one of the following)* ☐ In place ☐ Being developed ☐ No plans to develop
7.2	Do you use bundled contracting for COEs? If so, do your COE bundles include warranties? (e.g., preventable 30-day readmissions, ED care, death)	
7.3	Do you support plan design steerage to COEs? If so, what percentage of your book of business steers employees? (answer separately for transplants and all other categories)	

#	Question	Response
7.4	Do you have the capability to administer a travel benefit as a mechanism for promoting steerage to COEs? If so, please describe your capabilities and any limitations associated with this benefit. In your response, please describe how your other customers have structured this benefit for their employees (i.e., travel benefit provisions such as inclusion of food and lodging as travel costs, maximum amount of travel costs reimbursed, eligibility for companion travel costs to be covered under this benefit, etc.).	
7.5	Provide a listing of the COEs available in the pertinent State of Delaware markets.	

8.0 High Performance Networks

A **high performance network** is defined as subset of the broad provider panel (e.g., certain specialty physicians) identified through the evaluation of cost and quality metrics, may or may not include separate contract arrangements.

#	Question	Response
8.1	Do you provide a high-performance network in the State of Delaware's pertinent markets on July 1, 2017?	*(Pick one of the following)* ☐ No, there is no offering for commercial, self-insured clients ☐ Yes, complete the following questions
8.2	If you are not offering a high-performance network in the State of Delaware's pertinent markets on July 1, 2017, do you have a future anticipated date?	
8.3	Is plan design tiering available to steer members to high-performing providers? (e.g., lower copay or greater coinsurance coverage for utilizing a provider with a high-performing designation)	*(Pick one of the following)* ☐ Yes, describe: ☐ No, describe:
8.4	Please complete the following:	*(Membership should be as of January 1, 2016)*
	HPN network name	
	HPN location / market	

#	Question	Response
	Number of members	
	Network structure and steerage	*(Pick one of the following)* ☐ Closed 2 tier network (HPN providers and OON) ☐ 3 tier network, with benefit steerage to HPN providers required ☐ 3 tier network, with benefit steerage to HPN providers optional ☐ In-network only
	Additional product fee required (Y/N)	
	Physician types included with HPN designations	*(Check all that apply)* ☐ Allergy/immunology ☐ Cardiology ☐ Cardiothoracic surgery ☐ Dermatology ☐ Endocrinology ☐ ENT (otolaryngology) ☐ Gastroenterology ☐ Family/internal medicine ☐ General surgery ☐ Infectious disease ☐ Nephrology ☐ Neurology ☐ Neurosurgery ☐ Obstetrics/gynecology ☐ Ophthalmology ☐ Orthopedics ☐ Pediatrics ☐ Plastic surgery ☐ Pulmonary medicine ☐ Rheumatology ☐ Urology ☐ Vascular surgery ☐ Other, describe
	Other physician types within the HPN (describe)	
	Percent of providers in the broad-based PPO in this market that are also in the HPN:	
	% of PCPs	
	% of Specialists	
	% of Hospitals	
	Average HPN medical cost savings compared to your broad-access PPO network in this market – overall and by provider type – based on allowed claim cost only and not plan design shift:	

#	Question	Response
	Savings for PCPs	
	Savings for Specialists	
	Savings for Hospitals	
	Savings overall	
	Physician participation based on:	*(Pick one of the following)* ☐ Cost only ☐ Quality only ☐ Both cost and quality ☐ N/A, explain:
	Hospital participation based on:	*(Pick one of the following)* ☐ Cost only ☐ Quality only ☐ Both cost and quality ☐ N/A, explain:
	Major hospital/health systems considered "Tier 1 / in-network" in this HPN (list up to 5):	
	1	
	2	
	3	
	4	
	5	
	Major hospital/health systems considered "Tier 2 or out-of-network" in this HPN (list up to 5):	
	1	
	2	
	3	
	4	
	5	
	How are tier 2 hospitals (considered in-network in the PPO, but not tier 1 narrow network providers) reimbursed under the narrow network arrangement?	*(Pick one of the following)* ☐ N/A, hospitals are not included in the narrow network ☐ PPO contract ☐ OON wrap discount ☐ Medicare fee schedule, specify % ☐ R&C, specify % ☐ Other, describe:
	Describe reimbursement for hospital based ERAP providers within your narrow network offering.	
	Major physician groups considered "Tier 1 / in-network" in this HPN (list up to 5):	

#	Question	Response
	1	
	2	
	3	
	4	
	5	
	Major physician groups considered "Tier 2 or out-of-network" in this HPN (list up to 5):	
	1	
	2	
	3	
	4	
	5	
	How are tier 2 physicians (considered in-network in the PPO, but not tier 1 narrow network providers) reimbursed under the narrow network arrangement?	*(Pick one of the following)* ☐ PPO contract ☐ OON wrap discount ☐ Medicare fee schedule, specify % ☐ R&C, specify % ☐ Other, describe:
	Outline the benefit differential requirements associated with this network	
	Does the arrangement include better access to care?	*(Check all that apply)* ☐ No ☐ Same day PCP ☐ Next day PCP ☐ Accelerated specialist access ☐ Urgent care referrals ☐ 24/7 telephonic care assistance
	Does the arrangement track call center activity?	*(Check all that apply)* ☐ No ☐ Call wait ☐ Call abandonment ☐ First call resolution of question ☐ Care manager calls ☐ Urgent/non-urgent calls ☐ Warm transfers
	Does the arrangement assign a member to a provider?	*(Check all that apply)* ☐ No ☐ PCP ☐ Care team ☐ Clinic ☐ Care manager

#	Question	Response
	Does the arrangement measure clinical quality process?	*(Check all that apply)* ☐ No ☐ Diabetes (e.g., % of DM with HbA1C) ☐ Lipids (e.g., % of high risk on a statin) ☐ Hypertension (e.g., % of high risk on a medication) ☐ Depression (% of members on a medication) ☐ BMI (screened for BMI) ☐ Cervical cancer screening ☐ Colon cancer screening ☐ Breast cancer screening ☐ Prostate cancer screening ☐ Other, describe:
	Does the arrangement measure clinical quality outcomes?	*(Check all that apply)* ☐ No ☐ Diabetes (e.g., % with HbA1C levels >9mg) ☐ Lipids (e.g., % with good medication adherence) ☐ Hypertension (e.g., % of high risk with good BP control) ☐ Depression (% in remission at 6 months) ☐ BMI (% with a BMI over 30 referred for care) ☐ Other, describe:
	Does the arrangement measure customer service?	*(Check all that apply)* ☐ No ☐ Getting care quickly ☐ Getting care needed ☐ Communication of staff ☐ Communication of provider ☐ Rate my provider 9/10 ☐ NCQA other ☐ Press Ganey other ☐ Other, describe:
	Does the arrangement have systems that integrate data management?	*(Check all that apply)* ☐ No ☐ Hospital admissions shared (within 24 hours of admission) ☐ Hospital discharge notification (within 24 hours of discharge) ☐ Discharge summary available to the PCP within 48 hours ☐ PCP appointments made before discharge

#	Question	Response
		☐ Emergency department use (ED use notification) ☐ PBM pharmacy data (prescriber specific prescribing) ☐ Wellness vendors (biometrics, second opinions, etc.) ☐ Laboratory results ☐ Radiology results
	Does the arrangement attribute care to a provider?	*(Check all that apply)* ☐ No ☐ PCP (MD, ARNP, PA) by percent of visits ☐ PCP (MD, ARNP, PA) by cost of care ☐ Specialist ☐ Other, describe:
8.5	How many patients or cases does a physician need to have in order to be included in your high performance network (HPN)?	
8.6	What was the turnover within your HPN over the last three years?	
	2015	
	2014	
	2013	
8.7	How do you handle continuation of care of members whose HPN provider does not remain in the HPN?	*(Pick one of the following)* ☐ Higher level of benefits are continued ☐ Higher level of benefits are not continued ☐ Other, describe:

D. Health Management

1.0 Health Management Program Administration

#	Question	Response
1.1	Please complete the following information for your health management model(s):	
	Health Coaching (if offered)	

#	Question	Response
	Staffing model	*(Pick one of the following)* ☐ Primary Nurse ☐ Call Center
	Integrated into a single-team	*(Pick one of the following)* ☐ Designated team ☐ Dedicated team
	Hours of operation, AM	
	Hours of operation, PM	
	Time zone	*(Pick one of the following)* ☐ EST ☐ CST ☐ MST ☐ PST
	Day of the week	*(Pick one of the following)* ☐ Sunday-Saturday (7 days) ☐ Monday-Saturday (6 days) ☐ Monday-Friday (5 days) ☐ Other
	After hours coverage	*(Pick one of the following)* ☐ Nurseline ☐ Other
	Staff Ratio: Staff to Members	*(Pick one of the following)* ☐ 1: 6,000 ☐ 1: 6,000-10,000 ☐ 1: 10,000 – 30,000 ☐ 1: 30,000+ ☐ Not offered
	Case Ratio: Case Manager to Cases	
	System integration with Member Services platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with clinical (UM, DM, CM, and Wellness) platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with claims processing platform	*(Pick one of the following)* ☐ Yes ☐ No

#	Question	Response
	System integrated with behavioral health platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with pharmacy benefit management platform	*(Pick one of the following)* ☐ Yes ☐ No
	Utilization Management Pre-certification/ Pre-notification	
	Staffing model	*(Pick one of the following)* ☐ Primary Nurse ☐ Call Center
	Integrated into a single-team	*(Pick one of the following)* ☐ Designated team ☐ Dedicated team
	Hours of operation, AM	
	Hours of operation, PM	
	Time zone	*(Pick one of the following)* ☐ EST ☐ CST ☐ MST ☐ PST
	Day of the week	*(Pick one of the following)* ☐ Sunday-Saturday (7 days) ☐ Monday-Saturday (6 days) ☐ Monday-Friday (5 days) ☐ Other
	After hours coverage	*(Pick one of the following)* ☐ Nurseline ☐ Other
	Staff Ratio: Staff to Members	*(Pick one of the following)* ☐ 1: 6,000 ☐ 1: 6,000-10,000 ☐ 1: 10,000 – 30,000 ☐ 1: 30,000+ ☐ Not offered
	Case Ratio: Case Manager to Cases	
	System integration with Member Services platform	*(Pick one of the following)* ☐ Yes ☐ No

#	Question	Response
	System integrated with clinical (UM, DM, CM, and Wellness) platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with claims processing platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with behavioral health platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with pharmacy benefit management platform	*(Pick one of the following)* ☐ Yes ☐ No
	Disease Management (if offered)	
	Staffing model	*(Pick one of the following)* ☐ Primary Nurse ☐ Call Center
	Integrated into a single-team	*(Pick one of the following)* ☐ Designated team ☐ Dedicated team
	Hours of operation, AM	
	Hours of operation, PM	
	Time zone	*(Pick one of the following)* ☐ EST ☐ CST ☐ MST ☐ PST
	Day of the week	*(Pick one of the following)* ☐ Sunday-Saturday (7 days) ☐ Monday-Saturday (6 days) ☐ Monday-Friday (5 days) ☐ Other
	After hours coverage	*(Pick one of the following)* ☐ Nurseline ☐ Other
	Staff Ratio: Staff to Members	*(Pick one of the following)* ☐ 1: 6,000 ☐ 1: 6,000-10,000 ☐ 1: 10,000 – 30,000 ☐ 1: 30,000+ ☐ Not offered
	Case Ratio: Case Manager to Cases	

#	Question	Response
	System integration with Member Services platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with clinical (UM, DM, CM, and Wellness) platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with claims processing platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with behavioral health platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with pharmacy benefit management platform	*(Pick one of the following)* ☐ Yes ☐ No
	Basic or Enhanced Case Management	
	Staffing model	*(Pick one of the following)* ☐ Primary Nurse ☐ Call Center
	Integrated into a single-team	*(Pick one of the following)* ☐ Designated team ☐ Dedicated team
	Hours of operation, AM	
	Hours of operation, PM	
	Time zone	*(Pick one of the following)* ☐ EST ☐ CST ☐ MST ☐ PST
	Day of the week	*(Pick one of the following)* ☐ Sunday-Saturday (7 days) ☐ Monday-Saturday (6 days) ☐ Monday-Friday (5 days) ☐ Other
	After hours coverage	*(Pick one of the following)* ☐ Nurseline ☐ Other

#	Question	Response
	Staff Ratio: Staff to Members	*(Pick one of the following)* ☐ 1: 6,000 ☐ 1: 6,000-10,000 ☐ 1: 10,000 – 30,000 ☐ 1: 30,000+ ☐ Not offered
	Case Ratio: Case Manager to Cases	
	System integration with Member Services platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with clinical (UM, DM, CM, and Wellness) platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with claims processing platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with behavioral health platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with pharmacy benefit management platform	*(Pick one of the following)* ☐ Yes ☐ No
	Specialty Case Management – Transplant	
	Staffing model	*(Pick one of the following)* ☐ Primary Nurse ☐ Call Center
	Integrated into a single-team	*(Pick one of the following)* ☐ Designated team ☐ Dedicated team
	Hours of operation, AM	
	Hours of operation, PM	
	Time zone	*(Pick one of the following)* ☐ EST ☐ CST ☐ MST ☐ PST
	Day of the week	*(Pick one of the following)* ☐ Sunday-Saturday (7 days) ☐ Monday-Saturday (6 days) ☐ Monday-Friday (5 days) ☐ Other

#	Question	Response
	After hours coverage	*(Pick one of the following)* ☐ Nurseline ☐ Other
	Staff Ratio: Staff to Members	*(Pick one of the following)* ☐ 1: 6,000 ☐ 1: 6,000-10,000 ☐ 1: 10,000 – 30,000 ☐ 1: 30,000+ ☐ Not offered
	Case Ratio: Case Manager to Cases	
	System integration with Member Services platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with clinical (UM, DM, CM, and Wellness) platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with claims processing platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with behavioral health platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with pharmacy benefit management platform	*(Pick one of the following)* ☐ Yes ☐ No
	Specialty Case Management – Maternity	
	Staffing model	*(Pick one of the following)* ☐ Primary Nurse ☐ Call Center
	Integrated into a single-team	*(Pick one of the following)* ☐ Designated team ☐ Dedicated team
	Hours of operation, AM	
	Hours of operation, PM	
	Time zone	*(Pick one of the following)* ☐ EST ☐ CST ☐ MST ☐ PST

#	Question	Response
	Day of the week	*(Pick one of the following)* ☐ Sunday-Saturday (7 days) ☐ Monday-Saturday (6 days) ☐ Monday-Friday (5 days) ☐ Other
	After hours coverage	*(Pick one of the following)* ☐ Nurseline ☐ Other
	Staff Ratio: Staff to Members	*(Pick one of the following)* ☐ 1: 6,000 ☐ 1: 6,000-10,000 ☐ 1: 10,000 – 30,000 ☐ 1: 30,000+ ☐ Not offered
	Case Ratio: Case Manager to Cases	
	System integration with Member Services platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with clinical (UM, DM, CM, and Wellness) platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with claims processing platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with behavioral health platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with pharmacy benefit management platform	*(Pick one of the following)* ☐ Yes ☐ No
	Specialty Case Management – Oncology	
	Staffing model	*(Pick one of the following)* ☐ Primary Nurse ☐ Call Center
	Integrated into a single-team	*(Pick one of the following)* ☐ Designated team ☐ Dedicated team
	Hours of operation, AM	
	Hours of operation, PM	

#	Question	Response
	Time zone	*(Pick one of the following)* ☐ EST ☐ CST ☐ MST ☐ PST
	Day of the week	*(Pick one of the following)* ☐ Sunday-Saturday (7 days) ☐ Monday-Saturday (6 days) ☐ Monday-Friday (5 days) ☐ Other
	After hours coverage	*(Pick one of the following)* ☐ Nurseline ☐ Other
	Staff Ratio: Staff to Members	*(Pick one of the following)* ☐ 1: 6,000 ☐ 1: 6,000-10,000 ☐ 1: 10,000 – 30,000 ☐ 1: 30,000+ ☐ Not offered
	Case Ratio: Case Manager to Cases	
	System integration with Member Services platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with clinical (UM, DM, CM, and Wellness) platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with claims processing platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with behavioral health platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with pharmacy benefit management platform	*(Pick one of the following)* ☐ Yes ☐ No
	Specialty Case Management, Musculoskeletal – Treatment Decision Support	
	Staffing model	*(Pick one of the following)* ☐ Primary Nurse ☐ Call Center

#	Question	Response
	Integrated into a single-team	*(Pick one of the following)* ☐ Designated team ☐ Dedicated team
	Hours of operation, AM	
	Hours of operation, PM	
	Time zone	*(Pick one of the following)* ☐ EST ☐ CST ☐ MST ☐ PST
	Day of the week	*(Pick one of the following)* ☐ Sunday-Saturday (7 days) ☐ Monday-Saturday (6 days) ☐ Monday-Friday (5 days) ☐ Other
	After hours coverage	*(Pick one of the following)* ☐ Nurseline ☐ Other
	Staff Ratio: Staff to Members	*(Pick one of the following)* ☐ 1: 6,000 ☐ 1: 6,000-10,000 ☐ 1: 10,000 – 30,000 ☐ 1: 30,000+ ☐ Not offered
	Case Ratio: Case Manager to Cases	
	System integration with Member Services platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with clinical (UM, DM, CM, and Wellness) platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with claims processing platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with behavioral health platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with pharmacy benefit management platform	*(Pick one of the following)* ☐ Yes ☐ No
	24-Hour Nurseline	

#	Question	Response
	Staffing model	*(Pick one of the following)* ☐ Primary Nurse ☐ Call Center
	Integrated into a single-team	*(Pick one of the following)* ☐ Designated team ☐ Dedicated team
	Hours of operation, AM	
	Hours of operation, PM	
	Time zone	*(Pick one of the following)* ☐ EST ☐ CST ☐ MST ☐ PST
	Day of the week	*(Pick one of the following)* ☐ Sunday-Saturday (7 days) ☐ Monday-Saturday (6 days) ☐ Monday-Friday (5 days) ☐ Other
	After hours coverage	*(Pick one of the following)* ☐ Nurseline ☐ Other
	Staff Ratio: Staff to Members	*(Pick one of the following)* ☐ 1: 6,000 ☐ 1: 6,000-10,000 ☐ 1: 10,000 – 30,000 ☐ 1: 30,000+ ☐ Not offered
	Case Ratio: Case Manager to Cases	
	System integration with Member Services platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with clinical (UM, DM, CM, and Wellness) platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with claims processing platform	*(Pick one of the following)* ☐ Yes ☐ No
	System integrated with behavioral health platform	*(Pick one of the following)* ☐ Yes ☐ No

#	Question	Response
	System integrated with pharmacy benefit management platform	*(Pick one of the following)* ☐ Yes ☐ No
1.2	Please complete the following table for staff in the first care management model.	
	Credentials	
	1. Clinical Account Manager	
	2. Medical Director	
	3. Case Managers	
	% with case management certification	
	1. Clinical Account Manager	
	2. Medical Director	
	3. Case Managers	
	% time designated to the State of Delaware	
	1. Clinical Account Manager	
	2. Medical Director	
	3. Case Managers	
	Average years of experience with organization	
	1. Clinical Account Manager	*(Pick one of the following)* ☐ 0-1 year ☐ 2-5 years ☐ 5+ years
	2. Medical Director	*(Pick one of the following)* ☐ 0-1 year ☐ 2-5 years ☐ 5+ years
	3. Case Managers	*(Pick one of the following)* ☐ 0-1 year ☐ 2-5 years ☐ 5+ years

#	Question	Response
1.3	For patients with clinically severe obesity (BMI ≥ 40, or 35 with comorbid conditions), how long are counseling and lifestyle modification interventions prescribed before a person is considered a potential candidate for more invasive procedures such as bariatric surgery? Once a person has indicated a desire to pursue more invasive options, how does your approach to counseling and management strategies change (e.g., involvement of different clinical resources, etc.) before and after the invasive intervention?	
1.4	Please describe any programs or plans to put programs in place that specifically address health needs for members who are pre-diabetic, including interventions to reduce disease progression such as weight reduction.	
1.5	Please complete the following table reflecting your outreach for Model #1.	*(Fill in the below information for each of the following programs in bold)*
	Pre and Post Discharge Planning	
	% of the population identified	
	% of the identified population reached	
	% engaged in at least three calls with nurse case manager	
	Does mode of outreach and frequency vary based on risk stratification	*(Pick one of the following)* ☐ Yes ☐ No, explain:
	Initial outreach (i.e., nurse, auto-dialer, etc.)	*(Check all that apply)* ☐ Non-clinician ☐ Auto-dialer ☐ Mailer
	Frequency of outreach	*(Check all that apply)* ☐ Weekly ☐ Monthly ☐ Bi-monthly
	Conduct depression/behavioral health screening	*(Pick one of the following)* ☐ Yes ☐ No
	Treatment Decision Support	
	% of the population identified	
	% of the identified population reached	

#	Question	Response
	% engaged in at least three calls with nurse case manager	
	Does mode of outreach and frequency vary based on risk stratification	*(Pick one of the following)* ☐ Yes ☐ No, explain:
	Initial outreach (i.e., nurse, auto-dialer, etc.)	*(Check all that apply)* ☐ Non-clinician ☐ Auto-dialer ☐ Mailer
	Frequency of outreach	*(Check all that apply)* ☐ Weekly ☐ Monthly ☐ Bi-monthly
	Conduct depression/behavioral health screening	*(Pick one of the following)* ☐ Yes ☐ No
	Case/Disease Management	
	% of the population identified	
	% of the identified population reached	
	% engaged in at least three calls with nurse case manager	
	Does mode of outreach and frequency vary based on risk stratification	*(Pick one of the following)* ☐ Yes ☐ No, explain:
	Initial outreach (i.e., nurse, auto-dialer, etc.)	*(Check all that apply)* ☐ Non-clinician ☐ Auto-dialer ☐ Mailer
	Frequency of outreach	*(Check all that apply)* ☐ Weekly ☐ Monthly ☐ Bi-monthly
	Conduct depression/behavioral health screening	*(Pick one of the following)* ☐ Yes ☐ No
	Oncology	
	% of the population identified	
	% of the identified population reached	
	% engaged in at least three calls with nurse case manager	

