MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

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QUESTIONS AND RESPONSES # 1

Project No. F10B3400022
Health Plan Administration and Services (PPO, EPO, IHM)

January 9, 2014

Ladies/Gentlemen**:**

This List of Questions and Responses #1, questions #1 through #147, is being issued to clarify certain information contained in the above named RFP. The statements and interpretations of contract requirements, which are stated in the following questions from potential Offerors, are not binding on the State, unless the State expressly amends the RFP. Nothing in the State's responses to these questions is to be construed as agreement to or acceptance by the State of any statement or interpretation on the part of the vendor asking the question as to what the contract does or does not require.

1. *Will the State accept proposals from vision carriers for only the vision portion of the benefit plan?*

   RESPONSE: No, in order to propose under this RFP, a vendor must be able to meet all of the scope of work requirements for at least one functional area (PPO, EPO, and/or IHM), and not just the vision portion. However, a vendor that is strictly a vision carrier may be proposed by an Offeror as a subcontractor for that Offeror's Proposal.

2. *Asking for clarification on the requested benefit design for Functional Area 3. FA3 Attachment S-3 page 6, under Common and Preventative Services references the copay for Physician Office Visits-Specialist to be the same as the Physician Office Visits-Primary Care at 100% after $15 copay. In other types of services it references a $30 copay for Specialist. Please confirm if the Physician Office Visit-Specialist copay is expected to be $15 vs. the $30 copay similar to the other services.*

   RESPONSE: For Functional Area 3, both Physician Office Visits – Primary Care and Physician Office Visits – Specialist are 100% after $15 copay. See Amendment 2.

3. *Regarding the claims re-pricing, there are 3 each of the PPO, EPO and POS files created by Segal. As the POS will no longer be offered how should we re-price the claims for the POS? Can you provide any direction on how you wish to have the re-pricing completed?*

RESPONSE: Please refer to Attachment T, tab T-1: Financial Proposal Instructions for each respective Functional Area. As noted in Attachment T for Functional Area 3 – IHM (T-1, 3.):

Sample enrollment is used to calculate an estimated aggregate premium. Bidders are required to provide guaranteed rates for the first two contract years. For each following year bidders must provide a guaranteed maximum rate increase in the yellow highlighted cells. A total aggregate premium will be calculated in cell G16 using the guaranteed rates for the first two contract years and the maximum increase for each contract year thereafter. Contractors will be required to provide renewals in accordance with the RFP.

4. *Can you clarify Question CC-75 in FA3 Attachment S-1? It says that the "Contractor agrees to share claims data on participants who enroll in another Contractor's plan during the annual Open Enrollment..." If a State employee enrolls in, for example, a spouse's plan and that plan happens to be administered by a proposed sub-contractor that is a third party administrator with other clients, this provision seems to indicate that the State wants that to be disclosed. Please advise regarding the intent of this provision.*

   RESPONSE: No, what this means is if a State participant switches plans (among those offered by DBM) during Open Enrollment during the course of this contract, the previous plan will share the claims history of that individual with the new plan for consistency in treatment compliance, and healthy activity tracking for example.

5. *Regarding subcontractors, it may be possible that several proposed subcontractors also subcontract with other organizations for certain services. Please advise regarding the depth we need to go to disclose the subcontractor relationships.*

   RESPONSE: Please refer to RFP Section 4.4.3.13 and the Subcontractors Questionnaires included in Attachment "S" for each Functional Area. Regarding other organizations for which a proposed subcontractor has contractual relationships with, see Subcontractors Questionnaire question SQ-6. The State prefers that Offerors disclose all subcontractor relationships that are relevant to the services to be performed under the contracts to be awarded under this RFP, including any potential conflicts of interest.

6. *Please confirm an open access network with both in-network and out-of-network benefits will satisfy your "PPO" plan design.*

   RESPONSE: Confirmed; referrals are not required under the PPO plan design.

7. *In section 4.4.3.7 – Experience and Qualifications of Proposed Staff: It is requested that letters of intended commitment be produced. Does this apply to this solicitation and, if so, is it appropriate to produce one letter signed by an officer of the company?*

   RESPONSE: The request for letters of intended commitment does apply to this solicitation and is intended for key personnel proposed to work on the project and any proposed subcontractor(s). It is preferred that the letters be from the individual key personnel proposed and any proposed subcontractor(s).

8. *Section 4.2.4: Can each section in our response be numbered sequentially?*

RESPONSE: No. Numbering each section sequentially leads to confusion when referencing specific page numbers that may be used in other sections. Per RFP Section 4.2.4, "All pages of both proposal volumes shall be consecutively numbered from beginning (Page 1) to end (Page "x")."

9. *Section 4.4.3.5: Please confirm there are no Offeror Minimum Qualifications to be responded to.*

   RESPONSE: There are no specific Minimum Qualifications that an Offeror must meet in order submit a proposal. However, in order to be qualified for award, an Offeror must be determined to have the capability, reliability, and integrity to be able to provide the requested services (i.e. be determined "responsible"), and must meet any and all applicable Federal, State, and local laws in order to provide the services requested (See RFP Sections 1.27 and 5.5.1).

10. *If the State is requesting a tiered plan design how should that option be represented in Attachment S-3 Plan Design?*

    RESPONSE: The State is not currently requesting a tiered plan design; only gathering information on Offeror capabilities in this regard.

11. *Does the State have an established Health Risk Assessment? If so, please provide a copy. If the State does not have an existing HRA, will each vendor be using their own?*

    RESPONSE: Yes, the State does have an established Health Risk Assessment. It will be provided after award to all Offerors awarded a contract under this solicitation.

12. *Tab T-4: Under the Administrative fees section, please outline the service fees which should be included under Value Based Plan Administration versus Wellness and Disease Management.*

    RESPONSE: All fees associated with the administration of the value based plan including for example, if any, fees related to Centers of Excellence, high performing networks, copayment waivers should be included in the line "Value Based Plan Administration." Fees associated with performing, monitoring and tracking of wellness and disease management activities should be included in the line "Wellness and Disease Management."

13. *Tab T-6: Is the 1.07 trend factor for contract years 2 –10 for illustrative purposes or is it a requirement of the RFP? If it is a requirement, and a 7.0 percent annual trend is not achieved, would this be considered a violation of the Offeror's contractual obligation?*

    RESPONSE: The 7% is for illustrative purposes only. All vendors must submit their renewal methodology in accordance with the RFP.

14. *Can we have claim and enrollment data through at least 9/30/13?*

    RESPONSE: No additional claims or enrollment data will be provided. All potential offerors were provided with three (3) years of data. The data provided should be sufficient to develop an accurate projection of the State's future utilization.

15. *Is it possible to obtain a listing of individual large losses which have exceeded $100,000 over the most recent 12 months of claims experience?*

    RESPONSE: Please see the response to question #14. No such additional data will be provided.

16. *Please confirm that for each group the column labeled "Total Members," which is the total of the "Individual," "Double" and "Family" Employee columns, reflects the total number of enrolled subscribers.*

    RESPONSE: All counts are employee only.

17. *Each exhibit shows one column of monthly retiree claims, and two sections of monthly retiree enrollment. Is one section non-Medicare Retirees and the other Medicare retirees? Does the retiree claims column include both Medicare and non-Medicare retiree claims?*

    RESPONSE: Retiree claims include claims for both Early Retirees (those under age 65) and Medicare-eligible Retirees.

18. *Please provide an explanation of the monthly "Incurred" and "Paid" claim columns. Do the columns labeled "Incurred" reflect just the claims incurred in that particular month, while the "Paid" column reflects all claims paid in that month, regardless of incurred date?*

    RESPONSE: Incurred claims represent claims that were incurred during that month. Paid claims are all claims that were paid during that month.

19. *Section 3.3.1: Activity Requirements include "Showing blood pressure, glucose, and cholesterol in the normal range." Is it your intent that members must achieve the normal range to avoid the surcharge?*

    RESPONSE: The intent is that the participants take part in the required activities to avoid the surcharge.

20. *Section 3.3.1: Activity Requirements include "Members who discuss the personal health assessment with their primary care physician" as well as other activities requiring members to discuss topics with their physician. Would the State consider allowing members to discuss these topics with a Wellness Coach or DM Nurse instead of a primary care physician?*

    RESPONSE: The purpose of this requirement is to enable the participant to engage in a dialogue with his/her primary care physician and better understand their health needs. The State believes this conversation is best held between the participant and the PCP.

21. *Does the State supply member emails to vendors for communication campaigns? If the State is unable to provide email addresses, would the State send vendor-provided email content on our behalf?*

    RESPONSE: Not all State employees and retirees have email addresses. However, we do collect that information when available and pass that data on the eligibility files. Offerors should anticipate communicating via both U.S. mail and electronic means.

22. *Is the State considering selecting a vendor to provide Wellness across multiple medical plan vendors?*

    RESPONSE: No, wellness will be coordinated across all Contractors using the Contractors' resources.

23. *Section 3.1: What is the State's vision for how vendors should "Integrate community health workers into the overall health management of Members"?*

    RESPONSE: The State believes that community health workers can be utilized to help providers understand participants' barriers to treatment compliance. Community health workers could be part of a PCMH, or could go to patient homes to assess personal obstacles to treatment compliance and assist the PCP in developing a more personalized treatment plan that has a better chance of success. There are many other ways to utilize these workers and the State is open to creative ideas proposed by Offerors.

24. *Section 3.3.1: Starting in 2017, Employees and covered spouses identified for disease management who fail/refuse to engage in treatment recommendations and healthy activity requirements will be subject to surcharge. Please confirm that you are asking for the vendor to track/report disease management activity for moderate and high acuity only--those programs with telephonic outreach.*

    RESPONSE: There are healthy activity requirements for all levels of health and the vendor is responsible for tracking all participants' activities. Note that some surcharges begin in 2016.

25. *Section 3.3.1: Throughout this section, the State has specifically called out participation in a Nutrition Education, Weight Management, or Stress Management programs. We offer additional Wellness programs online and telephonically. If an individual is appropriately identified for a different program, such as heart health, would participation in that program instead meet the healthy activity requirement?*

    RESPONSE: Yes, the items listed in the RFP are not meant to be all-inclusive. Additional activities recommended through disease management may be specific to the individual member and consistent with the Offeror's programs.

26. *Is the State considering reasonable alternative activities for members who can't achieve "normal range" for biometric numbers or who can't complete other specific health activities? For example, if a member is pregnant and can't achieve a normal BMI range, could she submit a doctor form or complete another activity to avoid the surcharge?*

    RESPONSE: Yes the State will consider reasonable alternative activities for members who can't achieve "normal range" for biometric numbers or who can't complete other specific health activities for health related reasons.

27. *Section 3.3.1: When members are required to meet "normal ranges" for biometric screening numbers (ex. blood pressure, BMI), do members who are within normal range have to complete all other healthy activities to avoid the surcharge? For example, would a member who is within all healthy range for all of their numbers have to participate in a Nutrition Education, Weight Management, or Stress Management program? Or are there additional healthy reasonable alternative activities for individuals who are not within the healthy ranges?*

    RESPONSE: As stated in RFP Section 3.3 General Requirements for all Functional Areas, there are healthy activity requirements for all individuals.

28. *Will the SSAE 16 audit (formerly SAS 70) be acceptable in lieu of a SOC 2 Type II Audit?*

    RESPONSE: While a SSAE 16 report may be suitable for SOC ***1*** Type II audits, the RFP requirements are for a SOC ***2*** Type II audit, and the Contractor(s) will be required to meet the SOC 2 Type II Audit requirements. Please refer to the framework in Attestation Standards (AT) Section 101 (see also http://www.ssae16.org/glossary/72-at-section-101-soc-2-reports-and-soc-3-reports-ssae16org.html).

29. *PP 27 & 28 – Does the State have current benchmark information against which to measure hospital readmission rates within 30 days of discharge; ER visits for asthma, COPD and diabetes, etc.?*

    RESPONSE: Yes, the State does have benchmark information.

30. *PP 31 references tracking members who complete age/gender specific biometric screenings – are hosting biometric screenings part of the scope?*

    RESPONSE: Hosting biometric screenings is not required, but the State is open to having vendors do biometric screening at health fairs or other work site events and tracking those screenings if possible.

31. *PP 31 – When members begin to be penalized via surcharge for failure to engage – has the State determined how to handle members who cannot be reached?*

    RESPONSE: The State is still developing this aspect of the Program.

32. *Can the following documents be provided in an unlocked format?*
    - *Medical FA1_PPO-SF_Attach_S_Tech_Proposal_(Part_) (1).doc*
    - *Medical FA2_EPO-SF_Attach_S_Tech_Proposal_(Part_) (1).doc*
    - *Medical FA3_IHM-FI_Attach_S_Tech_Proposal_(Part_) (1).doc*

    The format provided prohibits responders from copying text from the compliance checklist and technical questionnaire into separate contacts documents for dissemination to internal subject matter experts. Additionally, the format provided prohibits the ability to copy information from spreadsheets into the technical questionnaire. As an example, in the provided template, FA1 Attachments S-4, S-5, S-6 S-7, S-8, require each field to be manually input versus simply copying into the chart from an excel spreadsheet. Additionally, the documents as provided are extremely restrictive in their availability, which limits our editing capabilities to comply with such a request as consecutive numbering.

RESPONSE: The State will not provide unlocked files. In the Word template, text fields can be copied using the keyboard. Drop down cells cannot be copied. To copy a range of text fields, click in the first cell, hold down the Shift key, and use the down arrow key to select additional cells. Press Control-C to copy them. To paste, click in the first cell of the range where you want to paste and press Control-V. Page numbering within the template updates automatically and does not need to be altered.

33. *Please confirm that for Functional Area 3 – IHM-FI that over-65 Medicare eligibles are not eligible to enroll in this plan (plan design and benefit summary)?*

    RESPONSE: Confirmed. Please see the footnote on FA 3 Attachment S-3: IHM-FI Plan Design. "Regional Network Only. Plan only available to those not eligible for Medicare."

34. *4.4.3.7 Experience and Qualification of Proposed staff indicates that individuals working on the project and proposed subcontractors are required to submit a letter of intended commitment. Is this a requirement of this solicitation?*

    RESPONSE: See the Response to Question #7: The request for letters of intended commitment does apply to this solicitation and is intended for key personnel proposed to work on the project and any proposed subcontractor(s). It is preferred that the letters be from the individual key personnel proposed and any proposed subcontractor(s).

35. *For the Network Access charts indicated below, the total number of employees/retirees for each county do not match the census files provided. This file is "locked" in the actual word template provided, as such we are not able to modify the county counts so that they match the census file provided. Please advise.*
    - *FA1 Attachment S-5(B & C) Access to Adult PCPs*
    - *FA1 Attachment S-6 (B & C) Access to Pediatricians*
    - *FA1 Attachment S-7 (B & C) Access to OB/GYN*
    - *FA1 Attachment S-8 (B & C) Access to Hospital*

    - *FA2 Attachment S-5(B & C) Access to Adult PCPs*
    - *FA2 Attachment S-6 (B & C) Access to Pediatricians*
    - *FA2 Attachment S-7 (B & C) Access to OB/GYN*
    - *FA2 Attachment S-8 (B & C) Access to Hospital*

    RESPONSE: The counts in the Network Access Charts should be used for the GeoAccess *Reports.* The counts should not be modified.

36. *The Network Access chart in FA3 Attachment S-4b: Participating Physicians does not match the counties/states mentioned in the RFP Section 3 – Scope of Work for Functional Area 3-IHM-FI.*

    RESPONSE: Offerors proposing for FA3 should complete Attachment S-4b: Participating Physicians for the counties included in the proposed service area.

37. *Please confirm that we should complete the Network Access Chart S-4Bb: Participating Physicians as is or should we complete the chart based on the counties/states mentioned in the RFP Section 3 – Scope of Work for Functional Area 3-IHM-FI?*

    RESPONSE: Please see response to question #36.

38. *For FA1, FA2 and FA3 regarding the provider columns in the Network Access Charts S-4b: Participating Physicians, please identify how providers should be included in the appropriate columns as follows:*

a. Are Nurse Practitioners to be included as Primary Care Physicians?

RESPONSE: No, Nurse Practitioners should not be included as Primary Care Physicians.

b. For Pediatricians can General and Family Care Practitioners also be included in this definition?

RESPONSE: No, General and Family Care Practitioners should not be included as Pediatricians.

c. For OBGYN's, can Family Practice, General Practice or Internal Medicine providers also be included in this provider definition?

RESPONSE: No, Family Practice, General Practice or Internal Medicine providers should not be included as OBGYNs.

d. What is the definition of specialists? Medical only or all providers included in the quoted network.

RESPONSE: Only Medical providers should be included as Specialists.

e. Can non MD's, i.e, Vision, Dental, Rx sites be included in the category of specialists?

RESPONSE: Please see response to question # 38 d.

f. In the specialty Hospitals, can pediatric and tertiary care hospitals, ambulatory surgical centers or urgent care centers be included?

RESPONSE: Ambulatory surgical centers or urgent care centers can not be included in Hospitals.

39. *Can FA1 and FA2 Attachment S-1: GeoAccess® GeoNetworks® Reports be provided electronically only (on CD)?*

RESPONSE: The State will accept FA1 and FA2 Attachments S-1: GeoAccess® GeoNetworks® Reports provided electronically on CD/DVD. The State's preference is that the CD/DVD include a PDF file generated from the system and an Excel file. Please see Amendment 2.

40. *Can FA1 and FA2 Attachment S: Technical Proposal (Part II) [Filename: FA1 and FA2 Attachment S Disruption Analysis.docx] be provided electronically only (on CD)?*

RESPONSE: The State will accept FA1 and FA2 Attachments S: Technical Proposal (Part II) *[Filename: FA1 and FA2 Attachment S Disruption Analysis.docx]* provided electronically on CD/DVD. Please see Amendment 2.