#	Question	Response
	Does mode of outreach and frequency vary based on risk stratification	*(Pick one of the following)* ☐ Yes ☐ No, explain:
	Initial outreach (i.e., nurse, auto-dialer, etc.)	*(Check all that apply)* ☐ Non-clinician ☐ Auto-dialer ☐ Mailer
	Frequency of outreach	*(Check all that apply)* ☐ Weekly ☐ Monthly ☐ Bi-monthly
	Conduct depression/behavioral health screening	*(Pick one of the following)* ☐ Yes ☐ No
	Transplant	
	% of the population identified	
	% of the identified population reached	
	% engaged in at least three calls with nurse case manager	
	Does mode of outreach and frequency vary based on risk stratification	*(Pick one of the following)* ☐ Yes ☐ No, explain:
	Initial outreach (i.e., nurse, auto-dialer, etc.)	*(Check all that apply)* ☐ Non-clinician ☐ Auto-dialer ☐ Mailer
	Frequency of outreach	*(Check all that apply)* ☐ Weekly ☐ Monthly ☐ Bi-monthly
	Conduct depression/behavioral health screening	*(Pick one of the following)* ☐ Yes ☐ No
	Maternity	
	% of the population identified	
	% of the identified population reached	
	% engaged in at least three calls with nurse case manager	
	Does mode of outreach and frequency vary based on risk stratification	*(Pick one of the following)* ☐ Yes ☐ No, explain:

#	Question	Response
	Initial outreach (i.e., nurse, auto-dialer, etc.)	*(Check all that apply)* ☐ Non-clinician ☐ Auto-dialer ☐ Mailer
	Frequency of outreach	*(Check all that apply)* ☐ Weekly ☐ Monthly ☐ Bi-monthly
	Conduct depression/behavioral health screening	*(Pick one of the following)* ☐ Yes ☐ No
1.6	Please complete the following table reflecting your predictive modeling.	
	Data elements used to identify individuals	*(Check all that apply)* ☐ Pre-certification/notification of inpatient admissions ☐ Medical claims ☐ Pharmacy claims (via direct data feed) ☐ Pharmacy first fill reports ☐ Behavioral health claims (via direct data feed) ☐ Lab values (via direct data feed from contracted in-network labs) ☐ Health risk assessment ☐ Biometric screening data ☐ Disability and absence data
	Frequency tool is run and output produced	*(Pick one of the following)* ☐ Daily ☐ Weekly ☐ Monthly ☐ Bi-monthly
	% of population identified	
1.7	Please briefly describe your standard utilization management programs.	
1.8	Provide a list of your standard services and procedures that require pre-notification and pre-certification for inpatient and outpatient services.	
1.9	Does your program review the utilization of specific high-cost and high frequency imaging and diagnostic procedures?	*(Pick one of the following)* ☐ Yes ☐ No

#	Question	Response
1.10	If yes, describe the process for both the member and provider and attach the frequency per 1,000 (before utilization management), average cost and average disapproval rate of each of these procedures.	
1.11	If yes, what is the denial rate, appeal rate, and rate of overturned denials for these procedures?	
1.12	What are the minimum requirements for confidentiality, participant release of information authorization, etc. that you will require for referrals or exchange of treatment information with third-parties?	
1.13	Please outline the level, type or mode of integration with other programs.	*(Fill in the below information for each of the following programs in bold)*
	Pharmacy	
	Mode	*(Check all that apply)* ☐ Fax ☐ Phone – call key contact ☐ "Warm transfer" members ☐ Electronic feed ☐ Access to system ☐ No, explain:
	Frequency	*(Pick one of the following)* ☐ Monthly ☐ Weekly ☐ Daily ☐ Real-time
	Employee Assistance Program	
	Mode	*(Check all that apply)* ☐ Fax ☐ Phone – call key contact ☐ "Warm transfer" members ☐ Electronic feed ☐ Access to system ☐ No, explain:
	Frequency	*(Pick one of the following)* ☐ Monthly ☐ Weekly ☐ Daily ☐ Real-time
	Behavioral Health	

#	Question	Response
	Mode	*(Check all that apply)* ☐ Fax ☐ Phone – call key contact ☐ "Warm transfer" members ☐ Electronic feed ☐ Access to system ☐ No, explain:
	Frequency	*(Pick one of the following)* ☐ Monthly ☐ Weekly ☐ Daily ☐ Real-time
	Wellness	
	Mode	*(Check all that apply)* ☐ Fax ☐ Phone – call key contact ☐ "Warm transfer" members ☐ Electronic feed ☐ Access to system ☐ No, explain:
	Frequency	*(Pick one of the following)* ☐ Monthly ☐ Weekly ☐ Daily ☐ Real-time
	Onsite/Near-site Health Centers	
	Mode	*(Check all that apply)* ☐ Fax ☐ Phone – call key contact ☐ "Warm transfer" members ☐ Electronic feed ☐ Access to system ☐ No, explain:
	Frequency	*(Pick one of the following)* ☐ Monthly ☐ Weekly ☐ Daily ☐ Real-time
	Short term disability	

#	Question	Response
	Mode	*(Check all that apply)* ☐ Fax ☐ Phone – call key contact ☐ "Warm transfer" members ☐ Electronic feed ☐ Access to system ☐ No, explain:
	Frequency	*(Pick one of the following)* ☐ Monthly ☐ Weekly ☐ Daily ☐ Real-time
1.14	Will your care management programs (managing care across the continuum from wellness to chronic condition) change under bundled payment, shared risk/shared savings or similar contracting models? For example, how does your care management program align with local ACO or APC efforts, when explicit care management fees or a capitation is paid to providers for care coordination? How do local providers integrate their efforts with yours, and how is "double-charging" of the client avoided?	
1.15	Please describe who will be responsible for health management services when a member is in a health plan and an ACO or APC center? What entity will be responsible for providing which services? Will there be coordination between the health plan and the ACO and how is this accomplished? How are specialty case management programs such as transplant and maternity coordinated?	
	This section applies to ACO(s) only.	
1.16	How does your organization measure and assess the impact and effectiveness of patient engagement activities? (e.g., improved use of preventive services, reduction in unnecessary treatments or services, patient activation levels and self-management)	

#	Question	Response
1.17	Does your ACO offer any clinical improvement programs?	*(Check all that apply)* ☐ Surgical improvement plan ☐ Programs to reduce potentially avoidable hospital readmissions ☐ Surgery bundles (facility and professional) ☐ Surgery bundles with warranty programs ☐ Adverse event reporting (not POA and reportable) with payment reduction ☐ Return to work improvement plan (e.g., low back pain reduction) ☐ End of life care improvement plan ☐ Addiction and dependence treatment improvement plan ☐ Other, describe:
1.18	Does your Medical Home/ Intensive Outpatient Care Program (IOCP)/Office based ensure the medical home meets some standard that escalates over time (e.g., NCQA levels)?	*(Pick one of the following)* ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Report on progress to level 3 ☐ Other, describe:
1.19	Does your ACO participate in patient registries that include employer populations?	*(Check all that apply)* ☐ STS ☐ NCDR ☐ Orthopedic (total joint and spine) ☐ Cancer ☐ OB ☐ Diabetes ☐ Other
1.20	Does your Medical Home/IOCP/Office based Care/Case management ensure integrated care/case management across medical, Rx, mental health and substance abuse?	*(Check all that apply)* ☐ Warm transfers ☐ Integrated EMRs ☐ Process and Outcomes metrics ☐ Performance goals (NQF remission rates at 6 months) ☐ Other

#	Question	Response
1.21	Does your Medical Home/IOCP/Office based Care/Case management include processes to manage high cost patients?	*(Check all that apply)* ☐ Predictive models ☐ CMO discusses cases with a member's PCP ☐ Post discharge PCP appointment (less than 7 days before discharge) ☐ Frequent ED users (>5 ED per year) ☐ High cost Rx members ☐ Other, describe:
1.22	Does your ACO have provisions for providers and affiliates who fail to follow care-design protocols?	*(Check all that apply)* ☐ Lock in programs ☐ CMO calls the PCP ☐ EDIE (Emergency department information exchange) ☐ Other, describe:
1.23	Does your Medical Home/IOCP/Office based Care/Case management track metrics for prevention management?	*(Check all that apply)* ☐ Breast cancer screening ☐ Cervical cancer screening ☐ Colon cancer screening ☐ Flu vaccinations ☐ Childhood immunizations ☐ Obesity screening and referral ☐ Depression screening and referral ☐ Other, describe:
1.24	Does you Medical Home/IOCP/Office based Care/Case management ensure integrated care/case management across medical, Rx, mental health and substance abuse?	*(Check all that apply)* ☐ Warm transfers ☐ Integrated EMRs ☐ Process and Outcomes metrics ☐ Performance goals (NQF remission rates at 6 months) ☐ Other, describe:
1.25	Does your Medical Home/IOCP/Office based Care/Case management track metrics for acute care management?	*(Check all that apply)* ☐ ED use ☐ Inpatient (Admissions, discharges, members multiple admissions) ☐ Other, describe:

#	Question	Response
1.26	Does your Medical Home/IOCP/Office based Care/Case management track metrics for chronic disease management?	*(Check all that apply)* ☐ Diabetes ☐ Hypertension ☐ Lipids ☐ Cancer ☐ Inflammatory Disorders (RA) ☐ Multiple Sclerosis ☐ Other, describe:
1.27	Are your care/case management programs and/or FTEs certified?	*(Check all that apply)* ☐ URAC ☐ Care management certified ☐ Other
1.28	What is the ratio of the members to care managers?	
1.29	What are the hours that care management is available?	
1.30	Does your Medical Home/IOCP/Office based Care/Case management ensure at risk for total cost of care (e.g., fee increases)?	*(Pick one of the following)* ☐ Yes, describe ☐ No
1.31	Does your Medical Home/IOCP/Office based Care/Case management have processes to manage high cost claimants?	*(Pick one of the following)* ☐ Yes, describe ☐ No
1.32	Describe how you would integrate with the following employer programs:	
	Health plan concierge or customer service	
	Health plan case managers	
	Transparency	
	Expert medical opinion	
	Shared decision support	
	Onsite or near-site health center	
	Biometric and Health Coaching	
	COE services	
	Other, describe:	

#	Question	Response
1.33	Briefly describe your quality assurance process for assessing and monitoring your health management program activities, statistics and reporting. Indicate how this quality assurance process may be modified by the State of Delaware.	
1.34	Is there a process in place to effectively transition the State of Delaware's population currently participating in an existing health management program to the proposed program? Include the recommended timeline.	*(Pick one of the following)* ☐ Yes, explain ☐ No ☐ Not applicable
1.35	Please describe your approach to demonstrating the rigor and success of your health management programs. Include book of business reports, including metrics around engagement, outcomes, and satisfaction. Please make sure you include a glossary of terms.	
1.36	Does your ACO link the pharmacy and EMR systems to provide feedback to prescribers for retail and specialty drugs in the inpatient and outpatient settings?	*(Check all that apply)* ☐ Costs and utilizations ☐ Generic prescribing ☐ Aggregated DUR edits ☐ Formulary compliance ☐ Other, describe:
1.37	Does your ACO have requirements for pharmacies to be accredited (retail, mail and specialty)?	*(Pick one of the following)* ☐ Yes, describe: ☐ No
1.38	Does your ACO allow for data sharing with the payer PBM?	*(Pick one of the following)* ☐ Yes ☐ No ☐ Fully integrated Rx and medical data ☐ Other, describe:
1.39	Does your ACO support Sure Script transactions from the inpatient and outpatient settings for retail and specialty drugs?	*(Pick one of the following)* ☐ Yes, describe: ☐ No

#	Question	Response
1.40	Does your ACO have processes for pharmacists, working with the Rx and EMR systems, conduct medication reviews for high risk members?	*(Check all that apply)* ☐ High dose opiates, >10-15 drug/year ☐ >5-10 prescriber/year ☐ Poor adherence in the inpatient and outpatient settings (MDA <80%) ☐ High cost retail and specialty drugs ☐ Other, describe:
1.41	Does your ACO offer prescriber Rx feedback?	*(Check all that apply)* ☐ Generic Fill Rates ☐ Specialty drugs (use and costs) ☐ medication adherence/alerts ☐ DUR edits ☐ Other, describe:
1.42	Does your ACO offer retail Rx access?	*(Check all that apply)* ☐ If yes, how many locations? ☐ Access to 340b pricing ☐ Mail order ☐ Other, describe:
1.43	Does your ACO offer specialty Rx access?	*(Check all that apply)* ☐ Mail order ☐ Home delivery ☐ Home infusion ☐ White bag (pharmacy deliveries to provider office) ☐ Brown bag (member picks up at pharmacy and deliver to a provider office)

2.0 Alternative Health

#	Question	Response
2.1	For which of the following alternative health care services can you administer benefits if the employer's plan allows?	*(Check all that apply)* ☐ Acupuncture ☐ Biofeedback ☐ Chiropractic ☐ Homeopathy ☐ Massage therapy ☐ Naturopathy ☐ Nutrition counseling ☐ Relaxation/stress reduction ☐ Yoga ☐ Other, describe: ☐ Cannot administer
2.2	For which of the following programs do you provide member discounts for benefits not otherwise covered in the plan?	*(Check all that apply)* ☐ Acupuncture ☐ Aromatherapy ☐ Body care ☐ Chiropractic ☐ DME/Hearing aids ☐ Foot care ☐ Health club/ fitness center membership ☐ Laser eye surgery (e.g., LASIK) ☐ Massage therapy ☐ Smoking cessation classes ☐ Stress relief ☐ Yoga tools ☐ Vision discounts ☐ Weight loss program ☐ Vitamins ☐ Pet insurance ☐ Other, describe: ☐ Discounts not provided

#	Question	Response
2.3	How do you communicate these benefits/discounts to members? (Check all that apply)	*(Check all that apply)* ☐ Website ☐ Special mailings ☐ Customer service ☐ Utilization management ☐ iPhone App ☐ Android App ☐ Tablet App ☐ Other, describe:

3.0 Gaps in Care Technology

#	Question	Response
3.1	Is your care gap technology proprietary or licensed from a third party?	*(Pick one of the following)* ☐ Proprietary ☐ Licenses from a third party, explain: ☐ Not applicable
3.2	What data is used in your analysis?	*(Check all that apply)* ☐ Medical and drug claims ☐ Behavioral health claims ☐ Demographic data ☐ Health risk data ☐ Dental claims ☐ Employee Assistance Plan (EAP) data ☐ Health improvement program participation ☐ Lab claims ☐ Other, describe: ☐ Not applicable, we do not use gaps in care technology

E. Member Support, Tools and Resources

1.0 Medical Plan Member Services Administration

#	Question	Response
1.1	For the most recent calendar year, please provide the requested information for your proposed member service center location.	
	Office location	
	Hours of operation Mon-Fri (specify time zone)	
	Hours of operation Sat/Sun (specify time zone)	
	Number of Member Service Representatives (MSRs)	
	Percent of MSRs working remotely (telecommuting)	
	Average MSR years of experience	
	Ratio of MSRs to members	
	Call blockage rate	
	Call abandonment rate	
	Average speed to answer (in seconds) by a live person	
	Member satisfaction level	
	Average MSR turnover rate	
	Average duration time, MSR Calls, plan standard	
	Average duration time, MSR Calls, unit actual	
	First call resolution rate (calls not requiring call back by either party)	
	Customer satisfaction level	
1.2	Please describe the customer service unit that will be assigned to handle the State of Delaware's account as follows:	*(Pick one of the following)* ☐ Dedicated unit, members from a single employer ☐ Designated unit, members from a specific group of employers ☐ Not a dedicated or designated unit, all members

#	Question	Response
1.3	Will this office provide information for all quoted products? (e.g., Medical, Account-based plan administration, Behavioral Health, HRA Administration, HSA Administration, other Value-Based Contracting Models)	
1.4	How many toll free numbers are available to the State and its members to handle claims or other member service issues?	
1.5	Are bilingual services available; either on the website or customer service telephone line?	
1.6	Please describe in detail your company's procedures for handling service complaints by providers.	
1.7	Please describe in detail your company's procedures for handling service complaints and grievances by members.	
1.8	How are emergency after-hour calls handled?	*(Check all that apply)* ☐ Access to IVR ☐ Directed to website ☐ Member leaves message and call is returned the next business day ☐ Live representatives are always available ☐ Other, specify
1.9	Describe concisely how member service staff will be trained and prepared, in advance, to support State members.	
1.10	Please explain the hiring criteria and length and type of mandatory training for newly hired member service representatives. Describe how hiring and initial and ongoing training are different for (a) higher levels of member service support and (b) for retired members.	
1.11	How are member service representatives trained to identify and refer potential candidates for programs such as disease management, case management, maternity programs, EAP, etc.?	
1.12	Regarding your process of measuring performance for member service representatives, how much of their performance is weighted to the following:	
	Average speed of answer	

#	Question	Response
	Call duration	
	First call resolution	
	Member satisfaction	
	Other, specify in details box below	
	Other, specify in details box below	
1.13	Which of the following methods are used by supervisors to assess member service representative performance and service?	*(Check all that apply)* ☐ Access to listen during live call ☐ Random calls are taped for training purposes ☐ All calls are taped and reviewed as necessary ☐ None of the above
1.14	Is automated technology used to capture calls for quality monitoring? Are both voice and data captured? If yes, please provide the name of the technology you use.	
1.15	Are 100% of member calls recorded?	
1.16	Do you currently offer a 24/7 interactive voice response (IVR) unit for members if live agents are not available?	
1.17	Does your IVR script give callers the option of opting out in order to speak to a live person without going through the entire menu?	
1.18	Please provide the URL, user ID and password to your member portal and personal health record (PHR).	
1.19	Please provide the name and demo access information for any smart-phone / tablet apps that support member services functionality.	
1.20	Do you have single sign-on capabilities from the State of Delaware's intranet site to your website?	
1.21	Are you willing to establish a link between your plan's website and the State of Delaware's intranet site?	
1.22	Do your member service representatives respond to member questions submitted via the member portal? If yes, what is the response rate and the turnaround time for a representative to respond to an internet question? (e.g., 95% of inquiries were responded to within 24 hours)	*(Pick one of the following)* ☐ Yes, turnaround time average is (% of inquired receive responses in, # of hours) ☐ No, representatives do not respond via the internet

#	Question	Response
1.23	Do you have a member chat function on your member portal? If yes, describe how it is staffed and what quality assurance procedures are in place to ensure accurate communication with the member. Also, if yes, describe in your comments if the service is for administrative, clinical or both areas.	
1.24	Please describe how you maintain the security and privacy of member supplied information through your website (e.g., member Personal Health Record (PHR) data) and mobile applications.	
1.25	When was your organization's last SSAE 16/SOC 1 audit?	
1.26	What is the frequency of your SSAE 16/SOC1 audits? If your audit period does not cover the State's fiscal year, please confirm your ability to provide the State with annual and gap letters to cover the State fiscal year period.	*(Pick one of the following)* ☐ Annual ☐ Semi-Annual ☐ Other, specify *(Pick one of the following)* ☐ Confirmed – will provide annual and gap letters to cover the State's fiscal year ☐ Not confirmed, explain:
The next question applies to your ACO(s) only:		
1.27	Do you have or are you developing the following member services?	*(Pick one of the following)* ☐ In place ☐ Being developed ☐ No plans to develop
	Case/Care Management	
	Medical Home	
	Call Center	
	Member Portal	
	Decision Support	
	Telehealth (e-Visits, e-OB, e-Surgery, eRx refill)	
	Sure Scripts	
	EMR	
	Data Warehouse and Systems (Epic, MyChart, etc.)	
	Decision Support	
	Other Member Services	

2.0 Medical Plan Member Self-Service: Technology and Tools

#	Question	Response
2.1	Indicate the decision support tool(s) available to plan members to aid in the selection of the most appropriate benefit plan to meet their needs.	*(Check all that apply)* ☐ Out of pocket cost modeler based on expected utilization ☐ Out of pocket cost modeler including employee premium cost sharing amounts ☐ Other, specify
2.2	Will your tool support benefit plans offered by another medical vendor? If yes, describe the level of support.	*(Pick one of the following)* ☐ Yes, describe ☐ No
2.3	Confirm that you will offer an employer-specific website during open enrollment. Please provide login information for a demo website.	*(Pick one of the following)* ☐ Yes, provide details ☐ No
2.4	Indicate the web-based, mobile app, or telephonic member self-service functionality supported by your plan.	
	Member can access eligibility information	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can change contact information	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can access product-specific provider network information	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available

#	Question	Response
	Member can access plan design and benefit information	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can contact member service to ask questions and receive answers	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can access claim status and/or date of claim payment	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can access deductible/out-of-pocket maximum accumulation	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can access HRA/HSA balances	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available

#	Question	Response
	Member can view/print ID Cards	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can request replacement ID cards	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can print temporary ID Cards	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can file a grievance or claim appeal	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can schedule provider appointments	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available

#	Question	Response
	Member can view Evidence of Coverage and/or Summary Plan Description and/or Certificate of Coverage	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can obtain lab results	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can link/transfer to partner vendors such as PBM, HSA bank, etc.	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can obtain actual cost for specific services and/or treatment estimates for network providers	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can print Explanation of Benefits statement	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available

#	Question	Response
	Member can access Personal Health Record	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
	Member can access online health and/or wellness programs	*(Check all that apply)* ☐ Via Web & 800# ☐ Via Web only ☐ Via 800# only ☐ Via iPhone ☐ Via Android ☐ Other mobile applications ☐ Not available
2.5	Confirm that decision support tools are available for HSA account holders assessing investment risks and estimated out of pocket costs. Please describe.	*(Pick one of the following)* ☐ Yes, explain ☐ No
2.6	Does your plan offer electronic personal health records (PHR) to members?	
2.7	Do you offer the following health information to members?	
	Evidence-based, treatment information that supports member-provider communication for common chronic conditions (e.g., hypertension, low back pain, etc.)	*(Pick one of the following)* ☐ Both web tools and mobile app ☐ Web tools only ☐ Mobile apps only ☐ Not available
	Interactive decision support tools through your own website to help members compare treatment options	*(Pick one of the following)* ☐ Both web tools and mobile app ☐ Web tools only ☐ Mobile apps only ☐ Not available
	Interactive decision support tools through links to other websites (from your website) to help members compare treatment options	*(Pick one of the following)* ☐ Both web tools and mobile app ☐ Web tools only ☐ Mobile apps only ☐ Not available
2.8	Indicate the types of information available through your web-based and mobile application based practitioner directory. Indicate if any additional fees apply for access to this information.	