41. *Plan Design S-3*

a. Common and Preventive Services: What is the definition of Basic Model Hearing Aid?

RESPONSE: A basic model hearing aid is a hearing aid worn on the exterior of the ear and is used primarily for hearing amplification. It does not include implant devices.

b. Emergency Treatment: What is the definition of Ambulance Services – land, air and sea?

RESPONSE: Ambulance services include all emergency transportation.

c. Other Services and Supplies: Family planning and fertility testing references a 6 – not on the legend, please explain criteria? This is only in FA1-PPO-SF, can this be removed?

RESPONSE: The reference to footnote 6 has been removed. See Amendment 2.

d. Vision Services: Vision - Routine Vision Exams are rendered by a specialist (Optometrist/Ophthalmologist) and carry a $30 copay. Should a $15 PCP copay be listed in this section?

RESPONSE: Please see Response to Question 2.

e. Vision Services: Frames – Further clarification is needed, as we cannot code "up to" dollar amount. Should this benefit read $45 reimbursement?

RESPONSE: The benefit for Vision Services is Up to $45 as in included in the Plan Design for each Functional Area.

f. Vision Services: No limits on vision hardware for children through age 18 – shouldn't limit show for frames or contact lenses per plan year like adult benefit? It reads no limits for children through age 18. Please provide clarification?

RESPONSE: No, the benefit listed complies with the Affordable Care Act pediatric vision requirement.

g. Diagnostic Lab and X-ray - is this only to be paid for services listed in legend (*) or will just those services be paid at 100% and all other in FA1 PPO-SF at in-network level?*

RESPONSE: As part of improving access to care and encouraging wellness activity, all diagnostic x-ray and lab services will be covered at 100%, even under the PPO plan.

h. Hospital (Outpatient Services): Should preauthorization requirement be listed in the header of this entire section?

RESPONSE: The requirement indicates that some services in the section may require pre-authorization. Specifically for Hospital Outpatient Services, preauthorization is required for out-patient surgery.

i. Therapies: Physical Therapy – PO should be PT, please advise?

RESPONSE: Yes, PO should be PT. Please see Amendment 2.

j. In the Mental Health and Chemical Dependency Services – please provide a definition for intensive outpatient services. This statement is included under Outpatient Services.

RESPONSE: Intensive Outpatient Services are provided in freestanding or hospital based facilities that specialize in treatment of mental health and co-occurring mental health and substance abuse disorders.

*k. IHM Diagnostic Lab Work and X-ray** - should the "**" be removed? If not, need explanation for what this footnote means given services already are to be paid at 100%.*

RESPONSE: Yes, for Functional Area 3, Diagnostic Lab Work and X-rays are covered at 100% so the "**" does not apply. Please see Amendment 2.

l. IHM Physician Office Visits – Specialist – is copay listed incorrectly? Shouldn't it be $30 based on other reference within plan design?

RESPONSE: Please see Response to Question #2. The RFP requirement is correct as written.

42. *Financial Proposal: Section 4.5.4 (p. 59) lists T-5 in FA3 as "Enrollment;" however, there is no "Enrollment" sheet in the Excel document, rather, T-5 is "Financial Proposal Summary." Is there an "Enrollment" document forthcoming?*

RESPONSE: No further enrollment information will be provided. FA 3 IHM-FI Attachment T-5 is the "Financial Proposal Summary." Please see Amendment 2 for the correction to Section 4.5.4.

43. *Is the expectation of the State to use each carrier's Health Assessment?*

RESPONSE: No, please see Response to Question #11.

44. *What will be the State/employee contribution to the EPO, PPO and IHM?*

RESPONSE: Employee contribution levels are covered by collective bargaining agreements. Currently, the splits are 85/15 for EPO, 80/20 for PPO.

45. *The State currently self-bills for the self-funded plans. For the IHM plan does the State expect to self-bill for this fully insured plan?*

RESPONSE: Yes.

46. *The claims re-pricing is not clear. Nine claims files were sent with the bid (3 PPO, 3 POS and 3 EPO). How should the POS claims be re-priced (under PPO, or IHM model) or do they need to be re-priced at all.*

RESPONSE: All claims must be re-priced for FA1 and FA2. FA3 does not require claims re-pricing.

47. *As the POS plans are being eliminated, please clarify if the State will be conducting an active enrollment for 1/1/2015 (in which all employees will need to select their medical plan) or a passive enrollment in which current POS plan enrollees will be automatically placed into a default plan. If it will be a passive enrollment, please identify the default plan elections that will apply.*

    RESPONSE: The State will conduct an Active Open Enrollment for the plan year beginning January 1, 2015.

48. *What is the State's specific rationale for eliminating the POS plans?*

    RESPONSE: The State's rationale for eliminating the POS plan will not be provided.

49. *Regarding the following three repricing files, PPO 1, EPO 2, and POS 2, the Place of Service indicator has some letter codes we are unable to translate. Can you please provide us with a key that specifies which codes are Inpatient, Outpatient or Physician?*

    RESPONSE: A response to this question will be included in Questions and Responses #2.

50. *Three sets of repricing files were provided: PPO, EPO and POS. Can you please confirm if we need to reprice all three files for the PPO RFP repricing, and all three files for the EPO RFP repricing? Or should we only use certain repricing files for certain plans? (The instructions in Attachments T5 for the EPO and PPO were different).*

    RESPONSE: Please see Response to Question #46.

51. *Please identify the vendors incumbent carriers currently use to meet the MBE requirements in the RFP and the specific services provided by each of those vendors.*

    RESPONSE: Information regarding the current contracts for Health Plan Administration and Services may be found on the Department of Budget and Management's website, under the Contract Library: http://dbm.maryland.gov/contractors/contractlibrary/Pages/HealthPlanAdmin.aspx

    Any additional information detailed in the technical proposal portions of each of these contractors' selected proposals may be provided upon submission of a Public Information Act (PIA) request to the procurement officer for those specific contracts.

52. *Please split the claims and enrollment out by carrier as a supplement to what was provided in "Attachments U_1 U_3 U_5 Claims and Enrollment.xlsx."*

    RESPONSE: Please see Response to Question #14.

53. *Regarding Attachment T-2, Item F-7: Contractor agrees that annual increases, after the initial three years of the contract, will be capped at annual CPI-U. Should we use All Items CPI-U or Services CPI-U?*

RESPONSE: Services CPI-U should be used.

54. *Bidders are asked in Section 1.43 to complete the Location of the Performance of Services Disclosure (Attachment N), indicating if they will offshore or not. However, the compliance checklist, item CC-3, prohibits off-shoring. Please clarify if offshoring of certain services is allowed. If offshoring is allowed for certain services only (e.g., non-member facing services), please clarify which services those are.*

RESPONSE: CC-3, prohibiting off-shoring, is correct. However, Attachment N, Location of the Performance of Services Disclosure, is still required to be submitted with an Offeror's technical proposal, as this document is required for State procurements estimated to be valued over $2,000,000.

55. *Where should we reflect the pricing for the Health Activities Program (3.3.1), Tobacco Programs (3.3.2) and Performance Management Program (3.3.4) in the Administration and Network Access Fees from of Attachment T-4? There is no specific line item for these.*

RESPONSE: These fees should be included in "Wellness and Disease Management" under Administration Fees.

56. *How will conventional premium equivalent rates be set for the EPO and PPO plans in 2015? If the State plans to base these rates off of the claims experience of the current plans, please describe the specific methodology that will be used.*

RESPONSE: The State's methodology for rate development is not required to respond to this RFP**.**

57. *Please describe the specific contribution strategy that the State proposes to use beginning in 2015.*

RESPONSE: Please see Response to Question #44.

58. *Given that the State is still uncertain as to how many vendors may be selected to provide EPO and PPO options in 2015, why is the State requiring that offerors use fixed enrollment of 115,195 subscribers for both of these products? Asking offerors to provide fees for several different enrollment thresholds (e.g., <25,000 subscribers, 25,000 – 49,999 subscribers, >50,000 subscribers) would seem more appropriate. Will the State consider proposals that provide bracketed fees at these levels?*

RESPONSE: No, the State will not consider proposals that provide fees based on enrollment brackets. All proposals must be completed based on the guidelines in the RFP.

59. *How did the State determine the target levels for CY2 identified in "FA2 Attachment S-13: Performance Metrics? Do they reflect the State's current experience? If not, would the State consider setting targets in CY2 and beyond that reflect a level of improvement from the results seen in CY1?*

RESPONSE: The target levels are set based upon acceptable levels of improvement above the current level of experience. No, the State will not accept setting targets differently from what has been developed in the RFP.

60. *Can we offer a telephonic Health Risk Assessment (HRA), rather than a paper HRA, if we feel we can get a better response on the former? (per Section 3.3.1)*

RESPONSE: A paper Health Risk Assessment (HRA) is required.