#	Question	Response
	Provider name search	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Urgent care center search	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Facility name search	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:

#	Question	Response
	Search for providers by County	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Search for providers by Zip Code	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Provider specialty search	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:

#	Question	Response
	Handicap accessible and hearing impaired assistance indicator	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Provider search tailored to member's specific plan design and/or network limitations	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Provider accepting new patients	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:

#	Question	Response
	Provider office hours	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Provider languages spoken	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Provider board certifications	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:

#	Question	Response
	Medical school attended by provider	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Driving directions to providers' locations	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Provider-specific price details based upon specific procedures	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:

#	Question	Response
	Consumer feedback / member satisfaction survey results	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Hospital admitting privileges	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Network participation (PPO, HMO, EPO, narrow, etc.)	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:

#	Question	Response
	Physician quality ratings	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:
	Hospital quality ratings	*(Check all that apply)* ☐ Web based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Mobile device app based ☐ Displayed only ☐ Searchable and displayed ☐ Not available ☐ Frequency of updates ☐ Daily ☐ Weekly ☐ Monthly ☐ Other, describe:

3.0 Provider Data Transparency – Pricing and Quality

#	Question	Response
3.1	What is the source of your pricing and quality data, and how frequently is each data source updated?	
3.2	What geographies are included in the provider pricing and quality member self-service tool?	
3.3	Are all of your networks (e.g., HMO, PPO, EPO, POS, Narrow, and HPN) available through your provider pricing and quality tool?	
3.4	Are you able to provide pricing and quality information for non-network providers?	

#	Question	Response
3.5	Are you able to incorporate pricing for client-specific provider contracting to support automatic adjudication?	
3.6	Are you able to incorporate pricing for employer-sponsored onsite/near-site health centers?	
3.7	Do you supplement your network pricing data with any other data sets? If yes, specify.	
3.8	For what medical procedures/services do you provide cost data?	
3.9	Is pricing based on CPT code or are you bundling in some other way?	
3.10	Do you incorporate episode of care pricing into your treatment cost estimator tool?	
3.11	Do you offer pricing for benefits beyond medical, such as prescription drugs, behavioral health, dental, or vision?	
3.12	Is your pricing the “actual projected price” for the member's health plan and employer, or is it more generic?	
3.13	Are you able to incorporate member-specific accumulators (cost-sharing and health account balances) into the pricing results?	
3.14	Does the provider pricing include any adjustments or explanations around age, gender, or other member clinical factors that might impact costs?	
3.15	Are there specific providers (or groups of providers) for whom you are contractually limited in sharing actual cost information with members? If so, please list the provider name, market, and types of cost information can and cannot be shared. Please describe efforts to have all of your network contracts permit the disclosure of cost data.	
3.16	Are the same member services representatives available to help a member with general questions as well as price transparency, or would it be different departments?	
3.17	If reference-based pricing is part of the offering, for which procedures do you have adequate data to support this approach?	

#	Question	Response
3.18	What other vendors (PBMs, price transparency specialty vendors, etc.) are you willing to work with to supplement your reference-based pricing capabilities? Provide number of current clients, names, number of employees and go live date.	
3.19	What other partnerships do you have in place to support reference-based pricing?	
3.20	Do you charge fees for reference-based pricing that are in addition to base ASO fees? If yes, please specify.	
3.21	Are you willing to offer your reference-based pricing service on a pilot basis for a select group or geography?	
3.22	Explain how you measure provider quality.	
3.23	Is the quality information for network providers or all providers?	
3.24	What quality data is integrated into the member self-service transparency tool described in the prior section? Please list sources and types of information.	
3.25	Describe member utilization of quality tools. How do clinical programs and customer service direct members to high quality provider?	
3.26	For what procedures/services do you provide quality data through the member self-service tool?	
3.27	Do you provide quality measures for both individual providers and facilities?	
3.28	Please describe your efforts to improve quality reporting, both for purposes of your own member tools and for the health care industry in general.	

F. Medicare Supplement

1.0 Medical Plan Member Services Administration

#	Question	Response
1.1	Please provide the location and hours of operation for the member services and claim administration offices for the Medicare Supplement plan:	

#	Question	Response
	Customer Service Unit	
	Location	
	Hours of Operation	
	Dedicated, Designated, or Neither	
	Claims Administration Unit	
	Location	
	Hours of Operation	
	Dedicated, Designated, or Neither	
1.2	The State of Delaware would expect your member services representatives to be trained and the toll-free line to be operational by October 1, 2016 at no additional cost. Please confirm that you can meet this operational date.	
1.3	For the proposed claim office, provide the following claims performance information for the 2 latest calendar years.	
	Plan Standard	
	a. Claims Accuracy, Financial: Percentage of claim dollars paid accurately	
	b. Claim Turnaround Time: Percentage of clean claims processed in 14 business days	
	c. Claim Turnaround Time: Percentage of clean claims processed in 30 calendar days	
	d. Claims Accuracy, Non-Financial: Percentage of claims processed correctly	
	Actual - Most recent full calendar year	
	a. Claims Accuracy, Financial: Percentage of claim dollars paid accurately	
	b. Claim Turnaround Time: Percentage of clean claims processed in 14 business days	
	c. Claim Turnaround Time: Percentage of clean claims processed in 30 calendar days	
	d. Claims Accuracy, Non-Financial: Percentage of claims processed correctly	
	Actual – Prior full calendar year	

#	Question	Response
	a. Claims Accuracy, Financial: Percentage of claim dollars paid accurately	
	b. Claim Turnaround Time: Percentage of clean claims processed in 14 business days	
	c. Claim Turnaround Time: Percentage of clean claims processed in 30 calendar days	
	d. Claims Accuracy, Non-Financial: Percentage of claims processed correctly	

2.0 Plan Administration

#	Question	Response
2.1	Are any of the communications that you send out to members customizable by the State of Delaware? If so, please describe.	
2.2	Confirm that you will produce and distribute (when applicable) ID cards, provider directories, claim forms, evidence of coverage, and marketing materials in your format for the State of Delaware members at their request and at no additional charge.	
2.3	Please confirm that your claims administration system has the following features:	
	Ability to accept eligibility information electronically	*(Pick one of the following)* ☐ Yes ☐ No
	Ability to feed eligibility information electronically to a third-party vendor in compliance with HIPAA standards	*(Pick one of the following)* ☐ Yes ☐ No
	Ability to feed eligibility information electronically to match the Medicare health insurance claim (HIC) number	*(Pick one of the following)* ☐ Yes ☐ No

#	Question	Response
2.4	Post-65 plans are now administered with Medicare "crossover" under which claims are automatically sent from Medicare to the secondary carrier for processing. Describe your Medicare crossover program process and confirm that this is included in your fees.	
2.5	It is the State's expectation that members who recently become eligible for Medicare remain enrolled in a non-Medicare Rx plan until those members are approved by CMS for the State's EGWP. Since the State's medical vendor is responsible for sending eligibility data to the State's PBM, please confirm your ability to continue transmitting eligibility for a non-Medicare Rx plan to the PBM that allows the newly Medicare-eligible member to maintain enrollment in a non-Medicare Rx plan until approved by CMS for the State's EGWP.	

3.0 Plan Design

#	Question	Response
3.1	Please review the current plan design (available at http://ben.omb.delaware.gov) and note any deviations to the State's Medicare Supplement plan that you cannot administer.	

4.0 Fees and Performance Guarantees

#	Question	Response
4.1	Please provide your ASO fees for the Medicare supplement plan in Appendix P. Please quote on a three-year contract running from January 1, 2017 through December 31, 2019. Please confirm that you will have rate caps that do not exceed 3% per year. Provide an attachment detailing services included and excluded from your standard fees. Provide fees on a per retiree/surviving spouse per month (PRPM) basis.	

#	Question	Response
4.2	Please provide your fully-insured premiums for the Medicare supplement plan in Appendix Q. Please quote on a three-year contract running from January 1, 2017 through December 31, 2019. Please confirm that you will have rate caps that do not exceed 3% per year. Provide an attachment detailing services included and excluded from your standard fees. Provide fees on a per retiree/surviving spouse per month (PRPM) basis.	
4.3	Please provide your proposed performance guarantees for this population.	

G. Medicare Advantage

1.0 General Questions

#	Question	Response
1.1	For 2014 and 2015, please provide the number of employer clients that offer your group national Medicare PPO programs and the number of members enrolled in these plans.	
	Enrollment as of 1/1/2014	
	Number of Employer Clients	
	Number of Members	
	Enrollment as of 1/1/2015	
	Number of Employer Clients	
	Number of Members	
1.2	Please provide at least two public sector client references who have experience with your MA plans and can speak to the State about their implementation and transition to MA from traditional Medicare Supplement coverage.	

2.0 Contact Information

#	Question	Response
2.1	Please provide the following information about this program.	

#	Question	Response
	Legal Name of Corporation	
	Trade Name/MA Operating Unit	
	Corporate Headquarters Address	
	MA Plan's Web Address for State of Delaware Retirees	
	URL for State of Delaware's link to Provider Directory	
	Tax Identification Number	
	Group Contract Numbers: Retirees	
	MA Physician Arrangement (Group or IPA)	
2.2	Contacts:	
	Account Manager	
	Name	
	Phone	
	Fax	
	Email	
	Address	
	City	
	State	
	Zip	
	Enrollment Contact	
	Name	
	Phone	
	Fax	
	Email	
	Address	
	City	
	State	
	Zip	
	IT Contact	
	Name	
	Phone	
	Fax	
	Email	
	Address	
	City	
	State	
	Zip	
2.3	Member Services Phone Number	

#	Question	Response
2.4	Health Advice Line	
2.5	Describe the nature of your provider compensation arrangements including a detailed description of any capitation, risk arrangements, withholds, incentives and performance measures.	

3.0 Terms & Conditions

#	Question	Response
3.1	Confirm that your organization will inform Willis Towers Watson and the State of Delaware within 30 days of all key events and changes affecting your MA program. These include but are not limited to CMS investigations, sanctions, warnings, or other regulatory actions, significant adverse publicity, loss of more than five percent of the network physicians, and loss of a network hospital.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
3.2	Confirm that your organization will inform Willis Towers Watson and the State of Delaware of any agreements contemplated or in progress between your organization and other third parties which may affect your organization's ownership, corporate structure or management within 30 days of signing a letter of intent or 90 days prior to the effective date.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
3.3	Does your organization execute group contracts to be signed by the State of Delaware for your MA programs?	
3.4	Confirm that your organization agrees to work with the State of Delaware to negotiate and execute a mutually agreed upon group contract covering terms and services to be delivered.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
3.5	Does your organization release “Evidence of Coverage” statements (EOCs) in lieu of group contracts?	*(Pick one of the following)* ☐ Yes, we only release EOCs and not group contracts ☐ No, we release group contracts and EOCs

4.0 Medical Plan Implementation

#	Question	Response
4.1	Indicate the ideal notification date to achieve a successful implementation for the State of Delaware's effective date of 1/1/18.	
4.2	What would be your expected level of engagement and involvement in meeting with retirees, attending meetings and one-on-one sessions with retirees during the implementation / transition process?	

5.0 Member Services Administration, Tools and Resources

#	Question	Response
5.1	For the most recent calendar year, please provide the requested information for your proposed member service center location.	
	a. Office location	
	b. Hours of operation M-F (specify time zone)	
	c. Hours of operation Sat/Sun (specify time zone)	
	d. Number of representatives (#.##)	
	e. % of representatives working remotely (telecommuting)	
	f. Average years of experience (#.##)	
	g. Ratio of representatives to members	
	h. Blockage rate	
	i. Abandonment rate	
	j. Average speed to answer (in seconds) by a live person	
	k. Member satisfaction level	
	l. Average member service rep turnover rate	
	m. Average duration time, member service rep calls, plan standard	
	n. Average duration time, member service rep calls, unit actual	
	o. First call resolution rate (calls not requiring call back by either party)	
	p. Member satisfaction level	

#	Question	Response
5.2	Please describe the customer service unit that will be assigned to handle the State of Delaware's account as follows:	*(Pick one of the following)* ☐ Dedicated unit, members from a single employer Directed to website ☐ Designated unit, members from a specific a group of employers ☐ Not a dedicated or designated unit, all members
5.3	The State of Delaware would expect your member services representatives to be trained and the toll-free line to be operational by October 1, 2017 at no additional cost. Please confirm that you can meet this operational date.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
5.4	Please explain the hiring criteria and length and type of mandatory training for newly hired member service reps. Describe how hiring and training are different for higher level of member service support.	
5.5	Please provide the URL, User ID and password to your member portal and personal health record.	
5.6	Are supervisors able to listen to calls by any of the following methods?	*(Check all that apply)* ☐ Access to listen during live call ☐ Random call are taped for training purpose ☐ All calls are taped and reviewed as necessary ☐ None of the above ☐ Other, specify
5.7	Is automated technology used to capture calls for quality monitoring? Are both voice and data captured? If yes, please provide the name of the technology you use.	
5.8	Are 100% of member calls recorded?	
5.9	What tools and resources are available to members to help them coordinate care across doctors and other health care providers, as well as any other value-added services such as Silver Sneakers?	
5.10	Do any of the plans in your proposal to the State include any type of concierge services to retirees to help them coordinate services and/or coverage?	

6.0 Claims Administration

#	Question	Response
6.1	Provide the following information (for the most recent calendar year) for your proposed claim office facilities:	
	a. Proposed office name	
	b. Location	
	c. Years in operation	
	d. Number of claims processed	
	e. Average number of claims per processor per day	
	f. Percentage of all claims submitted electronically	
	g. Number of member lives handled by this office	
	h. Average ratio of claims examiners to member lives in this office	
	i. Rate of claims processor turnover	
	j. Percentage of total claims submitted electronically for professional (non-facility) services	
	k. Percentage of total claims converted to electronic medical data by scanning, Optical Character Recognition (OCR) or Intelligent Character Recognition (ICR) method	
	l. Percentage of total claims automatically adjudicated, (no manual intervention of any kind)	
	m. Percentage of claims adjusted after initial payment,	
	n. Percentage of all claims processed that underwent random internal audit	
6.2	Are you planning any major upgrades to your claim system that will be used to process the State of Delaware's claims within the next 36 months?	

#	Question	Response
6.3	Indicate which of the following data systems are housed on the same platform as your medical claims system.	*(Check all that apply)* ☐ Eligibility ☐ Provider Pricing ☐ Utilization review program ☐ Customer service member call notes ☐ Large Case Management program ☐ HRA claims processing ☐ HSA claims processing ☐ FSA claims processing ☐ None ☐ Other, specify
6.4	Based on the State of Delaware's requested plan design for the MA plan, which mirrors the current Medicare Supplement plan design, i.e., passive PPO on a non-benefit differential basis that pays 100% of all Medicare services; in what manner does your claims system handle the following?	
	a. Eligibility of retiree	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	b. Eligibility of dependent	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	c. Benefit plan exclusions	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	d. Frequency limits	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	e. Calculate payment amount	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	f. Accumulation of deductible	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled

#	Question	Response
	g. Co-insurance	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	h. Co-pay	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	i. Out-of-pocket maximum	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	j. Lifetime maximum	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	k. Coordination of benefits including Medicare	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	l. Workers' Compensation	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	m. Subrogation	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	n. Check issuance	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	o. EOB issuance	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	p. UR coordination	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	q. Duplicate claims	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled

#	Question	Response
	r. In-network/out-of-network determination	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	s. Automatic rollover to flexible spending account	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
	t. Automatic rollover to personal health care account (HSA/HRA)	*(Pick one of the following)* ☐ Automated ☐ Manual ☐ Not handled
6.5	Does your system have the ability to accommodate a benefit revision or retroactive benefit change? If yes, is there a time limit?	
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	
	Plan Standard	
	Actual elapsed time (from most recent calendar year audit)	
	b. Between repricing and adjudication	
	Plan Standard	
	Actual elapsed time (from most recent calendar year audit)	
	c. Between adjudication and transmission of EOB	
	Plan Standard	
	Actual elapsed time (from most recent calendar year audit)	
6.7	For the proposed claim office, provide the following claims performance information for the 2 latest calendar years.	
	a. Claims Accuracy, Financial: Percentage of claim dollars paid accurately	
	Plan Standard	
	Actual - Most recent full calendar year	
	Actual – Prior full calendar year	

#	Question	Response
	b. Claim Turnaround Time: Percentage of clean claims processed in 14 business days	
	Plan Standard	
	Actual - Most recent full calendar year	
	Actual – Prior full calendar year	
	c. Claim Turnaround Time: Percentage of clean claims processed in 30 calendar days	
	Plan Standard	
	Actual - Most recent full calendar year	
	Actual – Prior full calendar year	
	d. Claims Accuracy, Non-Financial: Percentage of claims processed correctly	
	Plan Standard	
	Actual - Most recent full calendar year	
	Actual – Prior full calendar year	

7.0 Plan Administration

#	Question	Response
7.1	Please describe your typical annual communication cycle for your current Medicare Advantage clients.	
7.2	Are there any communications that your company sends to members that are required by law for the Medicare Advantage products? If so, please describe.	
7.3	Are any of the communications that you send out to Medicare Advantage members customizable by the State of Delaware? If so, please describe.	
7.4	Confirm that you will produce and distribute ID cards, provider directories, claim forms (if applicable), evidence of coverage, and marketing materials in your format for the State of Delaware members at their request and at no additional charge.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain

#	Question	Response
7.5	Your organization will be required to process a group default enrollment for all individuals to be covered under the group MA plan. Participants will be allowed to decline enrollment, if desired, but in doing so participants will also lose the State of Delaware prescription drug coverage and may not be able to re-enroll for coverage again in the future.	
	Please confirm that you have filed with CMS to process group enrollments and dis-enrollments.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
	Please confirm that you will notify CMS that State of Delaware members are covered under your program for the upcoming plan year or are no longer covered and should be placed back into Original Medicare effective 1/1/2018 as appropriate.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
7.6	Please confirm that your claims administration system has the following features:	
	Ability to accept eligibility information electronically	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
	Ability to feed eligibility information electronically to a third-party vendor in compliance with HIPAA standards	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
	Ability to feed eligibility information electronically to match the Medicare health insurance claim (HIC) number	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
7.7	For the PPO and HMO group MA plans included in your proposal, are referrals required to see a specialist?	*(Pick one of the following)* ☐ Required; explain: ☐ Not required
7.8	For the plans included in your proposal, how does the plan coordinate care for members, including case and disease management? Please be sure to include any fees for care coordination in your response to Appendix Q, *Fully-Insured Medical Premium Quotes*.	

#	Question	Response
7.9	Are nurses used in the care management process? If so, are they only available by phone or are home and/or site visits an option as well? If the latter is an option, please note whether there is an additional cost associated with home and/or site visits.	
7.10	What level of claims data would you be willing to provide to the State related to medical service utilization, care coordination, and disease management participation?	
7.11	What level of claims data would you be willing to provide to the State's data warehouse vendor (Truven Health Analytics)? See Attachment 3 for file layouts for outbound files to Truven.	
7.12	It is the State's expectation that members who recently become eligible for Medicare remain enrolled in a non-Medicare Rx plan until those members are approved by CMS for the State's EGWP. Since the State's medical vendor is responsible for sending eligibility data to the State's PBM, please confirm your ability to continue transmitting eligibility for a non-Medicare Rx plan to the PBM that allows the newly Medicare-eligible member to maintain enrollment in a non-Medicare Rx plan until approved by CMS for the State's EGWP.	

8.0 Provider Management

#	Question	Response
8.1	Indicate the conditions or terms that are included in your contracts with in-network providers.	
	a. Balance billing policy - member held harmless	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required

#	Question	Response
	b. Allowance for use of "passive" blind networks (no differentiation between in- and out-of-network benefits)	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	c. Credentialing	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	d. Compliance with UM	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	e. Claims submissions	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	f. Complaints/grievances	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	g. Electronic capabilities for member services/communications	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
	h. Disclosure of reimbursement rates for use in member transparency tools	*(Pick one of the following)* ☐ Required for Hospitals and Physicians ☐ Required for Hospitals only ☐ Required for Physicians only ☐ Not required
8.2	Are network physicians contractually obligated to admit to in-network hospitals only?	

#	Question	Response
8.3	Did you terminate any hospital contracts during the current year (or did any hospitals terminate their relationship with you)? If yes, indicate the approximate percentage of admissions in the prior year attributed to the terminated hospital(s). The percentage should be calculated by taking the number of admissions to the terminated hospital(s) last year and, dividing by the total number of admissions for the plan last year.	
8.4	Describe the financial arrangements established with hospitals in the network.	
8.5	Does your organization anticipate any provider contracting issues in the near future? If so, what providers will be impacted? Please provide the provider name and location.	
8.6	When do your existing contracts with all the major hospital systems in Delaware, Maryland and Philadelphia, PA expire?	
8.7	Does the network(s) included in your proposal include providers that do not accept assignment? If so, why?	
8.8	How would the Plan handle a situation where a member incurs a claim with a provider who does not accept assignment?	
8.9	Please describe any programs and/or incentives offered to providers to encourage the management of members' health while reducing members' total cost of care.	

9.0 Program Design

#	Question	Response
9.1.1	Please review the plan design on the State of Delaware's website (http://ben.omb.delaware.gov) and confirm if your organization is able to administer an MA plan that matches the current benefit provisions of the Medicare Supplement plan. Please disregard the Rx design as pharmacy coverage is not included in this RFP. We recognize that 2018 plan designs and premiums are not yet available, so please base your answer on your 2017 plan designs that have been filed with and approved by CMS. If your organization cannot match the current design, please explain any deviations from the current plan design and attach an exhibit with your proposed plan design. (Please ensure that the proposed plan design is as close as possible to the current plan.)	*(Pick one of the following)* ☐ Attached, explain ☐ Not attached, explain
	Does your organization have the capability to administer a national PPO program? (i.e., one out-of-area plan design for all retirees, regardless of geography)	
	Are there any states, counties or other areas that are not included in your national Medicare Advantage PPO network? If so, please list these areas.	
	If you answered Yes to the prior question, please review the census provided in this RFP and confirm whether any State of Delaware retirees reside in the excluded areas. If so, do you offer any alternative solutions for these individuals?	
9.1.2	Please confirm whether the 2017 program design you confirmed/provided in this section has been approved by CMS and can be considered final.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
9.1.3	If your organization has not already received CMS approval for the 2017 program design, please provide estimated timing for when CMS approval will be received.	

10.0 ID Cards

#	Question	Response
10.1	Please scan and attach a sample State of Delaware ID card (it should contain the appropriate State of Delaware information - phone number, benefit design, etc.) and note if any changes will need to be made for 2018.	*(Pick one of the following)* ☐ Attached ☐ Not attached, explain. (if not provided this will be deemed non-responsive and incomplete)
10.2	Will replacement ID cards be mailed to all enrolled participants annually?	
10.3	Will ID cards only be mailed to new participants and those who have enrollment changes? (e.g., change of address, coverage tier, etc.)	
10.4	What benefit changes will trigger replacement ID cards? (e.g., annual deductible, out-of-pocket maximum, PCP/SCP copay)	
10.5	Will you be making any changes to your ID cards across your book-of-business that will impact the State of Delaware's ID cards?	

11.0 Health Care Reform Compliance

#	Question	Response
11.1	Please confirm that the MA program offered to State of Delaware participants will comply with all PPACA requirements.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain

12.0 Additional Feedback

#	Question	Response
12.1	Use this space to make any special notes about your responses in any part of the RFP.	

13.0 Pricing

#	Question	Response
Note:	The State of Delaware would like to review quotes for a fully insured national group MA passive PPO plan with benefits as close as possible to the current Medicare Supplement plan and based on a 2017 plan that has been approved by CMS. Please review the current design and propose a blended national rate based on the plan design most like the State of Delaware's current plan. The rate should be on a per member per month (PMPM) basis and should be effective 1/1/2018. Please outline all assumptions used to project 2018 premium costs, including inflation or trend factors and any enrollment increases.	N/A
13.1	Will you agree to cover all retirees and their dependents that are covered on the day immediately preceding the effective date of your insured contract?	
	The State of Delaware's preference is for a uniform national premium rate, regardless of where the member resides. Please confirm that you can provide a uniform rate.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
13.2	Please provide the following assumptions used in underwriting and rate setting:	
	a. Credibility assigned to past experience	
	b. Trend	
	c. Retention	
	d. Taxes (including PPACA national health insurance tax)	
13.3	To what extent does the group-specific cost data we provided impact your quoted rates?	
	Please provide any additional detail regarding your rating methodology that is not documented in the prior questions.	

#	Question	Response
13.4	Due to the timing of the State's budget setting process, it is necessary for the State to have an understanding of projected plan premiums for each calendar year approximately fifteen (15) months in advance. For instance, the State will need a reliable estimate of plan premiums effective 1/1/2018 by October 2016 in order for the cost of those premiums to be factored into the State budget process for the next fiscal year beginning on 7/1/2017. Please describe how you would work with the State to supply the most accurate information on Medicare Advantage premiums available at the time that the State would need that information in October for the plan year that follows after the next calendar year.	

14.0 Response Documents

#	Question	Response
14.1	Please complete Appendix V: *Provider Disruption*.	*(Pick one of the following)* ☐ Attached ☐ Not attached, explain
14.2	If the network in your proposal includes providers who do not accept assignment, are you able to provide a GeoAccess report showing member access to providers who do and do not accept assignment? If so, please use the provider access standards outlined in Appendix U.	*(Pick one of the following)* ☐ GeoAccess report(s) provided ☐ Not provided, explain

V. Network Adequacy

For both the GeoAccess and Provider Disruption sections, please run each analysis separately for any traditional networks (i.e., PPO/POS, HMO/EPO) as well as any high performance networks, narrow networks or ACOs that you're proposing for the State.

1.0 GeoAccess

Using the ZIP Code data provided in the GeoAccess reporting templates (Appendices S, T and U), prepare and provide GeoAccess reports based on the standards included in the template. Exclude providers with closed practices from your analysis. Provide separate GeoAccess reports for the active, retired and Participating Group GHIP populations using the Urban, Rural and Suburban access criteria summarized in the GeoAccess Instructions. 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. If you are bidding on the Medicare Advantage plan and the network in your proposal includes providers who do not accept assignment, are you able to provide a GeoAccess report showing member access to providers who do and do not accept assignment? If so, please use the provider access standards outlined in Appendix U.

2.0 Provider Disruption

Part of the scoring criteria upon which all bidders will be evaluated is based on accurate completion of the *Provider Disruption* 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 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.

VI. Financial Proposal

1.0 Fee Requirements

For the following section, please note in your responses if there are any differences in your financial proposal by plan. If you do not note any differences by plan, the State will assume that your responses are consistent across all plans included in your proposal.

#	Question	Response
1.1	What is the allowance included in your quoted fees for ad hoc management reporting? (hours, number of reports, etc.)	
1.2	What fees are charged for ad hoc reporting if the above allowance is exceeded? ($$/hour, flat fee, etc.)	
1.3	Confirm you are willing to absorb any penalties arising from late payment of any state-mandated paid claim surcharges or taxes directly due to your delinquent reporting.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
1.4	Confirm you are willing to fund up to a minimum of $40,000 for a pre-implementation audit conducted by a third party designated by the State of Delaware.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
1.5	Confirm you are willing to fund up to a minimum of $70,000 per year for an annual claims audit conducted by a third party designated by the State of Delaware.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
1.6	For non-incumbents: Confirm you are willing to provide the State of Delaware with an implementation credit to offset the cost of implementing a new administrator. If yes, please confirm that this credit can be used throughout the entire contract period and that there are no stipulations on the use of the credit.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
1.7	Confirm you are willing to fund an annual or bi-annual clinical process review (clinical audit) administered by a third party designated by the State of Delaware, at a mutually agreeable fee by all parties. If yes, confirm the amount you are willing to fund for a clinical process review.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain

#	Question	Response
1.8	Confirm you are willing to provide the State of Delaware with an annual communication allowance to offset the cost of Open Enrollment and any other member communications. If yes, please indicate the amount, whether or not any unused funds will rollover into the next contract year, and any stipulations on the use of the credit.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
1.9	For incumbents: If awarded a contract, confirm you agree to roll-over the June 30, 2017, communication allowance balance.	

2.0 Financial Assumptions

#	Question	Response
2.1	Confirm that your fees are quoted on a mature basis for year one.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
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?	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
2.3	Under what conditions do you reserve the right to change your administrative fees (i.e., subscriber count changes by x% within y months)? Specify the percentage limits you apply and the resulting change in fees.	
2.4	Please attach a sample ASO contract.	
2.5	Confirm that you have completed Appendix P: *Medical ASO & Discounts* with details on your fees for each of the ASO quotes that you are proposing for the State. Please also confirm that you will have rate caps that do not exceed 3% per year.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain

#	Question	Response
2.6	Confirm that you have completed Appendix Q: *Fully-Insured Medical Premium Quotes* with details on your fees for each of the fully insured plans that you are proposing for the State. Please also confirm that you will have rate caps that do not exceed 3% per year.	*(Pick one of the following)* ☐ Confirmed ☐ Not confirmed, explain
	The following questions apply to proposals for fully-insured quotes only.	
2.7	If your proposal includes a quote for a group Medicare Advantage plan, will you agree to cover all retirees and their dependents that are covered on the day immediately preceding the effective date of your insured contract?	
2.8	For all fully insured plan quotes, if your monthly premium rates normally contain a margin for commissions/bonus payments to brokers and/or agents, the requirement that 100% of the margin is removed from the rates is stated in the Minimum Requirements. Please confirm your acceptance.	
2.9	Please confirm that you can provide a quote for a uniform national premium rate, regardless of where the member resides.	
2.10	Please provide the following assumptions used in underwriting and rate setting:	
	Credibility assigned to past experience	
	Trend	
	Retention	
	Taxes (including PPACA national health insurance tax)	
2.11	Please describe how you would approach the underwriting and rating methodology for a fully-insured renewal in a subsequent year if cost of the State's claims exceeds the premiums collected from the State in the current year.	
2.12	Of the plan sponsors within your book of business with at least 25,000 members, how many plan sponsors have fully insured medical plans that cover the majority of their enrolled members?	
2.13	Please provide any additional detail regarding your rating methodology that is not documented in the prior questions.	

3.0 Network Discounts

#	Question	Response
3.1	Confirm that you have completed Appendix P: *Medical ASO & Discounts* with details on your network discounts for each of the networks that you are proposing for the State.	

4.0 Performance Guarantees

#	Question	Response
4.1	Confirm your acceptance of the trend guarantee listed in Appendix D, and include in your response the specific information requested in Appendix D.	
4.2	Please provide what performance guarantee measures and/or fees at risk you would offer to the State in addition to the metrics and/or fees listed in Appendix C.	

VII. Other Alternatives

#	Question	Response
1.0	Please describe any other programs or services that you suggest the State of Delaware consider in order to meet the State's goals and objectives outlined in the Introduction section.	
2.0	Please review the SBO's website at http://ben.omb.delaware.gov and then describe any other creative ways that you suggest the State should consider to educate GHIP participants on their benefit programs and what it means to be a good health care consumer.	

VIII. Technical Standards and Security Requirements

The following minimum requirements are mandatory. Please carefully read each term and requirement. Failure to meet any of these proposal criteria may result in disqualification of the proposal submitted by your organization.

1. File Layouts:
   a. It is a minimum requirement that vendors be able to accept enrollment data in the HIPAA 834 file layout. Copies of the current file layouts are on the disc with the enrollment and claims files. The following data transfers are required:

      i. Weekly inbound enrollment files from all groups (currently 5 separate files) in the GHIP (active employees, pensioners, participating groups, etc.,) that contain all enrolled subscribers and dependents for the State Group Health plan;

      ii. Inbound bi-weekly claim files from the PBM, currently Express Scripts, Inc.

      iii. Weekly outbound enrollment files to the PBM for all enrolled participants (subscribers and their dependents).

      iv. Inbound weekly files from two Spousal Coordination of Benefits databases containing information from employees and pensioners who have completed a form in accordance with the State's Spousal Coordination of Benefits policy.

      v. Monthly outbound enrollment and claim files to the State's data mining vendor, currently Truven Health Analytics. Additional data elements may be requested to these files to accommodate value based payment models that may be implemented as part of an awarded contract.

      vi. Proposed monthly disease management and health risk assessment files to Truven Health Analytics.

      vii. ACO Plans Only – Monthly outbound supplemental data file to Truven Health Analytics.

   Please confirm that your organization can accept and load enrollment data in HIPAA 834 file layouts and send and receive enrollment and claims data using the layouts currently in use.

   Response:

b. Please confirm that your organization can accept inbound files containing information extracted from completed Spousal Coordination of Benefits forms. Preference is that these files would be loaded through an automated process. At minimum, confirm that your organization can analyze the information contained in these files, analyze the data to determine compliance with the State Spousal Coordination of Benefits policy and report to the State weekly the status of compliance for all spouses enrolled in health coverage.

Response:

c. Please confirm your ability to send data related to disease and health management participants to Truven Health Analytics using the layout referenced in 1(f) above.

Response:

d. For ACO bids only – please confirm your ability and willingness to send supplemental data to Truven Health Analytics using the layout referenced in 1(g) above.

Response:

e. Please confirm your ability and willingness to modify any existing or proposed file layouts as requested to accommodate value based payment models and various engagement and consumerism tools that may be implemented as part of an awarded contract.

Response:

2. Third Party Agreements:
Please confirm that you have global third party agreements in place with Express Scripts, Inc., and Truven Health Analytics, or, indicate your understanding and acceptance that it will be necessary to enter into an agreement before data exchanges can take place.

Response:

3. Indemnity[18]**:**

Please confirm your organization's acceptance. For your response, if you do not accept this indemnity paragraph as written, you must provide a redline of suggested changes. Be advised that the State cannot agree to major changes!

Vendor shall indemnify and hold harmless the State, its agents and employees, from any and all liability, suits, actions or claims, including any claims or expenses with respect to

[18] This is the same indemnity paragraph that is in the *Minimum Requirements* section with the phrase "data security breaches or incidents" inserted.

the resolution of any **data security breaches/ or incidents,** together with all reasonable costs and expenses (including attorneys' fees) directly arising out of (A) the negligence or other wrongful conduct of the vendor, its agents or employees, or (B) vendor's breach of any material provision of this Agreement not cured after due notice and opportunity to cure, provided as to (A) or (B) that (i) vendor shall have been notified in writing by the State of any notice of such claim; and (ii) vendor shall have the sole control of the defense of any action on such claim and all negotiations for its settlement or compromise.

The State shall not indemnify the Vendor in the contact awarded under this RFP or any related contract. Vendor shall not request the State to indemnify or provide quasi-indemnification under any contract. An example of an unacceptable quasi-indemnification provision is:

> The State asserting it is without legal authority to agree to such indemnification, acknowledge that Vendor, on behalf of itself and any affiliate, reserves such rights as it may have to obtain reasonable compensation from the State, against any loss, damage, costs of suit or other expenses resulting from the improper use or disclosure of data or any breach of this Agreement by State.

Response:

4. Security and Encryption:
Computer, network, and information security is of paramount concern for the State and the Department of Technology and Information.

a. Threats - The SANS Institute and the FBI have released a document describing the *Top 20 Internet Security Threats*: http://www.sans.org/critical-security-controls/. Confirm that any systems or software provided by the contractor are free of the vulnerabilities listed in that document. (A response that security threats are always changing is not acceptable.)

Response:

b. Security measures are required by the State of Delaware for the transmission of its data. Please refer to the following policies and respond:

i. **The requirement of at least ten (10) characters in a password is strongly preferred but not required.** If you do not have a ten (10) character password in place at this time, please explain why and if and when your organization will be implementing this security measure. (It is applicable for external access to the vendor's secure website by members/participants and the Statewide Benefits Office personnel. It is not a requirement for the vendor's internal data access system.) The policy document is located at:
http://dti.delaware.gov/pdfs/pp/StrongPasswordStandard.pdf

Response:

ii. Vendors that transmit confidential Delaware data via email must use a secure encryption system. Please confirm your organization has this capability and state the system you use. The following requirements apply: http://dti.delaware.gov/pdfs/pp/SecureEmail.pdf

Response:

iii. It is the State's preference that confidential Delaware data will not be accessible on a mobile devices, but if so, the following requirements apply: http://dti.delaware.gov/pdfs/pp/MobileDeviceEncryptionStandard.pdf Please state whether or not Delaware's confidential data could be, or will be, accessible on mobile devices and state the encryption method that is used.

Response:

5. Single-Sign-On Protocol:

It is the State's intent to use a single-sign-on portal to all health insurance providers from the State's employee and benefits. A link would be placed on the State's secure site that would allow users to connect to the vendor's web site via an SSO process utilizing a SAML 2.0 protocol and via the exchange of metadata between the vendor's Federated Identity Management ("FIM") software and the State's FIM software. Implementation of this feature could be required as soon as CY2017 Open Enrollment in May 2017 for the plan year that begins July 1, 2017.

Do you have the ability to establish a secure sign-on process using mutually agreed secure data elements and that would accurately authenticate users of the State's site before participants attempt to link over to your website? Please provide a detailed explanation of your current capabilities or plans to implement this feature. Would an implementation fund be available to defray any coding or IT costs by your company? Would you be able to meet a completion date as early as May 2017?

Response:

6. Software Inventory:

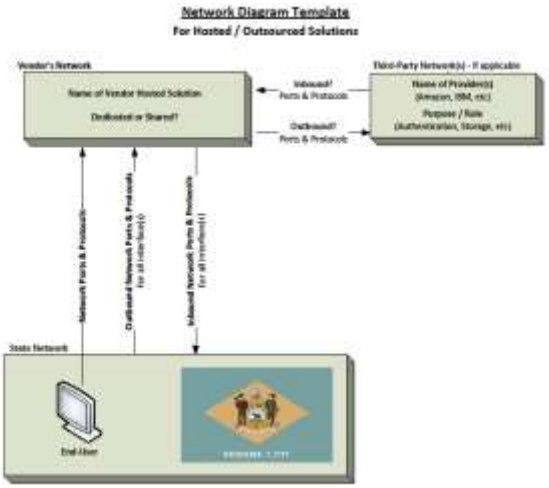
Please use the form at Appendix J – *Software Inventory*, for a list of any software that the Statewide Benefit Office's account management personnel may need. Also list the web browsers (IE) or web service that participants would need to access the customer service interface.

Confirm Attached:

7. Additional Data Requests:
Please confirm your agreement that if you are awarded the contract and then request additional data, whether or not on a file feed or in a report, the State shall determine the cost of supplying the data and may deny the request.

Response:

8. Network Diagram:
As an exhibit, please provide a diagram with ports that clearly documents the user's interaction with your organization's website and the State. The network diagram should follow the following example:



Confirm Attached:

^^

FOR INCUMBENTS ONLY: (Non-Incumbents, proceed to the next section)

Terms and Conditions:
Appendix K - *Non-Public Data - State of Delaware Cloud and/or Offsite Hosting Mandatory Terms and Conditions ("Terms and Conditions")*

Appendix K has two forms. One form is for self-funded plans – all plan designs other than fully-insured plans and Medicare Advantage – wherein the State retains ownership of its data. The second form is for vendors who are bidding on the Medicare Advantage plan; a fully insured plan where data ownership transfers to the vendor. **Therefore, if you are bidding on self-funded plans <u>and</u> fully-insured plans and/or Medicare Advantage, you need to complete both forms even if your responses are similar or identical.**

Please complete the appropriate Appendix K and include it in your bid package. If you have any response other than "accepted" or "confirmed" with an explanation, your response is considered an exception that will be evaluated by the Department of Technology and Information ("DTI"). Provide a detailed explanation and include any specific information as requested.

DTI will not allow changes to a term as it is written on their document, therefore the footnotes contain additional information or instructions for insurance products. **Please be sure to read the footnotes!**

Confirmed Attached:

^^

FOR NON-INCUMBENTS ONLY:

1. Data Confidentiality Agreement -
Within thirty (30) business days of the award (currently scheduled for the mid-November, 2016, SEBC meeting), the *Data Confidentiality Agreement*, Appendix L, must be signed by your organization (and any applicable subcontractor[s]) and approved by DTI.[19] If the document is not approved within thirty (30) business days, the SEBC may rescind the award.[20] For your response, if you do not accept the document as written, you must provide a redline of suggested changes. Be advised that the State cannot agree to major changes!

   Response:

2. Terms and Conditions -
Appendix K - *Non-Public Data - State of Delaware Cloud and/or Offsite Hosting Mandatory Terms and Conditions ("Terms and Conditions")*

   Appendix K has two forms. One form is for self-funded plans – all plan designs other than fully-insured and Medicare Advantage – wherein the State retains ownership of its data. The second form is for vendors who are bidding on the Medicare Advantage plan; a fully insured plan where data ownership transfers to the vendor. **Therefore, if you are bidding on self-funded plans and fully-insured plans and/or Medicare Advantage, you need to complete both forms even if your responses are similar or identical.**

   Please complete the appropriate Appendix K and include it in your bid package. If you have any response other than "accepted" or "confirmed" with an explanation, your response is considered an exception that will be evaluated by the Department of Technology and Information ("DTI"). Provide a detailed explanation and include a citation

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[19] The *Terms and Conditions* form is an attachment to the *Data Confidentiality Agreement*; see Paragraph 2.

[20] This is true, also, for the *Business Associate Agreement*. Refer to the corresponding minimum requirement for more information.

where requested, if applicable (for example, Delaware Department of Insurance or a federal law).

DTI will not allow changes to a term as it is written on their document, therefore the footnotes contain additional information or instructions for insurance products. **Please be sure to read the footnotes!**

Confirmed Attached:

APPENDICES

APPENDIX A

STATE OF DELAWARE NON-COLLUSION STATEMENT

This is to certify that the undersigned vendor has neither directly nor indirectly, entered into any agreement, participated in any collusion or otherwise taken any action in restraint of free competitive bidding in connection with this proposal**, and further certifies that it is not a sub-contractor to another vendor who also submitted a proposal as a primary vendor in response to this solicitation** submitted this date to the State of Delaware, Office of Management and Budget.