61. *Section 3.3.2 discusses reporting on tobacco cessation programs. Would this be reporting on programs you are going to offer from a third party, or would the proposer be expected to administer the program?*

RESPONSE: The Contractor is expected to provide, track and report on the required programs.

62. *The State's strategic vision incorporates a significant amount of activity tracking and reporting. As outlined in the RFP, this activity tracking and reporting would be performed by each individual medical carrier. Would the State consider a proposal from a third party to handle all of this activity tracking and reporting on a uniform basis? Each medical carrier would need to provide data to the third party but this solution would allow the State to receive aggregate reporting while ensuring absolute consistency across medical carriers. Aggregate reporting would also likely be more cost-effective and efficient for the State.*

RESPONSE: Please see Question #61.

63. *Within the RFP there is a request to help facilitate the discussion of health risk assessment results with a member's treating physician, supported by specific incentives. We are excited about this specific opportunity to enhance the member/physician relationship because that relationship has been core to the development of our population engagement strategy. We would like to know whether the State has considered strategies that would ensure consistent delivery and content of member and physician communication related to this. We believe that such consistency would be beneficial to the State, its employees, and the physician community by eliminating any potential variation in execution that may occur within each carrier's delivery model. Understanding this point would help us finalize how we might propose to integrate our solutions on behalf of the member and physician communities.*

RESPONSE: During implementation, the State will provide each Contractor with the State-developed health risk assessment to ensure consistency among Contractors.

64. *Will the State agree to vendor contingency fees that are paid as a percentage of claim savings? An example would be fees paid to a third-party subrogation vendor for the services it performs. Please note that this is how these services are handled today.*

RESPONSE: No, the State will not agree to vendor contingency fees.

65. *Will the State agree to optional program fees as a percentage of claim savings? An example would be an optional program that provides access to third-party negotiated*

rates for certain out-of-network services and case-specific rate negotiations with out-of-network providers. Such arrangements would be financially advantageous to both the State and its employees. Additionally, this is how such services are handled today.

RESPONSE: No, the State will not agree to optional program fees as a percentage of claim savings

66. *The Individual, Double, and Family enrollment columns in Attachment U-4 indicate "Employees" at the top of the columns; however, the Total enrollment column indicates "Members". Are these enrollment numbers Employees or Members?*

RESPONSE: Please see response to Question #16.

67. *Can we get both employee and member enrollment counts by month for Attachment U-4?*

RESPONSE: Please see response to Question #14.

68. *In section 3.1, the State outlines that it expects to conduct 130 or more quarterly wellness fairs throughout the State each year. This would total approximately 520 wellness fairs per year. Please confirm if this is the State's intent.*

RESPONSE: The State is confirming there will be approximately 520 wellness fairs per year.

69. *What are the 2014 medical administrative fees for each of the plans by carrier?*

RESPONSE: That information is confidential and will not be provided.

70. *What claim fiduciary option does the State want offerors to follow? Today, we perform claim fiduciary for Level 1 appeals only and the State performs claim fiduciary for all other Level 2 appeals and the State follows Federal external review program. Will the State continue to use this claim fiduciary process and Federal external review under this RFP contract?*

RESPONSE: For Functional Areas 1 and 2, the State will continue to follow the current claim fiduciary process. For FA 3, the Contractor will be responsible for all levels of appeals.

71. *The drop box in Compliance Item CC-17 in the PPO response document (FA-1) is not working. Would it be acceptable to put our responses to this item (and any others that might not work) in S-2 Explanations and Deviations worksheet?*

RESPONSE: The drop down has been corrected. Please see Amendment 2.

72. *Can the State please clarify what the intent of Compliance Checklist CC-61.a is? We would typically access electronic health records containing PHI multiple times throughout the day for clinical management and claim payment purposes, as a regular part of our plan administration.*

RESPONSE: A one-time notification by the Contractor that it uses or maintains electronic health records containing PHI as a part of its daily operations is sufficient to comply with this requirement. However, Contractor must comply with HIPAA and the contractual terms regarding mandatory notifications requirements for specific disclosures of electronic health records containing PHI.

73. *Section 1.4.4 Contract Duration: Please provide clarification regarding the term of the contract for IHM FA3. There is a discrepancy from FA1 and FA2 in the absence of renewal "option years." Will a separate RFP for IHM FA3 be solicited for coverage beyond year 6? If not, what is the "State's" intention for the IHM FA3 population beyond year 6?*

RESPONSE: Section 1.4.4 is correct. FA1 and FA2 are to be 6-year contract terms, with two 2-year option periods (for a possible total contract term of 10 years each). FA3's contract term is 6 years, without any option periods. The State will decide in the upcoming years how coverage beyond the 6-year FA3 term will be procured.

74. *Section 1.22 Offeror Responsibilities: Carriers use subcontractors for a wide range of operational functions. Are there key functional areas in the payment for or delivery of healthcare services that the State wants Offerors to focus on in identifying subcontractors, such as enrollment or billing or claims processing or disease management? We assume that certain vendor relationships, such as copying or maintenance services are not of interest to the State.*

RESPONSE: It is up to each Offeror to determine which area(s) it wishes to propose subcontractors to provide services for under the State's plans. The State will not provide specific areas for Offerors to focus on or preclude from subcontracting.

75. *Section 1.33 Minority Business Enterprise Goals: Once Contractors designate MBE and VBE subcontractors, is there a mechanism for substitution if, for any reason, any one of these subcontractors cannot perform for the entire term of the contract?*

RESPONSE: Offerors proposing subcontractors to meet the MBE and/or VSBE goals should plan and coordinate with those proposed subcontractors to fulfill the entire term of the contract. If an Offeror is awarded a contract, and a proposed subcontractor of that Offeror is later unable to perform for the entire term of the contract, the State will work with the Contractor in determining why that subcontractor could not complete performance, and a substitution may be possible, depending on the particular circumstances, via a modification to the contract.

76. *Section 1.34 Living Wage Requirement and Section 1.37 Non-Disclosure Agreement: Functional Area 3 (IHM) is not included among the proposal functional areas for which Offeror will obtain schedules and attachments relating to living wage rates, demographic data, provider and facility utilization and disruption reports. Was this intentional or an accidental omission? Offerors in FA 3 will also require this information in order to prepare the technical and financial sections of their proposal.*

RESPONSE: Regarding Section 1.34, Living Wage Requirement, the "Tier 1" and "Tier 2" rates are not to be confused with "Functional Area 1" and "Functional Area 2;" these are entirely different subjects. Regarding Section 1.37, Non-Disclosure Agreement," only specific confidential historic data related to Functional Area 1 and Functional Area 2 is being made available. The State does not have historic data for Functional Area 3 as the State does not have a current IHM (Functional Area 3) plan for its participants.

77. *Section 1.43 Location of the Performance of Services Disclosure: Please identify any compilation, directory, or list of pricing for services that the Department considers authoritative or definitive for use by an Offeror in determining whether "the price of services in the United States exceeds by an unreasonable amount the price of services provided outside the United States"? Is there a rate of compliance for Offerors?*

RESPONSE: Such pricing information is not readily available from the State. However, please also see the Response to Question #54. Compliance Checklist item CC-3 prohibits off-shoring. Attachment N, Location of the Performance of Services Disclosure, is still required to be submitted with an Offeror's technical proposal, as this document is required for State procurements estimated to be valued over $2,000,000.

78. *Section 1.45 Performance Guarantees and Liquidated Damages: Will the Contractor be given notice and the opportunity to challenge the merits of the assessment of Liquidated Damages before liquidated damages are deducted from any money payable to the Contractor or are billed to the Contractor as a separate item? If so, please describe the process.*

RESPONSE: The liquidated damages provisions that are assigned to these contracts are clearly delineated in the RFP and have specific standards/goals and performance measurements that leave little room for misinterpretation or misapplication. Therefore, Contractors will not be provided additional "notice" or opportunity to "challenge" a deduction in payment as a result of a liquidated damage assessment.

79. *Section 3.1 Background and Purpose, p. 28: The RFP states that the State is looking to Contractors to "Integrate community health workers into the overall health management of members." How does the State define "community health worker"?*

RESPONSE: Community health workers include health department workers, nurses, other community pharmacists, etc. Refer to the State of Maryland Department of Health and Mental Hygiene's State Innovation Project for more details. The website is: **http://dhmh.maryland.gov/newsroom1/Pages/$2.4-Million-State-Innovation-Model-Grant.aspx**

80. *Please provide clarification and greater detail on pg.28 with regards to the following:*
    - *Offer online tools for member for pricing basic services, tests and procedures.*
    - *Offer online resources allowing members to compare providers based on quality and efficiency.*
    - *Provide reports on provider outcomes.*

RESPONSE: As stated in Section 3.1 Background and Purpose, "The State is seeking Contractors that can provide the best in class health benefit services and together with the State support overall member health improvement and increase access to quality care and the efficiency of service delivery to meet this new program's goals and objectives." These three items are an important part of increasing access to quality care. The State is asking the Offeror to describe existing capabilities including reporting and online tools available to members, to aid them in making informed healthcare decisions.