It is agreed by the undersigned vendor that the signed delivery of this bid represents the vendor's acceptance of the terms and conditions of this solicitation including all specifications and special provisions.

NOTE: Signature of the authorized representative **MUST** be of an individual who legally may enter his/her organization into a formal contract with the State of Delaware, Office of Management and Budget.

	Corporation
	Partnership
	Individual

COMPANY NAME _____
(Check one)

NAME OF AUTHORIZED REPRESENTATIVE _____

SIGNATURE _____ TITLE _____

COMPANY ADDRESS _____

PHONE NUMBER _____ FAX NUMBER_____

EMAIL ADDRESS _____

FEDERAL E.I. NUMBER _____ STATE OF DELAWARE LICENSE NUMBER_____

	Certification type(s)	Circle all that apply
COMPANY CLASSIFICATIONS: CERT. NO.: _____	Minority Business Enterprise (MBE)	Yes No
	Woman Business Enterprise (WBE)	Yes No
	Disadvantaged Business Enterprise (DBE)	Yes No
	Veteran Owned Business Enterprise (VOBE)	Yes No
	Service Disabled Veteran Owned Business Enterprise (SDVOBE)	Yes No

[The above table is for informational and statistical use only.]

PURCHASE ORDERS SHOULD BE SENT TO (COMPANY NAME): _____

ADDRESS _____

CONTACT _____

PHONE NUMBER _____ FAX NUMBER _____

EMAIL ADDRESS _____

AFFIRMATION: Within the past five years, has your firm, any affiliate, any predecessor company or entity, owner, Director, officer, partner or proprietor been the subject of a Federal, State, Local government suspension or debarment?

YES _____ NO _____ if yes, please explain _____

THIS PAGE SHALL BE SIGNED, NOTARIZED AND RETURNED FOR YOUR BID TO BE CONSIDERED

SWORN TO AND SUBSCRIBED BEFORE ME this _____ day of _____, 20 _____

Notary Public _____My commission expires _____

City of County of State of _____

APPENDIX B

RESPONSES EXCEPTION TRACKING

Responses must include all exceptions to the requirements, specifications, terms or conditions in the *Minimum Requirements* and *Questionnaire* sections. If the vendor is submitting the response without exceptions, please state so below.

☐ By checking this box, the vendor acknowledges that they take no exceptions to the specifications, terms or conditions found in the *Minimum Requirements* and *Questionnaire* sections.

Name of Section, Page # and ? #	(Copied) Term	Detailed Exception	Proposed Alternative, if different

APPENDIX C

PERFORMANCE GUARANTEES

Instructions: If you propose alternative guarantees, performance results, or definitions, please use a strikeout font and insertion. **The State requires bidders to agree to place a minimum amount of at 40.0% of retention charge per contract year at risk for performance guarantees.** The State reserves the right to negotiate both financial and non-financial performance guarantees with the selected vendor.

Implementation: While some implementation activities occur each year, such as reviewing plan design features and issuing employee communications, the bulk of the implementation activities will take place in Year 1. Since a successful program depends on a flawlessly executed implementation, a separate guarantee of 15% on implementation activities is required. This requirement does apply to incumbents.

Terms: Vendor will perform a review of its records to determine whether each standard was met for the time period of the quarter immediately preceding the 45th day of the month following the end of a quarter (for example, November 15 for the first quarter (July 1 – September 30) of the plan year (July 1 to June 30). Quarterly results will be averaged on an annual basis and penalty payments, if any, will be made annually within six (6) months of the end of the plan year. In no instance will a measurement or penalties apply to any period less than a full quarter.

Total at Risk: 40.0% of Retention Charge

and 15.0% for Implementation

Performance	Standard	Performance Measure	Frequency of Reporting	Fee at Risk
Implementation				
Implementation and Account Manager Performance	Implementation manager and account executive /manager will participate in every implementation call and will be prepared to lead the calls, based on detailed agenda sent to team in advance.		n/a	2.0%
Maintenance of Detailed Project Plan	Project plan must delineate due dates, responsible parties and critical linkages between tasks, as appropriate. Project plan will be updated and distributed in		n/a	2.0%

Performance	Standard	Performance Measure	Frequency of Reporting	Fee at Risk
	advance of each implementation weekly call.			
Adherence to key deadlines	All key dates will be met to the extent Vendor has control and/or has notified State of risks of failure in advance of due date. State and Vendor will agree at the beginning of implementation on which deadlines are critical to program success.		n/a	2.0%
Plan Design	Systems will be updated for accurate plan designs in time for State to conduct a pre-implementation audit.		n/a	2.0%
Account Structure	Vendor will be prepared to replicate existing account structure and a conduct meeting with State to review current account structure to ensure it is adequate to meet current reporting needs.		n/a	2.0%
Enrollment Support	Accurate enrollment materials will be distributed to State employees in advance of open enrollment period. To provide accurate information to members of the State of Delaware's Group Health Insurance Program, 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 print communications being mailed or available electronically to State of Delaware members. All communications related to State of		n/a	2.0%

Performance	Standard	Performance Measure	Frequency of Reporting	Fee at Risk
	Delaware annual Open Enrollment (specifically Plan Benefit Booklets, Summary of Benefits and Coverage, Open Enrollment Booklets, plan information) shall be complete and delivered to the Plan Sponsor in advance of the annual Open Enrollment period, provided however, that the State of Delaware provides Vendor final decisions about its intended plan designs not less than 45 days prior to the first day of the Open Enrollment period.			
Initial ID Card Distribution	ID cards will be distributed at least 20 days in advance of effective date.		n/a	1.0%
Customer Service	Customer Service center will be trained and available to respond to employee inquiries prior to the open enrollment period and will remain open and available continuously from that point on.		n/a	2.0%
		Total for Implementation		**15.0%**

Claim Administration/Customer Service				
Turnaround Time for Claims	Percentage of Claims Processed in 30 days.	95% - 97%	Monthly	1.5%
Financial Payment Accuracy	Percentage of claims paid accurately (Total dollars of audited claims paid minus sum of absolute dollar value of all over/under	97% - 99%	Monthly	1.5%

Performance	Standard	Performance Measure	Frequency of Reporting	Fee at Risk
	payments] divided by the total dollars of audited claims paid.)			
Procedural Accuracy	Coding accuracy per month (Coding error that results in an incorrect payment of a claim. Formula = total number correct claims/total number of claims audited)	98.0%	Monthly	1.5%
Payment Incident Accuracy	Average year end accuracy (Number of correct audited payments/total number of payments audited)	97.5%	Annually	1.5%
Open Issue Resolution Time	The percentage of open inquiries completed within the stated number of days from initial receipt date to resolution date.	95.0% within 2 business days 98.0% within 5 business days	Quarterly	1.0%
Overpayment Recovery	The percentage of overpaid funds recovered within the stated number days.	85.0% recovered within 120 calendar days	Quarterly	0.5%
Telephone Response Time	Maintain an average speed of answer of 30 seconds or less from the time of selection to speak to a live representative via the IVR system to the time a live person is on the line.	30 seconds or less Book of Business	Monthly	1.0%

Performance	Standard	Performance Measure	Frequency of Reporting	Fee at Risk
Call Abandonment Rate	Calculated automatically via automatic telephone call distribution system.	2% Book of Business	Monthly	0.25%
Eligibility/Transfer Accuracy	Percentage of updates processed accurately	95% - 97%	Monthly	0.5%
Timely Submission of Data to Data Mining Vendor	Claims and eligibility sent by the 15th of the month	Claims and Enrollment files: 90% timely	Monthly	0.5%
ID Card Distribution (routinely throughout the plan year)	Percentage mailed within 10 days of data receipt	97% - 99%	Monthly (This PG will be evaluated in the first year of the contract for a May 2017 OE.)	0.25%
ID Card Distribution (open enrollment)	Percentage mailed within 10 days of data receipt	97% - 99%	Annually (This PG will be evaluated in the first year of the contract for a May 2017 OE.)	0.25%

Performance	Standard	Performance Measure	Frequency of Reporting	Fee at Risk
Coordination of Benefits (weekly) No-Form List	Weekly list of all contract holders/spouses non-compliant as have not submitted S-COB form	95%	Weekly (This PG will be evaluated in the first year of the contract for a May 2017 OE.)	Accuracy:[21] 1.25% Timeliness: 1.25%
Coordination of Benefits (weekly) Sanctioned Spouse List[22]	Weekly list of all contract holders whose spouses are sanctioned because non-compliance with the S-COB policy.	95%	Weekly (This PG will be evaluated in the first year of the contract for a May 2017 OE.)	Accuracy: 1.25% Timeliness: 1.25%
Coordination of Benefits (open enrollment)	List of contract holders effective 7/1 that are non-compliant (no form and sanctioned) with the S-COB policy. If the State provides all forms electronically, the due date is 6-15. If the State provides both electronic and paper	100%	Annually (This PG will be evaluated in the first year of the contract for a May 2017 OE.)	Accuracy: 1.25% Timeliness: 1.25%

[21] Accuracy with respect to the COB Guarantees shall be measured by terms mutually agreed to upon by the State and Vendor.

[22] The vendor must make a determination, either manually or by an automated system, for the non-compliance status which is defined as State members who have not completed and returned the State's S-COB form. The S-COB policy and S-COB form are available at http://ben.omb.delaware.gov/documents/cob.

Performance	Standard	Performance Measure	Frequency of Reporting	Fee at Risk
	forms, the due date is 6-22.			
Data Security	Regularly advise the State of any changes in status regarding implementation of required data security procedures.	100%	On-going	1.0%
Timeliness of Responding to CMS Demands	Provide written response to CMS or third party vendor (MSPRC) within 45 days of date demand is issued.	98%	On-going	0.25%
Member Satisfaction Survey	Positive Response Rate	85% or higher	Annually	0.25%
Enrollment Support for Open Enrollment	Accurate enrollment materials will be distributed to State employees in advance of open enrollment period. Vendor's participation in benefit representative meetings, health fairs, etc., at State's request; Customer Service staff trained to respond to concerns regarding plan design, programs.		Annually (This PG will be evaluated in the first year of the contract for a May 2017 OE.)	0.25%
Customer Service	Customer Service Center staff will be trained and available to respond to employee	Customer Service Center staff will be	On-going (This PG will be evaluated	0.50%

Performance	Standard	Performance Measure	Frequency of Reporting	Fee at Risk
	inquiries and will remain open and available 8:30 a.m. to 7:00 p.m. Monday through Friday, EST.	trained and available to respond to employee inquiries and will remain open and available 8:30 a.m. to 7:00 p.m. Monday through Friday, EST. (Excludes: Emergency or Weather Related Office Closings)	in the first year of the contract for a May 2017 OE.)	
First Call Resolution	90% of calls will be closed on the same day as received with no returned call for the same reason by the same individual within 30 calendar days.	The percentage of calls closed on the same day as received with no returned call for the same reason by the same individual within 30 calendar days.	Quarterly	0.5%
Open Issue Resolution Time	95.0% within 2 business days 98.0% within 5 business days	The percentage of open inquires completed within the	Quarterly	1.0%

Performance	Standard	Performance Measure	Frequency of Reporting	Fee at Risk
		stated number of days from initial receipt date to resolution date		
Reporting (See Attachment 1, *Master Report List*)	Complete and Timely Submission of accurate reports, as defined in Attachment 1, *Master Report List*.[23]	Complete, accurate and timely submission of reports, as defined in Attachment 1, *Master Report List*, unless agreed to in writing by the State and Vendor.	Per Attachment 1, *Master Report List*	Accuracy: 1.25% Timeliness: 1.25%
Data Submission from TPA to DHIN, ACOs	Timely submission of data (enrollment/attribution, medical and Rx claim files) from TPA to DHIN and ACOs (if offered by vendor as part of the network for the State) by the 15th of each month (or timing mutually agreed to by the State of Delaware and TPA)	100% of data submissions within 5 days of due date (15th of the month)	Monthly	3.50%
Account Management				

[23] Those items listed in Attachment 1, *Master Report List*, which also appear separately on this Performance Guarantee appendix, will be excluded from this specific standard.

Performance	Standard	Performance Measure	Frequency of Reporting	Fee at Risk
Account Management Satisfaction[24]	Score of 3.0 or higher on the State's Account Management Survey Form.	2.9-2.5=.75% 2.4-2.0=1.5% <2.0=2.50%	Quarterly	2.5%
Network Management and Development				
Credentialing	Every network provider or facility must be re-credentialed at least every three years. (Letter from Vendor at the end of each contract year confirming compliance with credentialing requirements.)	Every network provider or facility must be re-credentialed at least every three years	Annually	2.0%
Financial Guarantees				
In-Network Guarantee (PPO and CDHP)	Percentage of incurred claim payments (incurred July – June paid July – August) (incurred 12 and paid 14) plus an appropriate estimate for incurred but unpaid claim expense in-network, for non-Medicfill contracts.	95%	Annually	4.0%

[24] Overall Account Management performance will be measured quarterly, and the annual performance determination will be based on the arithmetic mean of the quarterly measurements.

Performance	Standard	Performance Measure	Frequency of Reporting	Fee at Risk
Trend reduction through value-based contracting	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.	0.5% in Year 1 1.0% in Year 2 and each year afterward	Annually	4.0%
			Total	**40.0%**

Performance Guarantees
Disease and Care Management Program

The SEBC wishes to measure and improve the clinical outcomes of its members via the use of accountable care contracting, care management and or requires a guaranteed return on investment for your proposed disease management programs. The table below has been constructed to address several significant drivers of health care cost and quality (e.g., high cost claimants, higher admission and ER use rates, depression, better chronic care for diabetes and members at risk for cardiac disease as well as prevention screening). Your proposed performance guarantees should be based off a percent of the disease and care management administration fee rather than the overall administration fee.

Instructions: Please respond to the table below with your best proposed fees at risk and target goals. If you propose alternative guarantees, performance results, or definitions, please use a strikeout font and insertion. Please reply at the end of each numbered section where you are prompted with "Response". The State reserves the right to negotiate both financial and non-financial performance guarantees with the selected vendor.

Table 1: Performance Guarantees

Metric	National Quality Forum Measure #	Performance Guarantee	Fees at Risk
Case Management Outreach		__%	% / $
Case Management Enrollment (2 two way conversations)		__%	% / $
Disease Management Program Enrollment		__%	% / $
High Cost Claimant Program Enrollment (high cost claimants >$50K)		__%	% / $
Pediatric Vaccinations	38	A __% improvement in the non-adherent population or achieve a target HEDIS benchmark (e.g., 50th or 75th)	% / $
Breast Cancer Screening	2372	A __% improvement in the non-adherent population or achieve a target HEDIS benchmark (e.g., 50th or 75th)	% / $

Metric	National Quality Forum Measure #	Performance Guarantee	Fees at Risk
Clinical Impact – Adult Asthma compliance	1799	A __% improvement in the non-adherent population or achieve a target HEDIS benchmark (e.g., 50th or 75th)	% / $
Clinical Impact – Adult Diabetes (A1c greater than 9%)	59	A __% improvement in the non-adherent population or achieve a target HEDIS benchmark (e.g., 50th or 75th)	% / $
Clinical Impact – Adult Diabetes (LDL cholesterol screening)	64	A __% improvement in the non-adherent population or achieve a target HEDIS benchmark (e.g., 50th or 75th)	% / $
Clinical Impact – CAD (LDL cholesterol screening)	543	A __% improvement in the non-adherent population or achieve a target HEDIS benchmark (e.g., 50th or 75th)	% / $
Colorectal Cancer screening		A __% improvement in the non-adherent population (regardless of whether the screening is preventive OR diagnostic) or achieve target HEDIS benchmark (e.g., 50th or 75th)	% / $
C-section Rates (NTSV)	471	A __% improvement or achieve a target benchmark (e.g., 50th or 75th)	% / $
Depression screening and remission rates at 12 months	711	A __% improvement in the non-adherent population or achieve a target benchmark (e.g., 50th or 75th)	% / $
Obesity screening and referral	421	A __% improvement in the non-adherent population or achieve a target benchmark (e.g., 50th or 75th)	% / $
Generic Fill Rate		A __% improvement in the non-adherent population or achieve a target national benchmark (e.g., 50th or 75th)	% / $
MRI use in Lower Back Pain	52	A __% improvement in the non-adherent population or achieve a target national benchmark (e.g., 50th or 75th)	% / $

Metric	National Quality Forum Measure #	Performance Guarantee	Fees at Risk
Inpatient Admission /1000		A __% improvement in the non-adherent population or achieve a target national benchmark (e.g., 50th or 75th)	% / $
Inpatient Readmission 30 day all cause per 1000	1768	A __% improvement in the non-adherent population or achieve a target national benchmark (e.g., 50th or 75th)	% / $
Member Satisfaction		Average of 4 or better on a 5 point scale	% / $
Total			% / $

APPENDIX D

TREND GUARANTEE

Instructions: Please review and confirm your acceptance of the following trend guarantee, filling in blank spaces in the charts below as appropriate and based on the guarantees you are willing to offer the State, which will be effective for the initial term of the contact (i.e., July 1, 2017 – June 30, 2020, for all plans except Medicare Supplement and Medicare Advantage) ***plus*** the optional two (2) one-year renewal periods (i.e., the following trend guarantee will be applicable for up to the first five (5) years of the Vendor's contract with the State). If you propose alternative guarantees, performance results, or definitions, please use a strikeout font and insertion and provide response below.

Vendor will provide a multiple year Claim Trend Guarantee developed by reviewing the State's full year 2016 actual claims experience for a continuously enrolled population, applying an age/gender adjustment, an incremental reduction in trend based on the application of Vendor programs designed to lower the State's claim costs. As part of the offer, Vendor will develop a Guaranteed Multi-Year Trend Factor and/or a regional or national benchmark goal (e.g., regional medical CPI plus/minus) which will be the basis of the guarantees beyond 2017.

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.

Vendor's trend projection is based upon the current programs implemented by the State as outlined in the final executed contract between the Vendor and the State. If the State elects new programs adjustments will be made to the State's 2016 incurred covered charges (factors are multiplicative – not additive). If the State does not elect certain programs promoted or offered by the TPA, the trend projection will not be adjusted.

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)					

(continued on the next page)

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%

Response:

APPENDIX E

OFFICER CERTIFICATION FORM

Please have an officer of your company review and sign this worksheet to confirm the information is valid. Please include completed form with proposal.

Officer's Statement	
Company's Legal Name	
Company's Marketing Name (if different)	
Street Address	
City	
State	
Zip	
Phone Number	
Fax Number	
Email Address	
Name of Officer Completing Statement	
Title of Officer Completing Statement	
Phone Number of Officer Completing Statement	
Email Address of Officer Completing Statement	

I certify that our response to the State of Delaware's Request for Proposal for a Medical Third Party Administrator, OMB16001-Health_Ins, is complete and accurate to the best of my knowledge and contains no material omissions or misstatements. I acknowledge that the State of Delaware will rely upon the information included in our response to make decisions concerning the administration of these benefits that are offered to their employees.

_____

Officer's Signature

_____

Date Signed

APPENDIX F

RFP TERMS AND CONDITIONS EXCEPTION TRACKING CHART

Responses must include all exceptions to the specifications, terms or conditions in the *Scope of Services* and *Terms and Conditions* section – not the *Minimum Requirements* and *Questionnaire* sections. If the vendor is submitting their response without exceptions, please state so below.

☐ By checking this box, the vendor acknowledges that they take no exceptions to the specifications, terms or conditions found in the *Scope of Services* and *Terms and Conditions* section.

Page and ? #s	(Copied) Term	Detailed Exception	Proposed Alternative, if different

APPENDIX G

SUBCONTRACTOR INFORMATION FORM

PART I – STATEMENT BY PROPOSING VENDOR		
1. CONTRACT NO.	2. Proposing Vendor Name:	3. Mailing Address
4. SUBCONTRACTOR		
a. NAME	4c. Company OSD Classification: Certification Number: _____	
b. Mailing Address:	4d. Women Business Enterprise ☐ Yes ☐ No 4e. Minority Business Enterprise ☐ Yes ☐ No 4f. Disadvantaged Business Enterprise ☐ Yes ☐ No 4g. Veteran Owned Business Enterprise ☐ Yes ☐ No 4h. Service Disabled Veteran Owned Business Enterprise ☐ Yes ☐ No	
5. DESCRIPTION OF WORK BY SUBCONTRACTOR		

6a. NAME OF PERSON SIGNING	7. BY (*Signature)*	8. DATE SIGNED
6b. TITLE OF PERSON SIGNING		

PART II – ACKNOWLEDGEMENT BY SUBCONTRACTOR		
9a. NAME OF PERSON SIGNING	10. BY (*Signature*)	11. DATE SIGNED
9b. TITLE OF PERSON SIGNING		

APPENDIX H

EMPLOYING DELAWAREANS REPORT[25]

As required by House Bill # 410 (Bond Bill) of the 146th General Assembly and under Section 30, no bid for any public works or professional services contract shall be responsive unless the prospective bidder discloses its reasonable, good-faith determination of:

1.	Number of employees that would reasonably be anticipated to be employed on this account.	
2.	Percentage of such employees who are *bona fide* legal residents of Delaware.	
3.	Total number of employees of the bidder.	
4.	Total percentage of employees who are *bona fide* residents of Delaware.	

If subcontractors are to be used:

1.	Number of employees who are residents of Delaware.	
2.	Percentage of employees who are residents of Delaware.	

[25] The number of Delawareans employed by your organization are not taken into consideration during the evaluation or scoring of your bid.

APPENDIX I

FINANCIAL RATINGS

Carrier's most recent rating or filing (identify date) from the following agencies:

Vendor Ratings	Rating
A.M. Best: Rating Status	
Financial Rating (if rated)	
Date (if rated; if not rated, leave response cell blank)	
Standard & Poors: Rating Status	
Financial Rating (if rated)	
Date (if rated; if not rated, leave response cell blank)	
Fitch (formerly Duff and Phelps): Rating Status	
Financial Rating (if rated)	
Date (if rated; if not rated, leave response cell blank)	
Moody's: Rating Status	
Financial Rating (if rated)	
Date (if rated; if not rated, leave response cell blank)	

1. Has there been any change in your organization's ratings in the last two years? If yes, please explain the nature and reason(s) for the change.

2. Are there any outstanding legal actions pending against your organization? If so, please explain the nature and current status of the action(s).

3. What fidelity and surety insurance or bond coverage does your organization carry to protect your clients? Specifically describe the type and amount of the fidelity bond insuring your employees, which would protect this plan in the event of a loss.

4. Does your organization agree to furnish a copy of all such policies for review by legal counsel if requested?

5. Do you anticipate any mergers, transfer of company ownership, sales management reorganizations, or departure of key personnel within the next three (3) years that might affect your ability to carry out your proposal if it results in a contract with the State of Delaware? If yes, please explain.

6. Is your Company affiliated with another company? If yes, please describe the relationship.

APPENDIX J

SOFTWARE INVENTORY

Please list any software that the Statewide Benefit Office's account management personnel may need. Also list the web browsers (IE) or web service that participants would need to access the customer service interface.

Software or IE Product Name	Version	Vendor	Required for Account Mgt Personnel?	Required for Customer Interface?
Example: Internet Explorer	IE8 in Compatibility Mode	Microsoft	Yes	Yes

Appendix K

NON-PUBLIC DATA - STATE OF DELAWARE CLOUD AND/OR OFFSITE HOSTING MANDATORY TERMS AND CONDITIONS

DATA OWNED BY THE STATE – SELF-FUNDED PLANS

1. **Data Ownership:** The State of Delaware shall own all right, title and interest in its data that is related to the services provided by this contract. The Service Provider (Contractor) shall not access State of Delaware User accounts, or State of Delaware Data, except (i) in the course of data center operations, (ii) in response to service or technical issues, (iii) as required by the express terms of this contract, or (iv) at State of Delaware's written request.

   Response:

2. **Data Protection:** Protection of personal privacy and sensitive data shall be an integral part of the business activities of the Service Provider to ensure that there is no inappropriate or unauthorized use of State of Delaware information at any time. To this end, the Service Provider shall safeguard the confidentiality, integrity, and availability of State information and comply with the following conditions:

   a) All information obtained by the Service Provider under this contract shall become and remain property of the State of Delaware. At no time shall any data or processes which either belongs to or are intended for the use of State of Delaware or its officers, agents, or employees, be copied, disclosed, or retained by the Service Provider or any party related to the Service Provider for subsequent use in any transaction that does not include the State of Delaware.

   b) At no time shall any data or processes which either belongs to or are intended for the use of State of Delaware or its officers, agents, or employees, be copied, disclosed, or retained by the Service Provider or any party related to the Service Provider for subsequent use in any transaction that does not include the State of Delaware.

   Response:

3. **Data Location**: The Service Provider shall not store or transfer non-public State of Delaware data outside of the United States. This includes backup data and Disaster Recovery locations. The Service Provider will permit its personnel and contractors to access State of Delaware data remotely only as required to provide technical support. It is explicitly forbidden for the primary contractor or subcontractor staff to "share" access privileges. The awarded vendor will be required to comply with the Offshore IT Staffing Policy:

http://dti.delaware.gov/pdfs/pp/OffshoreITStaffingPolicy.pdf The primary contractor must reside in the United States and servers that store Delaware data cannot be located offshore.[26]

Response:

4. **Encryption:**

a) **Data in Transit**: The Service Provider shall encrypt all non-public data in transit regardless of the transit mechanism. The policy documents are located at:
http://dti.delaware.gov/pdfs/pp/SecureFileTransport.pdf
http://dti.delaware.gov/pdfs/pp/DataClassificationPolicy.pdf

Response:

b) **Encryption at Rest**: For engagements where the Service Provider stores sensitive personally identifiable or otherwise confidential information, this **data shall be encrypted at rest**. The policy document is located at:
http://dti.delaware.gov/pdfs/pp/WebApplicationSecurity.pdf
Examples are: social security number, date of birth, driver's license number, financial data, federal/state tax information, and hashed passwords. The Service Provider's encryption shall be consistent with validated cryptography standards as specified in National Institute of Standards and Technology FIPS140-2, Security Requirements. The key location and other key management details will be discussed and negotiated by both parties.

When the Service Provider cannot offer encryption at rest, they must maintain, for the duration of the contract, cyber security liability insurance coverage[27] for any loss resulting from a data breach in accordance with the Cloud and Offsite Hosting Policy, http://dti.delaware.gov/pdfs/pp/CloudandOffsiteHostingPolicy.pdf. **Additionally**, where encryption of data at rest is not possible, the vendor must describe existing security measures that provide a similar level of protection.

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[26] However, if a call center or claims processing office, for example, is located offshore, the transmission of data via secured means is acceptable if the secure transit mechanism that you are asked to describe is approved by the State. Describe your organization's relationship with any offshore staff, either as employees of your company or that of any subcontractor. State the scope (number and location) of the personnel, their role, and the process of data exchange, including a description of the data security measures.

[27] The level of coverage is determined by the number of enrolled lives at $148 each. Depending on the contract(s) and plan designs awarded, proof of insurance is required at the time of award. If you have cyber liability insurance coverage (even if you have encryption-at-rest), please provide a copy as an exhibit. Please see the table at the end of this appendix for the number of coverage lives per plan design and coverage level.

Response:

5. **Breach Notification and Recovery**: Delaware Code requires public breach notification when citizens' personally identifiable information is lost or stolen. (Reference: 6 Del. C. § 12B-102. http://delcode.delaware.gov/title6/c012b/index.shtml) Additionally, unauthorized access or disclosure of non-public data is considered to be a breach. The Service Provider will provide notification without unreasonable delay and all communication shall be coordinated with the State of Delaware. When the Service Provider or their sub-contractors are liable for the loss, the Service Provider shall bear all costs associated with the investigation, response and recovery from the breach including but not limited to credit monitoring services with a term of at least three (3) years[28], mailing costs, website, and toll free telephone call center services. The State of Delaware shall not agree to any limitation on liability that relieves a Contractor from its own negligence or to the extent that it creates an obligation on the part of the State to hold a Contractor harmless.

   Response:

6. **Notification of Legal Requests**: The Service Provider shall contact the State of Delaware upon receipt of any electronic discovery, litigation holds, discovery searches, and expert testimonies related to, or which in any way might reasonably require access to the data of the State. The Service Provider shall not respond to subpoenas, service of process, and other legal requests related to the State of Delaware without first notifying the State unless prohibited by law from providing such notice.[29]

   Response:

7. **Termination and Suspension of Service:** In the event of termination of the contract, the Service Provider shall implement an orderly return of State of Delaware data in CSV or XML or another mutually agreeable format. The Service Provider shall guarantee the subsequent secure disposal of State of Delaware data.

   a) **Suspension of Services**: During any period of suspension or contract negotiation or disputes, the Service Provider shall not take any action to intentionally erase any State of Delaware data.

      Response:

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[28] **Three years is non-negotiable**.

[29] This includes Freedom of Information Act (FOIA) requests.

b) **Termination of any Services or Agreement in Entirety**:[30] In the event of termination of any services or agreement in entirety, the Service Provider shall not take any action to intentionally erase any State of Delaware data for a period of ninety (90) days after the effective date of the termination. After such 90 day period, the Service Provider shall have no obligation to maintain or provide any State of Delaware data and shall thereafter, unless legally prohibited, dispose of all State of Delaware data in its systems or otherwise in its possession or under its control as specified in section 7d) below. Within this ninety (90) day timeframe, vendor will continue to secure and back up State of Delaware data covered under the contract.

Response:

c) **Post-Termination Assistance**: The State of Delaware shall be entitled to any post-termination assistance generally made available with respect to the Services unless a unique data retrieval arrangement has been established as part of the Service Level Agreement[31].

Response:

d) **Secure Data Disposal**: When requested by the State of Delaware, the provider shall destroy all requested data in all of its forms, for example: disk, CD/DVD, backup tape, and paper. Data shall be permanently deleted and shall not be recoverable according to National Institute of Standards and Technology. The policy document is located at: http://dti.delaware.gov/pdfs/pp/DisposalOfElectronicEquipmentAndStorageMedia.pdf

Response:

8. **Background Checks:** The Service Provider shall conduct criminal background checks and not utilize any staff, including sub-contractors, to fulfill the obligations of the contract who has been convicted of any crime of dishonesty, including but not limited to criminal fraud, or otherwise convicted of any felony or any misdemeanor offense for which incarceration for a minimum of one (1) year is an authorized penalty. The Service Provider shall promote and

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30 The State acknowledges that the ninety (90) day requirement is not applicable to insurance products. That timeframe is replaced with the following: Service Provider will retain the data for business processing reasons, such as claims run-out for twelve (12) months or until federal regulatory or Delaware Insurance Code requirements have been satisfied. The State of Delaware acknowledges that, pursuant to 42 CFR 423.505, the Center for Medicare Services ("CMS") requires retention for the current year plus ten (10) years.

31 A service level agreement is defined as a contract.

maintain an awareness of the importance of securing the State's information among the Service Provider's employees and agents.

Response:

9. **Data Dictionary:** Prior to go-live,[32] the Service Provider shall provide a data dictionary in accordance with the State of Delaware Data Modeling Standard at http://dti.delaware.gov/pdfs/pp/DataModelingStandard.pdf

Response:

10. **Security Logs and Reports:** The Service Provider shall allow the State of Delaware access to system security logs that affect this engagement, its data and or processes. This includes the ability for the State of Delaware to request a report of the records that a specific user accessed over a specified period of time.

Response:

11. **Contract Audit:** The Service Provider shall allow the State of Delaware to audit conformance including contract's terms[33], system security and data centers as appropriate. The State of Delaware may perform this audit or contract with a third party at its discretion at the State's expense. Such reviews shall be conducted with at least thirty (30) days advance written notice and shall not unreasonably interfere with the Service Provider's business.

Response:

12. **Sub-Contractor Disclosure:** The Service Provider shall identify all of its **strategic business partners** related to services provided under this contract, including but not limited to, all subcontractors or other entities or individuals who may be a party to a joint venture or similar agreement with the Service Provider, who will be involved in any application development and/or **operations**.[34]

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[32] In this instance, "go live" means that if your organization is awarded the contract, for Delaware data only, upon approval by the State, and before the first data exchange.

[33] This would be only for the technology and data security terms in the contract.

[34] In order to comply with the requirement for "operations", any company that **delivers technology services** for the State's account would have access to the data and therefore is subject to all the requirements in this Section. Examples would be claims processor(s) and companies that lease a software platform with data storage. The company must provide their business information with a detailed description of the services provided on a signed

Response to 12:

13. **<u>Operational Metrics</u>:** The Service Provider and the State of Delaware shall reach agreement on operational metrics and document said metrics in the Service Level Agreement. Examples include but are not limited to:
    a) Advance notice and change control for major upgrades and system changes
    b) System availability/uptime guarantee/agreed-upon maintenance downtime
    c) Recovery Time Objective/Recovery Point Objective
    d) Security Vulnerability Scanning

Response to 13:

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Supplement to Footnote Referenced in #5 – Cyber Liability Insurance Coverage Levels

Proposal:	**# of Covered Lives**	**Required Cyber Liability Ins**
All Self-Funded Plans <u>except</u> Medicare Supplement	98,000	$ 14,504,000
Medicare Supplement o<u>nly</u>	24,500	$ 3,626,000
All Plans <u>including</u> Medicare Supplement	122,500	$ 18,130,000

Subcontractor form <u>and</u> respond to the requirements in the entire *Technical Standards and Security Requirements* section with applicable appendices in a separate document. Please confirm your understanding of this requirement, list the subcontractor's business information, and describe in detail the technology services that would be provided including how the data is accessed.

Appendix K

NON-PUBLIC DATA - STATE OF DELAWARE CLOUD AND/OR OFFSITE HOSTING MANDATORY TERMS AND CONDITIONS

DATA OWNED BY THE VENDOR – FULLY INSURED PLANS

1. **Data Ownership:** The State of Delaware shall own all right, title and interest in its data that is related to the services provided by this contract.[35]

   The Service Provider (Contractor) shall not access State of Delaware User accounts, or State of Delaware Data, except (i) in the course of data center operations, (ii) in response to service or technical issues, (iii) as required by the express terms of this contract, or (iv) at State of Delaware's written request.

   Response:

2. **Data Protection:** Protection of personal privacy and sensitive data shall be an integral part of the business activities of the Service Provider to ensure that there is no inappropriate or unauthorized use of State of Delaware information at any time. To this end, the Service Provider shall safeguard the confidentiality, integrity, and availability of State information and comply with the following conditions:

   a) All information[36] obtained by the Service Provider under this contract shall become and remain property of the State of Delaware. At no time shall any data or processes which either belongs to or are intended for the use of State of Delaware or its officers, agents, or employees, be copied, disclosed, or retained by the Service Provider or any party related to the Service Provider for subsequent use in any transaction that does not include the State of Delaware.

   b) At no time shall any data or processes which either belongs to or are intended for the use of State of Delaware or its officers, agents, or employees, be copied, disclosed, or retained by the Service Provider or any party related to the Service Provider for subsequent use in any transaction that does not include the State of Delaware.

   Response:

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[35] The State of Delaware acknowledges that the ownership of the data transfers to your organization when the data is under your control. Therefore, this statement does not apply. However, please respond to the second paragraph.

[36] In this instance, "information" does not include the vendor's confidential claims data.

3. **Data Location**: The Service Provider shall not store or transfer non-public State of Delaware data outside of the United States. This includes backup data and Disaster Recovery locations. The Service Provider will permit its personnel and contractors to access State of Delaware data remotely only as required to provide technical support. It is explicitly forbidden for the primary contractor or subcontractor staff to "share" access privileges.
The awarded vendor will be required to comply with the Offshore IT Staffing Policy: http://dti.delaware.gov/pdfs/pp/OffshoreITStaffingPolicy.pdf The primary contractor must reside in the United States and servers that store Delaware data cannot be located offshore.[37]

Response:

4. **Encryption:**

b) **Data in Transit**: The Service Provider shall encrypt all non-public data in transit regardless of the transit mechanism. The policy documents are located at:
http://dti.delaware.gov/pdfs/pp/SecureFileTransport.pdf
http://dti.delaware.gov/pdfs/pp/DataClassificationPolicy.pdf

Response:

b) **Encryption at Rest**:[38] For engagements where the Service Provider stores sensitive personally identifiable or otherwise confidential information, this **data shall be encrypted at rest**. The policy document is located at:
http://dti.delaware.gov/pdfs/pp/WebApplicationSecurity.pdf
Examples are: social security number, date of birth, driver's license number, financial data, federal/state tax information, and hashed passwords. The Service Provider's encryption shall be consistent with validated cryptography standards as specified in National Institute of Standards and Technology FIPS140-2, Security Requirements. The key location and other key management details will be discussed and negotiated by both parties.

When the Service Provider cannot offer encryption at rest, they must maintain, for the duration of the contract, cyber security liability insurance coverage for any loss resulting from a data breach in accordance with the Cloud and Offsite Hosting Policy,

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[37] However, if a call center or claims processing office, for example, is located offshore, the transmission of data via secured means is acceptable if the secure transit mechanism that you are asked to describe is approved by the State. Describe your organization's relationship with any offshore staff, either as employees of your company or that of any subcontractor. State the scope (number and location) of the personnel, their role, and the process of data exchange, including a description of the data security measures.

[38] **IMPORTANT!** Because the ownership of the data transfers to the vendor when it leaves the State's control for fully-insured plans, the State does not require encryption-at-rest or cyber liability insurance coverage. However, DTI does require *information* regarding your security measures for data at rest as set forth above.

http://dti.delaware.gov/pdfs/pp/CloudandOffsiteHostingPolicy.pdf. **Additionally**, where encryption of data at rest is not possible, the vendor must describe existing security measures that provide a similar level of protection.

Response:

5. **Breach Notification and Recovery**: Delaware Code requires public breach notification when citizens' personally identifiable information is lost or stolen. (Reference: 6 Del. C. § 12B-102. http://delcode.delaware.gov/title6/c012b/index.shtml) Additionally, unauthorized access or disclosure of non-public data is considered to be a breach. The Service Provider will provide notification without unreasonable delay and all communication shall be coordinated with the State of Delaware. When the Service Provider or their sub-contractors are liable for the loss, the Service Provider shall bear all costs associated with the investigation, response and recovery from the breach including but not limited to credit monitoring services with a term of at least three (3) years[39], mailing costs, website, and toll free telephone call center services. The State of Delaware shall not agree to any limitation on liability that relieves a Contractor from its own negligence or to the extent that it creates an obligation on the part of the State to hold a Contractor harmless.

   Response:

6. **Notification of Legal Requests**: The Service Provider shall contact the State of Delaware upon receipt of any electronic discovery, litigation holds, discovery searches, and expert testimonies related to, or which in any way might reasonably require access to the data of the State. The Service Provider shall not respond to subpoenas, service of process, and other legal requests related to the State of Delaware without first notifying the State unless prohibited by law from providing such notice.[40]

   Response:

7. **Termination and Suspension of Service:** In the event of termination of the contract, the Service Provider shall implement an orderly return of State of Delaware data in CSV or XML or another mutually agreeable format. The Service Provider shall guarantee the subsequent secure disposal of State of Delaware data.

   a) **Suspension of Services**: During any period of suspension or contract negotiation or disputes, the Service Provider shall not take any action to intentionally erase any State of Delaware data.

      Response:

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[39] **Three years is non-negotiable.**

[40] This includes Freedom of Information Act (FOIA) requests.

b) **Termination of any Services or Agreement in Entirety**:[41] In the event of termination of any services or agreement in entirety, the Service Provider shall not take any action to intentionally erase any State of Delaware data for a period of ninety (90) days after the effective date of the termination. After such 90 day period, the Service Provider shall have no obligation to maintain or provide any State of Delaware data and shall thereafter, unless legally prohibited, dispose of all State of Delaware data in its systems or otherwise in its possession or under its control as specified in section 7d) below. Within this ninety (90) day timeframe, vendor will continue to secure and back up State of Delaware data covered under the contract.

Response:

c) **Post-Termination Assistance**: The State of Delaware shall be entitled to any post-termination assistance generally made available with respect to the Services unless a unique data retrieval arrangement has been established as part of the Service Level Agreement.[42]

Response:

d) **Secure Data Disposal**: When requested by the State of Delaware, the provider shall destroy all requested data in all of its forms, for example: disk, CD/DVD, backup tape, and paper. Data shall be permanently deleted and shall not be recoverable according to National Institute of Standards and Technology. The policy document is located at: http://dti.delaware.gov/pdfs/pp/DisposalOfElectronicEquipmentAndStorageMedia.pdf

Response:

8. **Background Checks:** The Service Provider shall conduct criminal background checks and not utilize any staff, including sub-contractors, to fulfill the obligations of the contract who has been convicted of any crime of dishonesty, including but not limited to criminal fraud, or otherwise convicted of any felony or any misdemeanor offense for which incarceration for a minimum of one (1) year is an authorized penalty. The Service Provider shall promote and

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[41] The State acknowledges that the ninety (90) day requirement is not applicable to insurance products. That timeframe is replaced with the following: Service Provider will retain the data for business processing reasons, such as claims run-out for twelve (12) months or until federal regulatory or Delaware Insurance Code requirements have been satisfied. The State of Delaware acknowledges that, pursuant to 42 CFR 423.505, the Center for Medicare Services ("CMS") requires retention for the current year plus ten (10) years.

[42] A service level agreement is defined as a contract.

maintain an awareness of the importance of securing the State's information among the Service Provider's employees and agents.

Response:

9. **Data Dictionary:** [43] Prior to go-live, the Service Provider shall provide a data dictionary in accordance with the State of Delaware Data Modeling Standard at http://dti.delaware.gov/pdfs/pp/DataModelingStandard.pdf

   Response: N/A

10. **Security Logs and Reports:** The Service Provider shall allow the State of Delaware access to system security logs that affect this engagement, its data and or processes. This includes the ability for the State of Delaware to request a report of the records that a specific user accessed over a specified period of time.

    Response:

11. **Contract Audit:** The Service Provider shall allow the State of Delaware to audit conformance including contract's terms[44], system security and data centers as appropriate. The State of Delaware may perform this audit or contract with a third party at its discretion at the State's expense. Such reviews shall be conducted with at least thirty (30) days advance written notice and shall not unreasonably interfere with the Service Provider's business.

    Response:

12. **Sub-Contractor Disclosure:** The Service Provider shall identify all of its **strategic business partners** related to services provided under this contract, including but not limited to, all subcontractors or other entities or individuals who may be a party to a joint venture or similar agreement with the Service Provider, who will be involved in any application development and/or **operations**.[45]

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[43] The State of Delaware acknowledges that this requirement does not apply to fully-insured products.

[44] This would be only for the technology and data security terms in the contract.

[45] In order to comply with the requirement for "operations", any company that **delivers technology services** for the State's account would have access to the data and therefore is subject to all the requirements in this Section. Examples would be claims processor(s) and companies that lease a software platform with data storage. The company must provide their business information with a detailed description of the services provided on a signed

Response to 12:

13. **Operational Metrics:** The Service Provider and the State of Delaware shall reach agreement on operational metrics and document said metrics in the Service Level Agreement. Examples include but are not limited to:

    a) Advance notice and change control for major upgrades and system changes

    b) System availability/uptime guarantee/agreed-upon maintenance downtime

    c) Recovery Time Objective/Recovery Point Objective

    d) Security Vulnerability Scanning

Response to 13:

Subcontractor form and respond to the requirements in the entire *Technical Standards and Security Requirements* section with applicable appendices in a separate document. Please confirm your understanding of this requirement, list the subcontractor's business information, and describe in detail the technology services that would be provided including how the data is accessed.