81. *The Functional Area 3 (IHM) Scope of Work indicates that Medicare-eligibles are not included. However, the plan design in (FA3 Attachment S-3: IHM-FI Plan Design, p.5) refers to Medicare COB. It is unclear under which scenarios Medicare COB would occur for Functional Area 3 (IHM), based on the Scope of Work language. Please clarify.*

RESPONSE: In FA3 Attachment S-3: IHM-FI Plan Design, the reference to Medicare COB has been removed in Amendment 2.

82. *What benefit options are available to early retirees that age-into Medicare eligibility under FA3? Is State open to allow Medicare age-in ability to continue receiving benefits from existing FA3 carrier prior to age-in?*

RESPONSE: Ageing into Medicare eligibility will be considered a qualifying life event. Early retirees that age-into Medicare eligibility while enrolled in FA 3 will therefore have an opportunity to enroll in one of the other benefit plans (FA 1-PPO or FA-2 EPO).

83. *Value Based Benefit Design – Section 3.3.1-2 Health Activity Offerings and Tracking:*
    a. *Will State or Contractor develop the HIPAA authorization that members must sign to permit use and disclosure or data to employer for rewards/incentives purposes?*

RESPONSE: The State does not see a need to use a HIPAA authorization since the data being transferred is not PHI and it is data transferred to the Health Plan not the employer. The State is requesting the carriers to transfer a simple "yes" or "no" that the activities were or were no completed. No values or specifics about the activities should be transferred.

    b. *In plan year 2016, please clarify which PCP copays will be waived (i.e. preventative, sick office visits etc.) for those employees that have completed the State's Wellness activities (i.e. selected a PCP, completed a Health Risk Assessment and discussed their results with PCP)?*

RESPONSE: In plan year 2016 and future plan years, for each Functional Area, all PCP copayments will be waived for those employees that have completed the State's required Wellness activities.

    c. *Is the copay waiver applicable for all dependents if the employee and the spouse have been successful in engagement and qualify for the PCP copay waiver?*

RESPONSE: No the copayment waiver is not applicable for dependents if the employee and spouse qualify for the PCP waiver.

d. Is the copay waiver applicable to Functional Area 3?

RESPONSE: Yes, the copayment waiver is applicable to Functional Area 3.

e. Will the premium surcharge for those individuals who did not complete the required activities for 2015 be charged as early as 2016, or will surcharges not be charged until 2017 with refusal/failure to engage in treatment recommendations and healthy activity requirements?

RESPONSE: In 2016, the $50 surcharge is applicable to those who failed to select a PCP, complete the HRA and review the HRA with his/her PCP.

f. Will premium surcharges be administered by the State through employee contributions or through the contracted tiered rates with carrier?

RESPONSE: Premium surcharges will be administered through the State through employee contributions.

g. What is the anticipated premium surcharge amount and the frequency in which it will be imposed?

RESPONSE: More information on premium surcharges will provided during implementation.

h. Will on-line wellness coaching programs satisfy the State's requirements for carrier-offered Nutrition Education, Weight Management, Stress Management and Tobacco Cessation programs?

RESPONSE: No. A combination of in-person and online will be allowed, but both must be available.

i. Will the carrier self-define what actions constitute an enrollee meeting based on the requirements to qualify for plan design incentives? For example, will each carrier use its own eligibility definitions for a disease management program or must they follow a State definition? Or, will each carrier use its own definitions of what constitutes completion of tobacco cessation programming or must enrollees complete specific State-defined activities?

RESPONSE: Please see the guidelines for the Health Activity Requirements in RFP Section 3.3 General Requirement for all Functional Areas. Each vendor will be required to use their own compliance guidelines and definitions to determine eligibility for disease management programs. The objective is to emphasize participant engagement in the Disease Management program. Participants who do not meet the guidelines for engagement will be deemed not to have met the healthy activity requirement. The State reserves the right to review and make changes to the Disease Management guidelines for eligibility and completion during the contract period. Offeror should be sure to include in their Technical Response to RFP Requirements and Proposed Work Plan their plan for meeting the State's objectives related to Disease Management.

j. Will the Contractor define its targets for wellness program completion and success (e.g., number of smokers who quit)? Or does the State have program benchmarks established? If the State has its own benchmarks, will the State require the Contractor to apply the State's benchmarks or allow the Contractor to apply its own benchmarks?

RESPONSE: At this point, the State is requiring participants to attend the wellness program that they select and meet requirements set forth in the health activity requirements for the wellness program. The State will expect regular reports about the success of the program, such as number enrolled, number completing the program, dropout rates, graduation rates, etc**.**

84. *Section 3.3.5 – Network Tiering:*

a. How does the State define Centers of Excellence or High Performing Network?

RESPONSE: Centers of Excellence networks are the gold standard in complex health care, such as a Transplant Centers of Excellence network. However, many carriers offer products and services that promote safe, successful and cost-effective treatment options for many other complex medical conditions, including cancer, congenital heart disease and infertility.

The State is also expecting carriers to actively work to improve hospital outcomes for many high volume tier two level procedures such as – knee, hip and joint replacement, heart by-pass surgery, and others. It is desired that the carrier will be working actively to develop outcomes data that the State in partnership can use to optimize hospital outcomes and play an active role in guiding participants to the best provider at the best provider in the best facility.

b. What does the State mean by "incentivize the use of high-quality, high performing providers"? Would providing members lower out of pocket copays if they use these providers satisfy these criteria? Are there other ways to satisfy these criteria?

RESPONSE: Incentives come in many forms from variations in copayments to setting up more restrictive network access for certain procedures.

85. *Section 3.4 - Functional Area Specifications:*

a. Please confirm that FA3 does not currently include attachments for Adult PCPs, Access to Pediatricians, and Access to OB/GYN. Was this an oversight?

RESPONSE: Confirmed. The information required for participating Physicians is included in S-4. There are no additional S-4 attachments required for FA 3. In addition, in response to FA3 Attachment S-1: Plan Information, Section III Medical Delivery System, the Offeror should provide a website address for a complete provider directory.

b. Was "Access to Hospitals" not included for FA3 because FA 3 is an integrated plan? How should Offerors submitting proposals in FA3 report parts of the delivery system (Hospitals or SNFs for example)?

RESPONSE: Yes, "Access to Hospitals" was not included for FA3 because FA3 is an integrated plan. The information required for participating Physicians and Hospitals is included in S-4. There are no additional S-4 attachments required for FA 3. In addition, in response to FA3 Attachment S-1: Plan Information, Section III Medical Delivery System, the Offeror should provide a website address for a complete provider directory.

86. *Section 3.11 – SOC 2 Type II Audit: Is this SOC 2 audit specific to Contractor's operations for the State of Maryland Contract? Please define the audit scope (i.e. Eligibility, Claims, and Call Center etc.)?*

RESPONSE: The SOC 2 Type II Audit requirements are specific to the Contractor's operations for the State of Maryland Contract. Please refer to RFP Section 3.11. The SOC 2 Type II Audit requirements apply to "Insurance Claims Processing Services, to include member portal, enrollment eligibility and billing functions (collectively referred to as the 'Information Functions and/or Processes')."

87. *Section 4.4.3.14 – Legal Action Summary: The RFP asks for summaries of, among other things, "potential claims" against the Offeror etc. The term "Potential claims" is ambiguous, and, in our view, overly broad. We propose to narrow this request to active or pending lawsuits.*

RESPONSE: "Potential claims" refers to any adverse claims against the Offeror that the Offeror is aware of that may not have yet been formally filed, or that may have been filed, but not yet received a formal, published filing/docket number. Offerors are requested to meet the RFP requirements and disclose any such potential claims.

88. *Section 5.2.4: Ability to cover current eligible participants is N/A for FA3: FA3 does not currently include attachments for Adult PCPs, Access to Pediatricians, and Access to*

OB/GYN. Was this an oversight? FA3 does not include a disruption analysis as part of the evaluation criteria. Was this an oversight as well?

RESPONSE: Please see response to Question #85.

89. *Section 5.1 – 5.5 Evaluation Committee, Evaluation Criteria, and Selection Procedure:*
    a. *Please provide the category percentage weighting (prioritization) that will be employed to score and award contracts under the RFP (i.e., Financial Proposal x%, Network Access x%, Wellness x% etc.)?*

    RESPONSE: The State will not utilize a "scoring" or "percentage" weighting system during the technical evaluation. Instead, the Evaluation Committee will rank Offerors' technical proposals using the evaluation criteria stated in Section 5.2. While these criteria are stated in descending order of importance, no specific points or percentages will be assigned to any criteria. Technical proposals will be ranked by number, depending on the total number of proposals evaluated (ex. If five proposals are evaluated, a technical proposal will be ranked, 1, 2, 3, 4, or 5, depending on its technical merit). See also the Response to Question #90 below.

    b. *The FA3 Financial Proposal (Attachment T-2, F-6) requires adherence to the Medical Loss Ratio standards as defined in PPACA. This is further detailed under the Compliance Checklist S-5, C-81, p.23. However, the Financial Proposal for IHM (T-1 through T-5) does not include language in reference to the State-specific MLR request noted in S-6, Q-44. What weighting will a guarantee under the State-specific MLR (Q-44) have vis-à-vis the weighting of the Financial Proposal (T-1 to T-5)?*

    RESPONSE: Financial Proposals will not be "weighted." See RFP Section 5.3 for financial proposal ranking information.