Appendix L

DATA CONFIDENTIALITY AGREEMENT

Data Exchange for Enrollment in the Group Health Insurance Plan

This Data Confidentiality Agreement ("Agreement") is undertaken and effective on the date of the State Employee Benefit Committee (SEBC") award on _____ pursuant to the parties' performance of a certain contract ("Contract") effective July 1, 2017, by and between the State of Delaware ("State") by and through the Office of Management and Budget ("OMB") on its own behalf and on behalf of the group health plan it sponsors for employees, retirees, and other covered persons, collectively referred to hereafter as "Covered Persons", and _ ("Contractor") with offices at _____ _____, ("Parties").

WHEREAS, the State issued a Request for Proposal ("RFP") for a Third Party Administrator for the Group Health Insurance Plan on August 15, 2016;

WHEREAS, in order to implement enrollment by the Covered Persons, the State and Contractor must exchange test and enrollment files prior to the effective date of the Contract;

WHEREAS, Contractor desires to provide such data technology services to the State on the terms set forth in the Request for Proposal and as stated below;

WHEREAS, the information provided by the State is classified as Personally Identifiable Information (PII) and is information that, if divulged, could compromise or endanger the people or assets of the State and is data that is specifically protected by law; and

WHEREAS, the State and Contractor represent and warrant that each party has full right, power and authority to enter into and perform under this Agreement;

FOR AND IN CONSIDERATION OF the premises and mutual agreements herein, the State and Contractor agree as follows:

1. The RFP provides for a data extract by and through Payroll Human Resources Statewide Technology ("PHRST") and the Pension Office (hereafter "State") to be provided to the Contractor to be used for implementation testing and enrollment.

2. The enrollment files generated by the State will be placed in a sub-folder on the State's SFTP server. The Contractor is responsible to obtain the files from the server.

3. The RFP requires that the Contractor accept the enrollment files in specified formats.

4. The data is to be used for the following purposes and is not to be used for any other purpose.

a. To populate the Contractor's test environment; and

b. To populate the Contractor's system so that the Covered Persons may elect the benefit and/or plan design via the State's secure website during the Open Enrollment term in May, 2017.

5. No clause of this Agreement shall be considered a waiver of any portion of the terms set forth in the RFP for which a Contract has been awarded to the Contractor. The terms of the document entitled *Non-Public Data - State of Delaware Cloud and/or Offsite Hosting Mandatory Terms and Conditions*, which is part of the RFP and a copy of which is attached hereto for reference, shall apply to the test and enrollment files to be provided by the State prior to the effective date of the Contract.

This Agreement was drafted with the joint participation of the undersigned Parties and shall be construed neither against nor in favor of either, but rather in accordance with the fair meaning thereof.

IN WITNESS THEREOF, the Parties hereto have caused this Agreement to be in effect as of the latest date and year below written.

STATE OF DELAWARE **OFFICE OF MANAGEMENT AND BUDGET**	**CONTRACTOR**
_____	_____
Signature	Signature
Brenda L. Lakeman	Printed Name:_____
Director of HR Mgt and Benefits Administration	Title: _____
_____	_____
Date	Date

APPENDIX M

CMS-APPROVED ACO METRICS

For ACO facilities only:

Based on the 33 CMS approved ACO metrics, please provide any actively tracked outcomes for your ACO (in aggregate or by affiliated systems).

Note: PY = Performance Year

Measure	Description	PY1	PY2	PY3
ACO #1	Getting Timely Care, Appointments, and Information			
ACO #2	How Well Your Doctors Communicate			
ACO #3	Patients' Rating of Doctor			
ACO #4	Access to Specialists			
ACO #5	Health Promotion and Education			
ACO #6	Shared Decision Making			
ACO #7	Health Status/Functional Status			
ACO #8	Risk Standardized, All Condition Readmissions			
ACO #9	ASC Admissions: COPD or Asthma in Older Adults			
ACO #10	ASC Admission: Heart Failure			
ACO #11	Percent of PCPs who Qualified for EHR Incentive Payment			
ACO #12	Medication Reconciliation			
ACO #13	Falls: Screening for Fall Risk			
ACO #14	Influenza Immunization			
ACO #15	Pneumococcal Vaccination			
ACO #16	Adult Weight Screening and Follow-up			
ACO #17	Tobacco Use Assessment and Cessation Intervention			
ACO #18	Depression Screening			
ACO #19	Colorectal Cancer Screening			
ACO #20	Mammography Screening			
ACO #21	Proportion of Adults who had blood pressure screened in past 2 years			
Diabetes Composite	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24.			

Measure	Description	PY1	PY2	PY3
ACO #22 – 26	Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use			
ACO #27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)			
ACO #28	Percent of beneficiaries with hypertension whose BP < 140/90			
ACO #29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl			
ACO #30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic			
ACO #31	Beta-Blocker Therapy for LVSD			
CAD Composite ACO #32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD			

APPENDIX N

UPDATED CMS-APPROVED ACO METRICS

For ACO facilities only:

Based on the newer CMS approved ACO metrics, please any ACO metrics that are tracked (in aggregate or by affiliated systems) if available (put N/A if not available).

Note: PY = Performance Year

Measure	Description	PY1	PY2	PY3
Cardiovascular Care				
0018	Controlling High Blood Pressure Description: The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN)			
0330	Hospital 30-day, all-cause, risk- standardized readmission rate (RSRR) following heart failure hospitalization			
0229	Hospital 30-day, all-cause, risk- standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older			
0081	Heart Failure (HF): (ACE) Inhibitor or (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)			
0083	Heart Failure (HF): Beta- Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)			
Endoscopy & Polyp Surveillance Measures				
0658	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients			
0659	Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use			
PQRS #343	Screening Colonoscopy Adenoma Detection Rate Measure.			
PQRS #439	Age Appropriate Screening Colonoscopy			
Inflammatory Bowel Disease				
PQRS #271	IBD: Preventive Care: Corticosteroid Related Iatrogenic Injury – Bone Loss Assessment*			
PQRS #275	IBD: Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy*			
Consensus Draft CMS HIV Measures				
0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis			

Measure	Description	PY1	PY2	PY3
0409	HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis			
2082	HIV viral load suppression			
2079	HIV medical visit frequency			
0579	Annual cervical cancer screening or follow-up in high-risk women			
N/A PQRS #P22	HIV Screening of STI patients: Percentage of patients diagnosed with an acute STI who were tested for HIV.			
Consensus Draft CMS Cancer Measures				
Breast Cancer				
0559	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer.			
1857	Patients with breast cancer and negative or undocumented human epidermal growth factor receptor 2 (HER2) status who are spared treatment with trastuzumab			
1858	Trastuzumab administered to patients with AJCC stage I (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy			
Colorectal Cancer				
0223	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer			
1859	KRAS gene mutation testing performed for patients with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy			
1860	Patients with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-epidermal growth factor receptor monoclonal antibodies			
Medical Oncology Core Measures				
Hospice / End of Life				
0210	Proportion receiving chemotherapy in the last 14 days of life			
0211	Proportion with more than one emergency room visit in the last 30 days of life			
0213	Proportion admitted to the ICU in the last 30 days of life			
0215	Proportion not admitted to hospice			

Measure	Description	PY1	PY2	PY3
0216	Proportion admitted to hospice for less than 3 days			
0384	Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology			
Prostate Cancer				
0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients			
1853	Radical Prostatectomy Pathology Reporting			
Prevention				
0041	Immunization: Influenza			
NA	Percentage of adults who smoke cigarettes			
NA	Percentage of adults reporting 14 or more days of poor mental health			
0275	Ambulatory Care Sensitive Condition Hospital Admissions: Chronic Obstructive Pulmonary Disease			
NA	Child and Adolescent Access to Primary Care Practitioners			
NA	Unintended Pregnancies			
1516	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life			

APPENDIX O

ACO DOMESTIC MEDICAL CARE

For ACO facilities only:

Please provide the Last 2 years of domestic member Care for the two Largest Hospital Systems in the ACO.

Actives		2014 Domestic 1	2015 Domestic 1	2014 Domestic 2	2015 Domestic 2
Enrollment & Demographic					
	Members Avg Med				
	Employees Avg Med				
	Member Age Avg Med				
Allowed Costs - Total					
	Allow Amt PEPM Med				
High Cost Claims (>$50K)					
	Member %				
	Members % of total costs				
Rx Net Payments - Total					
	Allow Amt PMPM Rx				
	Allow Amt Per Day Supply Rx				
	Average number of Rx per member				
	Scripts Maint Rx % Mail Order				
	Scripts Rx % Generic				
	Specialty Drug % of total Rx spend				
Inpatient Measures					
	Allow Amt PMPM IP Acute				
	Allow Amt Per Adm Acute				
	Allow Amt Per Day Adm Acute				
	Admits Per 1000 Acute				
	Days Per 1000 Adm Acute				
	Days LOS Admit Acute				
	Admits Per 1000 Acute Avoidable				
	Readmissions Per 1000 Acute				
	C-sections (total)				
Outpatient Measures					
	Allowed Pay PMPM OP Med				
	Allowed Pay OP Fac Med PMPM				
	Allowed Pay OP Prof Med PMPM				
	Allowed Pay Per Svc OP Med				

Actives		2014 Domestic 1	2015 Domestic 1	2014 Domestic 2	2015 Domestic 2
	Svcs Per 1000 OP Med				
	Visits Per 1000 ER*				
	Allowed Amt PMPM OP Lab				
	Svcs Per 1000 OP Lab				
	Allowed Amt PMPM OP Rad				
	Svcs Per 1000 OP Rad				
	Allowed Amt PMPM Office Med				
	Allowed Amt Per Visit Office Med				
	Visits Per 1000 Office Med				
	Svcs Per 1000 Office Med				

APPENDIX P

MEDICAL ASO & DISCOUNTS

Please populate the following tables outlining all fees included in your proposal to the State of Delaware. In your response, please include any and all assumptions used in generating your proposed fees and all caveats to those fees as appropriate. **Please specify any assumptions for discounts on your proposed fees that are based on the volume of lives and/or number of plans that could be potentially awarded by the State; otherwise, the State will assume that the pricing you provide below will apply as if you were awarded a contract for only one plan within your proposal as well as if you were awarded a contract for all plans within your proposal.**

If your proposal to the State of Delaware includes any fees associated with value-based contracting models (such as ACOs, APC, or COEs), please note all of those fees in Appendix R: *Supplemental Financial Questions*, and include a comment within this appendix noting that additional fees have been provided in Appendix R.

PPO/POS Medical ASO Fee

For the First State Basic, PPO, and Port Authority Plans; also include fees for the CDH Gold plan, if quote is based on the same underlying PPO/POS network.

		A Year 1 Mature	B Year 2	C Year 3	D Comments
1	**Assumptions**				
2	Enrollment				
3	Estimated Claims - PEPM				
4	Estimated Claims - PEPY				
5	Estimated Claims - Total				
6	**Set Up**				
7	One Time Set-up fee				
8	**ASO Fees - PEPM**				
9	Total Monthly ASO Fees (PEPM)	$ -	$ -	$ -	
10	**Components of your Total Monthly ASO Fees (PEPM)**	**Please provide the breakdown of the Total Medical ASO PEPM fee that you have provided by the items listed. If any of these items can't be carved out, please include the fee in the "Other Fees in Total ASO Fee" row. All items in this section should add up to your Total PEPM fee (see below for ASO Fee Calculation Check).**			
11	Medical Claims Administration	$ -	$ -	$ -	
12	Network Access	$ -	$ -	$ -	
13	BH/SA Administration	$ -	$ -	$ -	
14	Member Services Toll Free Telephone line	$ -	$ -	$ -	

15	General Administration (eligibility processing, ID Cards, banking, standard reports)	$ -	$ -	$ -	
16	Claim Fiduciary Liability	$ -	$ -	$ -	
17	Utilization Review (pre-cert, CR, discharge planning)	$ -	$ -	$ -	
18	Case Management	$ -	$ -	$ -	
19	24 Hour Nurse-line	$ -	$ -	$ -	
20	Maternity Management Program	$ -	$ -	$ -	
21	Other Fees in Total ASO Fee	$ -	$ -	$ -	
22	ASO Fee Components Calculated Total (Monthly)	$ -	$ -	$ -	
23	**Total ASO Fee**				
24	Total Monthly Cost	$ -	$ -	$ -	
25	Total Annual Cost	$ -	$ -	$ -	
26	Dollar Change	n/a	$ -	$ -	
27	Percentage Change	n/a	%	%	
		Please ensure that your ASO fee increases do not exceed 3% per year.			
28	**Other Fees (Not included in Total ASO Fee)**				
29	Appeals Review (per hour)	$ -	$ -	$ -	
30	Ad-hoc Reporting (per hour)	$ -	$ -	$ -	
31	Case Management (per hour)	$ -	$ -	$ -	
32	Subrogation (per hour)	$ -	$ -	$ -	
33	Claim Repricing (Per Claim)	$ -	$ -	$ -	
34	Claim Run-in (PEPM)	$ -	$ -	$ -	
35	Claim Run-out (PEPM)	$ -	$ -	$ -	
36	COBRA Admin (PPPM)	$ -	$ -	$ -	
37	Customized Web Site (PEPM)	$ -	$ -	$ -	
38	HIPAA Coverage Certificates (PEPM)	$ -	$ -	$ -	
39	Real-time Eligibility Access (PEPM)	$ -	$ -	$ -	
40	Non-network Claim Negotiations (Per Claim)	$ -	$ -	$ -	
41	Onsite nursing (per participant per hour)	$ -	$ -	$ -	
42	Onsite health coaching (per participant per hour)	$ -	$ -	$ -	
43	Paper Directories (PEPM)	$ -	$ -	$ -	
44	Custom ID Cards (PEPM)	$ -	$ -	$ -	
45	Data transfer to partners (per feed to 5 vendors)	$ -	$ -	$ -	
46	Data receipt from partners (per feed from 5 vendors)	$ -	$ -	$ -	

47	Data transfer to Delaware Health Information Network (DHIN) (if excluded from #46 above)	$ -	$ -	$ -	
48	Other fees not included	$ -	$ -	$ -	
49	Other fees not included	$ -	$ -	$ -	

HMO/EPO Medical ASO Fee

		A Year 1 Mature	B Year 2	C Year 3	D Comments
1	**Assumptions**				
2	Enrollment				
3	Estimated Claims - PEPM				
4	Estimated Claims - PEPY				
5	Estimated Claims - Total				
6	**Set Up**				
7	One Time Set-up fee				
8	**ASO Fees - PEPM**				
9	Total Monthly ASO Fees (PEPM)	$ -	$ -	$ -	
10	**Components of your Total Monthly ASO Fees (PEPM)**	**Please provide the breakdown of the Total Medical ASO PEPM fee that you have provided by the items listed. If any of these items can't be carved out, please include the fee in the "Other Fees in Total ASO Fee" row. All items in this section should add up to your Total PEPM fee (see below for ASO Fee Calculation Check).**			
11	Medical Claims Administration	$ -	$ -	$ -	
12	Network Access	$ -	$ -	$ -	
13	BH/SA Administration	$ -	$ -	$ -	
14	Member Services Toll Free Telephone line	$ -	$ -	$ -	
15	General Administration (eligibility processing, ID Cards, banking, standard reports)	$ -	$ -	$ -	
16	Claim Fiduciary Liability	$ -	$ -	$ -	
17	Utilization Review (pre-cert, CR, discharge planning)	$ -	$ -	$ -	
18	Case Management	$ -	$ -	$ -	
19	24 Hour Nurse-line	$ -	$ -	$ -	
20	Maternity Management Program	$ -	$ -	$ -	
21	Other Fees in Total ASO Fee	$ -	$ -	$ -	
22	ASO Fee Components Calculated Total (Monthly)	$ -	$ -	$ -	
23	**Total ASO Fee**				
24	Total Monthly Cost	$ -	$ -	$ -	
25	Total Annual Cost	$ -	$ -	$ -	
26	Dollar Change	n/a	$ -	$ -	
27	Percentage Change	n/a	%	%	
		Please ensure that your ASO fee increases do not exceed 3% per year.			
28	**Other Fees (Not included in Total ASO Fee)**				
29	Appeals Review (per hour)	$ -	$ -	$ -	
30	Ad-hoc Reporting (per hour)	$ -	$ -	$ -	
31	Case Management (per hour)	$ -	$ -	$ -	

32	Subrogation (per hour)	$ -	$ -	$ -	
33	Claim Repricing (Per Claim)	$ -	$ -	$ -	
34	Claim Run-in (PEPM)	$ -	$ -	$ -	
35	Claim Run-out (PEPM)	$ -	$ -	$ -	
36	COBRA Admin (PPPM)	$ -	$ -	$ -	
37	Customized Web Site (PEPM)	$ -	$ -	$ -	
38	HIPAA Coverage Certificates (PEPM)	$ -	$ -	$ -	
39	Real-time Eligibility Access (PEPM)	$ -	$ -	$ -	
40	Non-network Claim Negotiations (Per Claim)	$ -	$ -	$ -	
41	Onsite nursing (per participant per hour)	$ -	$ -	$ -	
42	Onsite health coaching (per participant per hour)	$ -	$ -	$ -	
43	Paper Directories (PEPM)	$ -	$ -	$ -	
44	Custom ID Cards (PEPM)	$ -	$ -	$ -	
45	Data transfer to partners (per feed to 5 vendors)	$ -	$ -	$ -	
46	Data receipt from partners (per feed from 5 vendors)	$ -	$ -	$ -	
47	Data transfer to Delaware Health Information Network (DHIN) (if excluded from #46 above)	$ -	$ -	$ -	
48	Other fees not included	$ -	$ -	$ -	
49	Other fees not included	$ -	$ -	$ -	

Narrow Network / High Performance Network Medical ASO Fee

For proposals that include a narrow network or high performance network that is priced separately from the bidder's broad PPO/POS or HMO/EPO network.

		A Year 1 Mature	B Year 2	C Year 3	D Comments
1	**Assumptions**				
2	Enrollment				
3	Estimated Claims - PEPM				
4	Estimated Claims - PEPY				
5	Estimated Claims - Total				
6	**Set Up**				
7	One Time Set-up fee				
8	**ASO Fees - PEPM**				
9	Total Monthly ASO Fees (PEPM)	$ -	$ -	$ -	
10	**Components of your Total Monthly ASO Fees (PEPM)**	**Please provide the breakdown of the Total Medical ASO PEPM fee that you have provided by the items listed. If any of these items can't be carved out, please include the fee in the "Other Fees in Total ASO Fee" row. All items in this section should add up to your Total PEPM fee (see below for ASO Fee Calculation Check).**			
11	Medical Claims Administration	$ -	$ -	$ -	
12	Network Access	$ -	$ -	$ -	
13	BH/SA Administration	$ -	$ -	$ -	
14	Member Services Toll Free Telephone line	$ -	$ -	$ -	
15	General Administration (eligibility processing, ID Cards, banking, standard reports)	$ -	$ -	$ -	
16	Claim Fiduciary Liability	$ -	$ -	$ -	
17	Utilization Review (pre-cert, CR, discharge planning)	$ -	$ -	$ -	
18	Case Management	$ -	$ -	$ -	
19	24 Hour Nurse-line	$ -	$ -	$ -	
20	Maternity Management Program	$ -	$ -	$ -	
21	Other Fees in Total ASO Fee	$ -	$ -	$ -	
22	ASO Fee Components Calculated Total (Monthly)	$ -	$ -	$ -	
23	**Total ASO Fee**				
24	Total Monthly Cost	$ -	$ -	$ -	
25	Total Annual Cost	$ -	$ -	$ -	
26	Dollar Change	n/a	$ -	$ -	
27	Percentage Change	n/a	%	%	
		Please ensure that your ASO fee increases do not exceed 3% per year.			
28	**Other Fees (Not included in Total ASO Fee)**				
29	Appeals Review (per hour)	$ -	$ -	$ -	

30	Ad-hoc Reporting (per hour)	$ -	$ -	$ -	
31	Case Management (per hour)	$ -	$ -	$ -	
32	Subrogation (per hour)	$ -	$ -	$ -	
33	Claim Repricing (Per Claim)	$ -	$ -	$ -	
34	Claim Run-in (PEPM)	$ -	$ -	$ -	
35	Claim Run-out (PEPM)	$ -	$ -	$ -	
36	COBRA Admin (PPPM)	$ -	$ -	$ -	
37	Customized Web Site (PEPM)	$ -	$ -	$ -	
38	HIPAA Coverage Certificates (PEPM)	$ -	$ -	$ -	
39	Real-time Eligibility Access (PEPM)	$ -	$ -	$ -	
40	Non-network Claim Negotiations (Per Claim)	$ -	$ -	$ -	
41	Onsite nursing (per participant per hour)	$ -	$ -	$ -	
42	Onsite health coaching (per participant per hour)	$ -	$ -	$ -	
43	Paper Directories (PEPM)	$ -	$ -	$ -	
44	Custom ID Cards (PEPM)	$ -	$ -	$ -	
45	Data transfer to partners (per feed to 5 vendors)	$ -	$ -	$ -	
46	Data receipt from partners (per feed from 5 vendors)	$ -	$ -	$ -	
47	Data transfer to Delaware Health Information Network (DHIN) (if excluded from #46 above)	$ -	$ -	$ -	
48	Other fees not included	$ -	$ -	$ -	
49	Other fees not included	$ -	$ -	$ -	