90. *Section 5.5.3 Award Determination: Please clarify the process for making the "most advantageous" determination in the event that the overall rankings of two competing proposals are deemed essentially equivalent. For example, assume a "1" technical ranking coupled with a "2" financial ranking for Proposal A, and a "2" technical ranking coupled with a "1" financial ranking for Proposal B. If technical and financial factors will be given equal weight, that's a tie. In those circumstances, will technical factors or financial factors serve as the tiebreaker in determining whether Proposal A or Proposal B is "most advantageous" to the State?*

    RESPONSE: The evaluation and award recommendation process (see RFP Section 5) does not operate in the exact manner as you have described.

First, the technical evaluation and ranking process is a subjective process; while one Technical Proposal may receive a ranking of "1" and another Technical Proposal may receive a ranking of "2," those two Offerors' Proposals may be determined to be relatively similar (similar strengths and/or weaknesses) or they may be considered to be vastly different (significantly different in strengths and/or weaknesses). As no points/percentages/scores/etc. are used in the technical evaluations, an Offeror's technical rank does not necessarily equate to a numeric difference between Offerors' technical proposals. "1" is considered to be better than "2," but the degree that "1" is considered to be better than "2" is not immediately apparent based solely on the ranking numbers.

Second, the financial evaluation is an objective process; Offeror's financial Proposals are ranked simply based upon their bottom-line price for the particular Functional Area, but similar to the technical evaluation, the differences between the Financial Proposal ranked "1" and the Financial Proposal ranked "2" are not immediately apparent. The difference between the two Financial Proposals could be $100 million or $1.

Therefore, as technical and financial rankings do not immediately indicate the actual varying strengths and weaknesses of proposals, giving equal weighting to technical and financial proposals in the final analysis does not mean that "1 and 2" or "2 and 1," as described in the question, automatically results in a "tie." Giving equal weighting may instead be interpreted as there being no default "starting point" or initial preference for technical or financial factors in the final evaluation. In the final analysis, the evaluation committee will look at the technical and financial proposals as a whole when determining which proposal is most advantageous for the State, but there will be no initial preference for higher-ranked technical proposals (technical greater weight) or vice versa, higher-ranked financial proposals (financial greater weight).

Note that it is actually very rare, and virtually impossible, for there to be an exact "tie" in the competitive sealed proposal process used for this RFP, as there is no mathematical evaluation or "blending" of technical and financial proposals as the question describes. Offerors' proposals will have varying technical and financial strengths and weaknesses, and it is up to the evaluation committee to make a subjective determination as to which total proposal (technical and financial combined) is considered to be ranked number "1" overall and the most advantageous for award recommendation.

91. *FA3 – S-3 IHM Technical Questionnaire:*
    a. *Is it the State's intent that "Hospitals" are counted, or "hospitalists?" Would that include all facilities or only General Acute?*

RESPONSE: For FA3 Attachment S-4 Participating Physicians, the number of Hospitals should include the number of acute inpatient hospital facilities only. The hospital counts should not include hospitalists.

b. *Retirees could have dependents that are Medicare eligible but still continue to work. In which case, they are not required to purchase Part B Medicare per Federal MSP regulations. Also, the retiree will not have to purchase part B because they will be considered MSP. In both cases, they are allowed to defer Medicare part B coverage without penalty until their MSP status changes. Is the State making it mandatory for ALL Medicare Part B eligible members to purchase Part B, even when they are not required to enroll into the Part B program*?

RESPONSE: The State requires its retirees and the retiree's dependents to enroll in Medicare A and B when first eligible to avoid the gap in care that may result due to the State plans automatically becoming secondary to Medicare at that time. In the example provided, the actively-working dependent's employer-provided healthcare would presumably be the primary payor for the dependent's coverage. Therefore, the lack of enrollment in Medicare Part B for that individual would be moot.

c. *Is the State saying that if a member is eligible for Medicare Part B coverage, but decides not enroll in the program, he/she will have to pay for the entire cost of Part B related services? Meaning that we will have to bill the member/guarantor for the entire Part B related charge?*

RESPONSE: That is correct.

d. *ESRD members who are in a group plan do not have to sign up for Part B Medicare for 30 months. They are considered MSP during the ESRD coordination period. Is the state saying that the ESRD Medicare entitled member must purchase Part B or pay for the entire cost of Part B related services?*

RESPONSE: It is correct that the ESRD members do not have to sign up for Part B Medicare for 30 months. But after the 30 months the Medicare entitled members must purchase Part B or pay for the entire cost of Part B related services.

92. *IHM Plan Design:*
   a. *Will the incumbent carrier's benefit plans be considered Grandfathered, and not subject to EHB requirements?*

RESPONSE: The Stare is unclear what is being asked. There is no incumbent for the IHM Functional Area.

b. *Please confirm if the Urgent Care Copay (p.7) is expected to be $15 vs. $30.*

RESPONSE: The urgent care copay is correct as written and is $30 under FA1 and FA2, but $15 under FA3.

c. Please confirm if the Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) copays (p. 6) are expected to be $15 or $30.

RESPONSE: The copays for PT, OT and ST are $15 for FA3 only; $30 for FA1 and FA2.

d. Please clarify whether the dollar amounts represented in the description for Vision Services represent allowance or employee cost share (p.9).

RESPONSE: The dollar amounts represented in the description for Vision Services represent allowance.

e. Please clarify what is meant by "Medically Necessary" for Contact Lenses (p.9).

RESPONSE: No additional clarification will be provided.

f. Please clarify what is meant by "Cosmetic" for Contact Lenses (p.9).

RESPONSE: No additional clarification will be provided.

93. *Compliance Checklist:*

a. CC-12, CC-13: Will the FA3 Contractor be expected to attend Open Enrollment meetings outside of its geographic service area? Will the Account Management staff be allowed to cover only those meetings in its foot-print?

RESPONSE: The FA3 Contractor will be expected to attend all Open Enrollment Meetings inside its geographic service area and those outside its service area but within 15 miles of the Service Area boundary.

b. CC-36: Will the State clarify its intent regarding CC-36 in terms of who needs to receive notification via written letter about a participating physician termination? Is the State asking for carriers to send a postal letter every time any doctor in the carrier's network leaves and is no longer accepting the carrier's insurance? In particular, if a physician leaves a group practice, but the group contract remains in place, is notification required to the State? Second, is the communication/letter meant to notify every single enrollee in the entire State account, or is the intent to

only directly inform enrollees who have seen that physician in the recent past (e.g., 6 months) or have that physician as their PCP? Third, if the communication letter is a standard template, will the State need to review and approve communications each time or just the first time?

RESPONSE: The Contractor will be required to notify participants treated by a participating provider within the previous 12 months when a physician terminates. If the participating provider within a group practice terminates and the group remains active the participant should be notified when they call to schedule an appointment but a letter is not required. The State reserves the right to review all participant communications in advance of release.

c. *CC-37: Will the State clarify its intent regarding CC-37 in terms of the trigger that would force a carrier to inform the State about a termination? Is the State asking carriers to notify them of every time any doctor in the carrier's network leaves and is no longer accepting the carrier's insurance? In particular, if a physician leaves a group practice, but the group contract remains in place, is notification required to the State?*

RESPONSE: Please see response to Question # 93 b.

d. *CC-107: The RFP requires Contractor's reporting of individual participants' compliance with requirements for healthy activities, etc. in order to support the State's administration of copay waivers and a premium surcharge. Will the State develop the written individual HIPAA Privacy Authorization form to facilitate this reporting, or is the Contractor expected to develop that form? (p. 27)*

RESPONSE: Please see response to Question #83 a.

94. *FA3 IHM-FI Technical Proposal Attachment 6: Questionnaire:*
   a. *Q-43: "Identify the annual percentage increase in payments (on a per unit of service basis) made to contracted providers for 2012 and estimated for 2013 and 2014." Vendor does not distinguish payments to its primary medical group based on provider type and the payments are not made based on unit of service basis. Please clarify what information the State is seeking so that a responsive answer can be provided.*

RESPONSE: The State is seeking information about the change in provider payments made by the Offeror for the stated time periods. Please provide with your proposal.

b. *Q. 86 The RFP asks the Contractor to "[c]onfirm that OBGYNs, pediatricians or others may be selected as primary care physicians." While OBGYNs are not*

designated as primary care physicians by Offeror, vendor provides access to OBGYNs in accordance with state and federal law. We assume this is acceptable; if not, please advise.

RESPONSE: Yes it is acceptable as long as the Offeror provides access to OBGYNs in accordance with state and federal law.

c. *Q-116: The RFP asks the Contractor to provide biographical information of the "medical management staff assigned to the state's account." How does the State define Medical Managements staff—utilization review, case management, or both? (p. 45)*

RESPONSE: Medical Management staff includes both utilization review and case management staff. In response to Q-116, please provide biographical information as requested for both.

d. *Q-173: The RFP asks whether the State would have "real-time data regarding employees' health and wellness activities being tracked" by the Contractor. Please define real-time access to reports? Is this a request for read-only capabilities or a request to run reports on-demand? (P. 53)*

RESPONSE: In response to Q-173 Offeror should describe capabilities to provide the State access to current employees' health and wellness activity data being tracked by the Contractor and ad hoc reporting on wellness activities.

95. *FA3 Attachment S-9: Performance Metrics, p. 81-83:*

a. *Under the Performance Guarantees "Liquidated Damages," are the amounts calculated as a percentage of total fees? Is this the approach intended for the Functional Area 3 (IHM) Fully-Insured offering?*

RESPONSE: Yes. The same method is being used for all plan options.

b. *In Attachment S-9: Performance Metrics. The total number of available points adds up to be 122; however, the actual payment model shows a maximum of 100 points. Is this intentional or an error?*

RESPONSE: For FA 3 the Clinical Compliance Metrics for Utilization Rates have been omitted. See Amendment 2. The points now total 100.

c. *FA3 Attachment S-8. For Performance Guarantees 11, 12, and 13, what are the criteria for who should receive a call? Are these criteria to be defined by the Contractor or the State? And, would documentation of outreach via other methods*

suffice or must the outreach be telephonic (e.g., email, postal mail, video consultation, other electronic formats)?

RESPONSE: The criteria will be determined by the Contractor but the standard/goal regarding the type of outreach is telephonic as stated in the RFP.

d. *Please clarify if Carriers will receive credit under the "Shared Savings" arrangement for having stronger performance metric scores than competing Carriers (i.e. application of a risk score?) or is each Carrier only competing against their own prior year metrics? Please clarify if there are incentives to have better scores than the competing carriers?*

RESPONSE: The shared savings model is developed to measure performance of each carrier separately and not on a comparative basis. Each carrier is credited with shared savings based on the population that it manages. The allocation of rewards is proportional to the total population under management.

e. *Please detail the payment process under the "Shared Savings" arrangement. Will there be a separate payment at a pre-specified time, or will the funds be netted from our monthly billing? Will documentation be provided regarding the specific payments and at what frequency?*

RESPONSE: The shared savings pay outs will be made following review of all the carriers reported of results. For example, if a report is received at the end of the 1st quarter following the year measured, payout would be made during the 2nd quarter.

96. *General Questions for FA3 (IHM) Technical Questionnaire and Attachments:*

a. *Will the State allow two different proposals from the same Offeror in Functional Area 3 if these offerings use different provider networks?*

RESPONSE: No. Please refer to RFP Section 1.12: "Multiple and/or alternate Proposals will not be accepted. Submitting a Proposal for more than one Functional Area is not considered to be 'multiple' Proposals." While an Offeror may submit one Proposal for each Functional Area, submitting a second, "alternate" proposal for a Functional Area is not permitted. Offerors are requested to submit what they consider to be their best single Proposal for the Functional Area(s) proposed.

b. *Given the opportunity for the Integrated Health Model to save significant dollars through the integration of health and pharmacy benefits, will the State consider allowing the Offeror to submit a proposal which combines health and pharmacy benefits in Functional Area 3 in addition to the requested health benefit proposal?*

RESPONSE: No, the State will not consider at this time a proposal which combines health and pharmacy benefits in Functional Area 3.

c. *For the Health Activity offerings and tracking, what is the frequency desired for reporting on required activity for covered employees and spouses?*

RESPONSE: The required frequency of reporting on Healthy Activities is Quarterly.

d. *Please define State and Employee premium contribution percentages for all three Functional Areas.*

RESPONSE: Please see response to Question #44.

i. *If the Contribution Strategy changes before contract termination, will carriers be provided advance notice and offered the ability to adjust rates?*

RESPONSE: Carriers will be provided advance notice if there is a change to the Contribution Strategy, but will not be permitted to adjust rates. The State contribution strategy is not used to steer members into one plan over another.

ii. *Can the Contribution Strategy change between the RFP due date and the effective date? If so, how much prior notice of such change will be provided to carriers?*

RESPONSE: Yes, contributions are collectively bargained. While unlikely to change, they could.

e. *FA3 Attachment S-1, Part III. Do "service centers" refer to locations where insurance functions (member services, claims processing, etc.) are performed, or should "services centers" include locations where medical services are provided?*

RESPONSE: "Service centers" refers to locations where administrative/insurance functions are performed.

f. *FA3 Attachment S-3. Are Referrals ever permitted in this plan? State mentions "No referrals in this plan." Can this requirement be clarified? Does this mean an open access plan where enrollees can self-direct to any specialist any time? And, what would apply if enrollees wanted to see a specialist out of the network or that is not on staff within the IHM? It would seem a referral process needs to be in place for care outside the IHM and also internally (for initial consultation to a specialty), not to represent gatekeeper model, but simply for the benefit of care coordination and information gathering.*

RESPONSE: As there is no out of network coverage under this Functional Area and this plan will have the strictest managed care with the PCP directing the member's care, it did not appear necessary to include referrals. In the IHM plan option participants will follow the referral protocols of the IHM carrier. The State does not anticipate that in an IHM plan that members will be self-referring.

g. *FA3 Attachment S-3. Can the State clarify that specialty office visits are $15 copay, but seeing an Allergist is $30 copay? Or is the $30 only for allergy testing, not general office visits?*

RESPONSE: All specialist copayments including copayments for allergy testing under FA3 should be $15. Please see Amendment 2.

h. *FA3 Attachment S-3. Can the State clarify if there is an annual visit limit for chiropractic services?*

RESPONSE: There is no annual visit limit for chiropractic services.

i. *FA3 Attachment S-4. Can the State clarify if facilities other than acute inpatient hospitals should be counted in the hospital column (e.g., Skilled Nursing Facilities, Ambulatory Surgery Centers, Rehabilitation Centers, Residential Treatment Centers for chemical dependency, etc.)? If they are not to be included, should a count of such facilities be submitted somewhere else in the Offer's proposal?*

RESPONSE: Please see the response to Question # 91 a.

j. *FA3 Attachment S-4. Can the State clarify how to complete the rows "# of physicians" and "# of Quality Efficient Contract (QEC) physicians" for the "Hospitals" column since a Hospital is a facility, not a physician?*

RESPONSE: Please see the response to Question # 91 a.

k. *FA3 Attachment S-4. Can the State clarify if non-physician providers should be included as other specialists or excluded from the counts? Examples are optometrists, psychotherapists, physical therapists, audiologists.*

RESPONSE: Non-Physician providers should not be included in the counts.

l. *FA3 Attachment S-4. Can the State clarify how you would like general practitioners, internists, and pediatricians who work exclusively as hospital based physicians (i.e., are not carrying a panel of patients for general outpatient care) counted? Should they be in the columns based on their specialty or do those columns pertain to physicians seeing patients in outpatient clinic settings and hospitalists are therefore counted as a specialist?*

RESPONSE: The State views these hospital based physicians as Hospitalists. Please see the response to Question # 91 a.

m. *May an Offeror include specialist in its network in Northern Virginia if Northern Virginia is part of an Offeror's service area and State of Maryland members' needs could be met by Northern Virginia network physicians without unreasonable delay or travel? (p. 11)*

RESPONSE: Yes, for FA 3, an Offeror can include specialists in Northern Virginia if Northern Virginia is part of the proposed Offeror's service area and the State of Maryland members' needs could be met by the network physician. FA3 Attachment S-4: Participating Physicians should be completed for the County/Metro Areas included. The Offerors response to FA3 Attachment S-1: Plan Information, III Medical Delivery System, 1, 2 and 3 should provide additional information on the proposed geographic service area and provider network.

n. *FA3 Attachment S-5. Please clarify what the State means by the statement in CC-44 "Contractor agrees that the State reserves the right to explore the Contractor's tiered network, and if decided, implement this structure in future plan years."*

RESPONSE: At its discretion, the State may seek to make use of an Offeror's tiered network at some point during the Contract period.

o. *FA3 Attachment S-5. For CC-95j. Can the State clarify the scope and definition of "responses to all UR prior authorization/precertification requests?" In particular, is the 24 hour timeframe applicable to all situations 7 days per week? In particular, does this include or exclude weekends and holidays? Does this include or exclude clinically non-urgent requests? Also, is the definition of response meant to imply a definitive response (i.e., approve or deny) or rather a confirmation of receipt and indication that it is pending review? In addition, what is the expectation if the clinical information provided is incomplete to make a definitive approval or denial?*