Medicare Supplement Medical ASO Fee

		A Year 1 Mature	B Year 2	C Year 3	D Comments
1	**Assumptions**				
2	Enrollment				
3	Estimated Claims - PEPM				
4	Estimated Claims - PEPY				
5	Estimated Claims - Total				
6	**Set Up**				
7	One Time Set-up fee				
8	**ASO Fees - PEPM**				
9	Total Monthly ASO Fees (PEPM)	$ -	$ -	$ -	
10	**Components of your Total Monthly ASO Fees (PEPM)**	**Please provide the breakdown of the Total Medical ASO PEPM fee that you have provided by the items listed. If any of these items can't be carved out, please include the fee in the "Other Fees in Total ASO Fee" row. All items in this section should add up to your Total PEPM fee (see below for ASO Fee Calculation Check).**			
11	Medical Claims Administration	$ -	$ -	$ -	
12	Network Access	$ -	$ -	$ -	
13	BH/SA Administration	$ -	$ -	$ -	
14	Member Services Toll Free Telephone line	$ -	$ -	$ -	
15	General Administration (eligibility processing, ID Cards, banking, standard reports)	$ -	$ -	$ -	
16	Claim Fiduciary Liability	$ -	$ -	$ -	
17	Utilization Review (pre-cert, CR, discharge planning)	$ -	$ -	$ -	
18	Case Management	$ -	$ -	$ -	
19	24 Hour Nurse-line	$ -	$ -	$ -	
20	Maternity Management Program	$ -	$ -	$ -	
21	Other Fees in Total ASO Fee	$ -	$ -	$ -	
22	ASO Fee Components Calculated Total (Monthly)	$ -	$ -	$ -	
23	**Total ASO Fee**				
24	Total Monthly Cost	$ -	$ -	$ -	
25	Total Annual Cost	$ -	$ -	$ -	
26	Dollar Change	n/a	$ -	$ -	
27	Percentage Change	n/a	%	%	
		Please ensure that your ASO fee increases do not exceed 3% per year.			
28	**Other Fees (Not included in Total ASO Fee)**				
29	Appeals Review (per hour)	$ -	$ -	$ -	
30	Ad-hoc Reporting (per hour)	$ -	$ -	$ -	
31	Case Management (per hour)	$ -	$ -	$ -	

32	Subrogation (per hour)	$ -	$ -	$ -	
33	Claim Repricing (Per Claim)	$ -	$ -	$ -	
34	Claim Run-in (PEPM)	$ -	$ -	$ -	
35	Claim Run-out (PEPM)	$ -	$ -	$ -	
36	COBRA Admin (PPPM)	$ -	$ -	$ -	
37	Customized Web Site (PEPM)	$ -	$ -	$ -	
38	HIPAA Coverage Certificates (PEPM)	$ -	$ -	$ -	
39	Real-time Eligibility Access (PEPM)	$ -	$ -	$ -	
40	Non-network Claim Negotiations (Per Claim)	$ -	$ -	$ -	
41	Onsite nursing (per participant per hour)	$ -	$ -	$ -	
42	Onsite health coaching (per participant per hour)	$ -	$ -	$ -	
43	Paper Directories (PEPM)	$ -	$ -	$ -	
44	Custom ID Cards (PEPM)	$ -	$ -	$ -	
45	Data transfer to partners (per feed to 5 vendors)	$ -	$ -	$ -	
46	Data receipt from partners (per feed from 5 vendors)	$ -	$ -	$ -	
47	Data transfer to Delaware Health Information Network (DHIN) (if excluded from #46 above)	$ -	$ -	$ -	
48	Other fees not included	$ -	$ -	$ -	
49	Other fees not included	$ -	$ -	$ -	

Health Reimbursement Account Administration

		A	B	C	D	
(To be added to base PPO/POS medical plan admin fees)		**Year 1**	**Year 2**	**Year 3**	**Fee Basis**	**Comments**
1	**Participation Assumptions**	**Mature**				
2	Health Reimbursement Account participants					
3	**Monthly HRA Fees**					
4	HRA Account Administration Fee (PPPM)	$ -	$ -	$ -		
5	Debit Card (PPPM)	$ -	$ -	$ -		
6	Other (specify)	$ -	$ -	$ -		
7	Other (specify)	$ -	$ -	$ -		
8	Total Monthly HRA Account Admin Fee	$ -	$ -	$ -		
9	**Total HRA Admin Cost**					
10	Total Monthly Fee	$ -	$ -	$ -		
11	Total Annual Cost	$ -	$ -	$ -		
12	Dollar Change	n/a	$ -	$ -		
13	Percentage Change	n/a	%	%		
		Please ensure that your ASO fee increases do not exceed 3% per year.				
14	**Other HRA Admin Fees**					
15	One Time Set-up fee	$ -	$ -	$ -		
16	Paper statements	$ -	$ -	$ -		
17	Debit card replacement	$ -	$ -	$ -		
18	Member decision support tools (e.g., plan modeler, treatment cost estimator)	$ -	$ -	$ -		
19	Other (specify)	$ -	$ -	$ -		

Health Savings Account Administration Fees

	(To be added to base PPO/POS medical plan admin fees)	A Year 1 Mature	B Year 2	C Year 3	D Fee Basis	Comments
1	**Participation Assumptions**					
2	Health Savings Account participants					
3	**Monthly HSA Fees**					
4	HSA Account Administration Fee (PPPM)	$ -	$ -	$ -		
5	Debit Card (PPPM)	$ -	$ -	$ -		
6	Other (specify)	$ -	$ -	$ -		
7	Other (specify)	$ -	$ -	$ -		
8	Total Monthly HSA Account Admin Fee	$ -	$ -	$ -		
9	**Total HSA Admin Cost**					
10	Total Monthly Fee	$ -	$ -	$ -		
11	Total Annual Cost	$ -	$ -	$ -		
12	Dollar Change	n/a	$ -	$ -		
13	Percentage Change	n/a	%	%		
		Please ensure that your ASO fee increases do not exceed 3% per year.				
14	**Other HSA Admin Fees**					
15	One Time Set-up fee	$ -	$ -	$ -		
16	Check transaction	$ -	$ -	$ -		
17	Non-sufficient funds	$ -	$ -	$ -		
18	ATM withdrawal	$ -	$ -	$ -		
19	Bank teller withdrawals	$ -	$ -	$ -		
20	Monthly investment	$ -	$ -	$ -		
21	Paper statements	$ -	$ -	$ -		
22	Check copy	$ -	$ -	$ -		
23	Check replacement	$ -	$ -	$ -		
24	Check stop payment	$ -	$ -	$ -		
25	Debit card replacement	$ -	$ -	$ -		
26	Account closing	$ -	$ -	$ -		
27	Member decision support tools (e.g., plan modeler, treatment cost estimator)	$ -	$ -	$ -		
28	Other (specify)	$ -	$ -	$ -		

Methodology for Reporting Provider Discounts

Instructions

The State of Delaware is requesting each Bidder to provide historical and projected provider discounts for each 3 digit ZIP code in the Bidder's service area using the methodology described below. Discounts are to be reported in the tables provided. ***These discounts are to be attested by the Bidder's Chief Actuary.***

Data Specifications

Time Period

Include all medical claims incurred **1/1/2015-12/31/2015 and paid through February 28, 2016** for the Historical Discounts.

The Projected Discounts should reflect the projected discounts based on signed agreements that are in place as of **July 1, 2016**.

Please note that for Inpatient claims, admission date should be considered the incurred date.

Groupings

Data should be separated into one of the following four groups based on type of service:

A. Inpatient Facility (facility charges only; does not include associated professional charges)
B. Outpatient Facility (facility charges only; does not include associated professional charges)

C. Professional and Other services (including professional charges associated with facility claims)
D. Out-of-Network Contracted (Services **where the provider is contracted with the health plan and benefits are paid at an out**-of-network benefit level. An example of this is when a plan has a "wrap" network for out-of-network claims)

Data Content

Please *include* the following in your analysis:

- Commercial Group claims only
- All claims from all providers except as noted in exclusions below
  - Include claims for both contracted and non-contracted providers
  - Include high cost claims - do not exclude any claim because of high dollar amounts
  - Include all claims for services covered under medical benefits, regardless of the discount percentage amount
  - Include claims that are paid through networks that your organization rents if these rental networks are normally part of the product offering you make to your customers

- Include any additional claim expenses/credits passed back to employer groups as a result of provider reimbursement agreements such as withholds, bonuses, and pay for performance arrangements.

All adjudication adjustments for a claim should be applied to that claim before the claim is summarized.

Please *exclude* the following in your analysis:

- Claims for members age 65 or older where age is measured as the difference between the date of service and member's birth date rounded down to the integer
- All Medicare Supplement, Medicare Advantage and Individual claims
- All Medicare and Medicaid claims
- All claims with COB where your organization is the secondary payer
- All mail order prescription drug, retail prescription drug, dental and vision hardware claims not covered under medical benefits
- Payments for interest expense, regulatory fees and prompt pay penalties
- Claims paid through custom network arrangements established for specific customers that are not generally available to other groups
- Claim lines that include ineligible services and related charges
- All capitation paid as well as any claim lines and/or encounter data associated with or paid through capitated arrangements
- All surcharges and covered life assessments such as the New York Health Care Reform Act (NYCHRA)
- All network access fees including access fees for rental networks

Discount Analysis – Inpatient

	Historical Discounts				Projected Discounts
Three Digit ZIP	Total Inpatient Days Included	Total Billed Charges	Total Allowed Charges	Total Discount	Inpatient

Discount Analysis – Outpatient

	Historical Discounts				Projected Discounts
Three Digit ZIP	Number of Outpatient Services Included	Total Billed Charges	Total Allowed Charges	Total Discount	Outpatient

Discount Analysis – Professional

	Historical Discounts				Projected Discounts
Three Digit ZIP	Number of Professional Services Included	Total Billed Charges	Total Allowed Charges	Total Discount	Professional

Discount Analysis – Out-of-Network Contracted

	Historical Discounts			Projected Discounts
Three Digit ZIP	Total Billed Charges	Total Allowed Charges	Total Discount	Out-of-Network Contracted

Network Discounts

Attestation by Chief Actuary

By signing below, I certify that I have reviewed the data submitted. Based on my thorough review, I believe it presents a fair and accurate representation of the provider reimbursement arrangements of this organization, as reflected in book-of-business claims data.

Except as disclosed below, we have followed the procedures outlined by in this document to fulfill the data request.

Carrier Name: _____

Signature: _____

Printed Name:_____

Title:_____

Date:_____

Please disclose and explain any other deviations from this data specification that have not been addressed above:

Please disclose any reliance you have made on other parties in completing this data submission as well as any other areas of concerns you may have as they relate to guidance offered under Actuarial Standard of Practice (ASOP) #23, Data Quality.

APPENDIX Q

FULLY-INSURED MEDICAL PREMIUM QUOTES

Please populate the following tables outlining all fees included in your proposal to the State of Delaware for all plans included in your proposal. In your response, please include any and all assumptions used in generating your proposed fees and all caveats to those fees as appropriate. **Please specify any assumptions for discounts on your proposed fees that are based on the volume of lives and/or number of plans that could be potentially awarded by the State; otherwise, the State will assume that the pricing you provide below will apply as if you were awarded a contract for only one plan within your proposal as well as if you were awarded a contract for all plans within your proposal.** If you are not providing fully insured premiums for the plans included in your proposal, you must provide a response as to why within this Appendix.

If your proposal to the State of Delaware includes any fees associated with value-based contracting models (such as ACOs, APC, or COEs), please note all of those fees in Appendix R: *Supplemental Financial Questions*, and include a comment within this appendix noting that additional fees have been provided in Appendix R.

PPO/POS Medical Premiums

For the First State Basic, PPO, and Port Authority Plans; also include fees for the CDH Gold plan, if quote is based on the same underlying PPO/POS network.

		A Year 1 Mature	B Year 2	C Year 3	D Comments
1	**Assumptions**				
2	Enrollment				
3	**Set Up**				
4	One Time Set-up fee				
5	**Premiums by Coverage Tier – PEPM**				
6	Employee only (PEPM)	$ -	$ -	$ -	
7	Employee + Spouse (PEPM)	$ -	$ -	$ -	
8	Employee + Child(ren) (PEPM)	$ -	$ -	$ -	
9	Family (PEPM)	$ -	$ -	$ -	

Please ensure that your premium increases do not exceed 3% per year.

11	**Other Fees (Not included in Premiums above)**				
12	Appeals Review (per hour)	$ -	$ -	$ -	
13	Ad-hoc Reporting (per hour)	$ -	$ -	$ -	
14	Case Management (per hour)	$ -	$ -	$ -	
15	Subrogation (per hour)	$ -	$ -	$ -	
16	Claim Repricing (Per Claim)	$ -	$ -	$ -	
17	Claim Run-in (PEPM)	$ -	$ -	$ -	
18	Claim Run-out (PEPM)	$ -	$ -	$ -	

19	COBRA Admin (PPPM)	$ -	$ -	$ -	
20	Customized Web Site (PEPM)	$ -	$ -	$ -	
21	HIPAA Coverage Certificates (PEPM)	$ -	$ -	$ -	
22	Real-time Eligibility Access (PEPM)	$ -	$ -	$ -	
23	Non-network Claim Negotiations (Per Claim)	$ -	$ -	$ -	
24	Onsite nursing	$ -	$ -	$ -	
25	Onsite health coaching	$ -	$ -	$ -	
26	Paper Directories (PEPM)	$ -	$ -	$ -	
27	Custom ID Cards (PEPM)	$ -	$ -	$ -	
28	Data transfer to partners (per feed to 5 vendors)	$ -	$ -	$ -	
29	Data receipt from partners (per feed from 5 vendors)	$ -	$ -	$ -	
30	Data transfer to Delaware Health Information Network (DHIN) (if excluded from #28 above)	$ -	$ -	$ -	
31	Other fees not included	$ -	$ -	$ -	
32	Other fees not included	$ -	$ -	$ -	

HMO/EPO Medical Premiums

		A Year 1 Mature	B Year 2	C Year 3	D Comments
1	**Assumptions**				
2	Enrollment				
3	**Set Up**				
4	One Time Set-up fee				
5	**Premiums by Coverage Tier – PEPM**				
6	Employee only (PEPM)	$ -	$ -	$ -	
7	Employee + Spouse (PEPM)	$ -	$ -	$ -	
8	Employee + Child(ren) (PEPM)	$ -	$ -	$ -	
9	Family (PEPM)	$ -	$ -	$ -	
		Please ensure that your premium increases do not exceed 3% per year.			
11	**Other Fees (Not included in Premiums above)**				
12	Appeals Review (per hour)	$ -	$ -	$ -	
13	Ad-hoc Reporting (per hour)	$ -	$ -	$ -	
14	Case Management (per hour)	$ -	$ -	$ -	
15	Subrogation (per hour)	$ -	$ -	$ -	
16	Claim Repricing (Per Claim)	$ -	$ -	$ -	
17	Claim Run-in (PEPM)	$ -	$ -	$ -	
18	Claim Run-out (PEPM)	$ -	$ -	$ -	
19	COBRA Admin (PPPM)	$ -	$ -	$ -	
20	Customized Web Site (PEPM)	$ -	$ -	$ -	
21	HIPAA Coverage Certificates (PEPM)	$ -	$ -	$ -	
22	Real-time Eligibility Access (PEPM)	$ -	$ -	$ -	
23	Non-network Claim Negotiations (Per Claim)	$ -	$ -	$ -	
24	Onsite nursing	$ -	$ -	$ -	
25	Onsite health coaching	$ -	$ -	$ -	
26	Paper Directories (PEPM)	$ -	$ -	$ -	
27	Custom ID Cards (PEPM)	$ -	$ -	$ -	
28	Data transfer to partners (per feed to 5 vendors)	$ -	$ -	$ -	
29	Data receipt from partners (per feed from 5 vendors)	$ -	$ -	$ -	
30	Data transfer to Delaware Health Information Network (DHIN) (if excluded from #28 above)	$ -	$ -	$ -	
31	Other fees not included	$ -	$ -	$ -	
32	Other fees not included	$ -	$ -	$ -	

Narrow Network Medical Premiums

		A Year 1 Mature	B Year 2	C Year 3	D Comments
1	**Assumptions**				
2	Enrollment				
3	**Set Up**				
4	One Time Set-up fee				
5	**Premiums by Coverage Tier – PEPM**				
6	Employee only (PEPM)	$ -	$ -	$ -	
7	Employee + Spouse (PEPM)	$ -	$ -	$ -	
8	Employee + Child(ren) (PEPM)	$ -	$ -	$ -	
9	Family (PEPM)	$ -	$ -	$ -	
		Please ensure that your premium increases do not exceed 3% per year.			
11	**Other Fees (Not included in Premiums above)**				
12	Appeals Review (per hour)	$ -	$ -	$ -	
13	Ad-hoc Reporting (per hour)	$ -	$ -	$ -	
14	Case Management (per hour)	$ -	$ -	$ -	
15	Subrogation (per hour)	$ -	$ -	$ -	
16	Claim Repricing (Per Claim)	$ -	$ -	$ -	
17	Claim Run-in (PEPM)	$ -	$ -	$ -	
18	Claim Run-out (PEPM)	$ -	$ -	$ -	
19	COBRA Admin (PPPM)	$ -	$ -	$ -	
20	Customized Web Site (PEPM)	$ -	$ -	$ -	
21	HIPAA Coverage Certificates (PEPM)	$ -	$ -	$ -	
22	Real-time Eligibility Access (PEPM)	$ -	$ -	$ -	
23	Non-network Claim Negotiations (Per Claim)	$ -	$ -	$ -	
24	Onsite nursing	$ -	$ -	$ -	
25	Onsite health coaching	$ -	$ -	$ -	
26	Paper Directories (PEPM)	$ -	$ -	$ -	
27	Custom ID Cards (PEPM)	$ -	$ -	$ -	
28	Data transfer to partners (per feed to 5 vendors)	$ -	$ -	$ -	
29	Data receipt from partners (per feed from 5 vendors)	$ -	$ -	$ -	
30	Data transfer to Delaware Health Information Network (DHIN) (if excluded from #28 above)	$ -	$ -	$ -	
31	Other fees not included	$ -	$ -	$ -	
32	Other fees not included	$ -	$ -	$ -	

Medicare Supplement Medical Premiums

		A Year 1 Mature	B Year 2	C Year 3	D Comments
1	**Assumptions**				
2	Enrollment				
3	**Set Up**				
4	One Time Set-up fee				
5	**Premiums by Coverage Tier – PEPM**				
6	Employee only (PEPM)	$ -	$ -	$ -	
7	Employee + Spouse (PEPM)	$ -	$ -	$ -	
8	Employee + Child(ren) (PEPM)	$ -	$ -	$ -	
9	Family (PEPM)	$ -	$ -	$ -	
		Please ensure that your premium increases do not exceed 3% per year.			
11	**Other Fees (Not included in Premiums above)**				
12	Appeals Review (per hour)	$ -	$ -	$ -	
13	Ad-hoc Reporting (per hour)	$ -	$ -	$ -	
14	Case Management (per hour)	$ -	$ -	$ -	
15	Subrogation (per hour)	$ -	$ -	$ -	
16	Claim Repricing (Per Claim)	$ -	$ -	$ -	
17	Claim Run-in (PEPM)	$ -	$ -	$ -	
18	Claim Run-out (PEPM)	$ -	$ -	$ -	
19	COBRA Admin (PPPM)	$ -	$ -	$ -	
20	Customized Web Site (PEPM)	$ -	$ -	$ -	
21	HIPAA Coverage Certificates (PEPM)	$ -	$ -	$ -	
22	Real-time Eligibility Access (PEPM)	$ -	$ -	$ -	
23	Non-network Claim Negotiations (Per Claim)	$ -	$ -	$ -	
24	Onsite nursing	$ -	$ -	$ -	
25	Onsite health coaching	$ -	$ -	$ -	
26	Paper Directories (PEPM)	$ -	$ -	$ -	
27	Custom ID Cards (PEPM)	$ -	$ -	$ -	
28	Data transfer to partners (per feed to 5 vendors)	$ -	$ -	$ -	
29	Data receipt from partners (per feed from 5 vendors)	$ -	$ -	$ -	
30	Data transfer to Delaware Health Information Network (DHIN) (if excluded from #28 above)	$ -	$ -	$ -	
31	Other fees not included	$ -	$ -	$ -	
32	Other fees not included	$ -	$ -	$ -	

Medicare Advantage Premiums

		A Year 1 Mature	B Year 2	C Year 3	D Comments
1	**Assumptions**				
2	Enrollment				
3	**Premium Cost – PMPM**				
4	PMPM Plan Cost	$ -	$ -	$ -	
5	**Aggregate Plan Cost**				
6	Gross Plan Cost	$ -	$ -	$ -	
7	CMS capitation	$ -	$ -	$ -	
8	Retention	$ -	$ -	$ -	
9	**Net Insured Rate**	$ -	$ -	$ -	

Please ensure that your premium increases do not exceed 3% per year.

APPENDIX R

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 market requested. 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)

Market:

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:	
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? 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).	
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 the market.

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)

Market:

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:	

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? 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).	
Total estimated savings for this model. Please outline any key assumptions not already disclosed (e.g., migration assumptions, etc.).	

(continued on the next page)

Current State Summary

This is intended to capture additional adjustment data and factors to be used to reflect emerging market differences from your standard offering in the market. One copy of this table should reflect all alternative delivery models and markets. 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
Examples	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
Examples	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
Examples	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 markets. 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
Examples	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
Examples	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
Examples	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. 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**
Examples	**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				

Provided on the disc:

Appendix S: GeoAccess Open Access Network

Appendix T: GeoAccess HMO Network

Appendix U: GeoAccess Medicare Advantage Network

Appendix V: Provider Disruption