RESPONSE: The definition of response is a definitive response. The Offeror is asked to respond based upon its current practice.

p. *FA3 Attachment S-5. Does CC-106 actually refer to Attachment S-9 Performance Metrics as compared to P-13 Performance Metrics, as stated?*

RESPONSE: Yes CC 105 and CC-106 refer to Attachment S-9 Performance Metrics. See Amendment 2.

q. *FA3 Attachment S-5. Does CC-109 actually refer to Attachment S-8 Performance Guarantees as compared to S-12 Performance Guarantees, as stated?*

RESPONSE: Yes CC-109 refers to Attachment S-8 Performance Guarantees. See Amendment 2.

r. *FA3 Attachment S-9. Are clinical quality metric definitions meant to match technical specification of NCQA or MHCC (i.e., will the definition of the eligible population ("denominator") be consistent)? If definitions change, will the State RFP change (e.g., target/eligible age for women to get mammogram)?*

RESPONSE: The metrics are not intended to match NCQA or MHCC exactly, but the State expects the definitions to remain consistent.

s. *Please provide the details/listing regarding the Express Scripts formulary currently in place for SOM coverage through 2017.*

RESPONSE: The Express Scripts formulary is not available beyond 2014 at this time. The 2014 formulary is available on the Department's Health Benefits website: **www.dbm.maryland.gov/benefits**

t. *Please provide the Rx trend projected for the duration of the 2012-2017 Express Scripts contract.*

RESPONSE: This is not applicable to this RFP and will not be provided.

u. *Please confirm if Express Scripts incorporates Rx rebates into their rates, or if they are provided in addition to the rates.*

RESPONSE: Please see response to Question #96 t.

v. *What is the status of union negotiations and how will this impact the contract?*

RESPONSE: Negotiations with collective bargaining representatives are confidential until an agreement is reached. Should negotiations impact the Contract(s) in question, the State will advise Offerors of the impact when it is permissible to do so.

97. *FA3 Attachment T-2: Financial Questionnaire, F-3: As new unexpected Federal and/or State mandated benefits and/or taxes arise and are effective during the 6 year contract period, will carriers be allowed to pass the cost on in the rates, over and above any previously accepted rate guarantees or caps?*

RESPONSE: Generally any additional contractor expenses, including taxes, during the contract term are to be assumed in the Contractor's financial proposal (while any increase in claims costs is absorbed by the State). However, if any unexpected Federal and/or State mandated changes (including potentially additional benefits and/or fees) arise during the contract period, the State will work with the Contractor in modifying the underlying contract agreement to make the necessary plan/benefit changes.

98. *FA3 Attachment T-4: Integrated Health Model Pricing Grid: Both Actives and Retirees are referenced under the rate tiers. Please confirm if "Retiree" refers to Early Retirees only in this exhibit.*

RESPONSE: Retirees include all Retirees.

99. *Attachment U-4: Incurred and Paid Claims & Enrollment:*
    a. *Clarification is needed to determine whether the enrollment provided represents subscriber or member totals. The column for total membership currently matches the sum of the enrollment by tier (labeled as Employees).*

RESPONSE: Please see response to Question # 16.

    b. *Please provide large claims in excess of $50K by plan, (broken out by incurred and paid claims) for the period Jan'10 to Jun'13. At a minimum, we would prefer the most recent 12 month period July'12 to Jun'13. Include diagnosis and prognosis. Please identify any individual lasered (high-risk individual) claims for the same period, indicating the dollar amounts and diagnosis/prognosis for each individual.*

RESPONSE: The State currently only has self-insured medical plans with no Stop-Loss coverage. There are no lasered members.

c. *Please provide specific and aggregate limits applied to the claims under the incumbent carriers' contracts for the prior 5 years. This was not disclosed in the RFP documents/attachments received under this solicitation.*

RESPONSE: The State has no stop loss insurance on any of its plans.

d. *As we strive to provide our best and most advantageous rating for the State, we would like to know if more current claims data is available. A more up to date claim period would reduce the months of trend necessary for the 2015 rating. Specifically, is it possible for the State to provide incurred claims and paid claims through September 2013? If not, could we receive run-out through September 30, 2013, for the incurred claims already released through June?*

RESPONSE Please see response to Question # 14.

e. *Please provide the relevant member months for the month by month claims. The columns entitled "total members" actually represent the summation of the employee counts in the preceding columns.*

RESPONSE: Please see response to Question # 16.

f. *Please clarify whether the retiree counts for Medicare represents subscribers or members.*

RESPONSE: The retiree counts include retirees only and do not include the member's dependents.

g. *Please clarify whether the provided retiree claims are a combination of Early Retirees and Medicare Retirees (age 65+). If yes, please provide claims broken out by Early Retirees and Medicare as our understanding of FA-3 is that it excludes the Medicare.*

RESPONSE: The retiree claims provided are a combination of Early Retirees and Medicare Retirees (age 65). A breakdown of these claims will be provided in Questions and Responses #2.

100. *Attachment U-7: Census:*

a. *Please define the Medical Plan status of "none" on the provided census.*

RESPONSE: A medical plan status of "none" means the individual is not currently enrolled in a medical plan under the State Employee and Retiree Health and Welfare Benefits Program (the Program).

b. How can an Offeror identify valid waivers on the census?

RESPONSE: Please see response to Question #100 a.

c. *What percentage of the current enrolled population is anticipated to opt out of group coverage to enroll into the individual exchange?*

RESPONSE: No speculation has been made in this regard by the State.

d. What is the anticipated growth of the eligible population over the duration of the contract period?

RESPONSE: The State is not anticipating any major growth in eligible population during the contract period.

e. What is the effective date of the census?

RESPONSE: The census was effective October 2013.

f. Please clarify the total number of enrolled vs. eligible members?

RESPONSE: Please see response to Question # 16.

g. Could the State provide complete dates of birth in census (i.e. MMDDYYYY)?

RESPONSE: No, the dates of birth will not be provided. The year of birth as provided is sufficient to determine the age demographics of the population.

h. Could the State provide complete employee addresses (i.e. street address, city, state, zip)?

RESPONSE: No, complete employee addresses will not be provided.

i. Please explain the variance between the subscriber counts listed in the census v. the subscriber counts as of 6/2013.

Plan	Subscribers (Census)[1]	Subscribers as of 6/2013[2]	Subscriber Variance
EPO	30,813	32,964	(2,151)
POS	15,775	17,646	(1,871)
PPO	27,387	31,207	(3,820)

[1] Total Active subscribers from census in Attachment U_7 received on 12/5/13.

[2] Total subscribers (excludes Medicare Retirees) as of 6/2013 from Attachment U-4 Claims & Enrollment.

RESPONSE: Census data includes both Early Retirees and Medicare-Eligible Retirees. The vendor needs to use the data of birth to determine those retirees that are over and under 65. The above numbers included for the census do not include Early Retirees, while the numbers in the second column do include Early Retirees.

101. *MBE: Will there be an opportunity for additional credits/points for utilizing certified vendors for work in addition to State of Maryland account business (using proration methodology)?*

RESPONSE: Please refer to RFP Section 1.33.3:

Section 1.33.3.2 states: "When preparing **Attachment D-1**, the Offeror must consider and include ***only those MBE payments that are attributable to the State's contract***."
Section 1.33.3.3 states: "The **Attachment D-1** is to be completed using only the amount of the MBE participation that is attributable to the State's Contract. The Attachment D-1 shall indicate the percentage (%) of the Contract to be subcontracted to each MBE firm."

Only MBE payments that are attributable to the State's contract will be counted towards meeting the MBE goal commitment. No additional "credits/points" will be given for use of MBEs outside of the State's Contract.

102. *Claims Repricing: For the repricing request, should the 3 files (PPO, POS and EPO) be combined for an overall summary or should repricings be completed by product?*

RESPONSE: All re-pricing files must be completed for both FA1 and FA2.

103. *GeoAccess Requests:*

a. *FA1 Attachment S-5: Access to Adult PCPs, states that all employee and retirees in both the PPO and POS be included in the analysis. FA1 Attachment S-6, S-7, and S-8 all request we use only the PPO employees and retirees. Please confirm if what products (PPO only or PPO and POS) we should use for these requests.*

RESPONSE: All employee and retirees in both the PPO and POS should be included in the analysis included in B on FA S-5, S-6, S-7 and S-8. See Amendment 2.

b. *FA2 Attachment S-5 (EPO; Pages 14-21) the total number of employees is already entered into the template. What should we do if the actual census numbers do not match this template?*

RESPONSE: The numbers in the census and the prefilled numbers should be the same. No changes can be made to the numbers pre-filled in the template.

c. *FA1 Attachment S-5 (PPO; Pages 16-23) the total number of employees is already entered into the template. What should we do if the actual census numbers do not match this template?*

RESPONSE: Please see response to Question #103 b.

d. *FA1 and FA2 Attachment S-5 – Response Attachment S-1, can the report be provided in PDF? If not, please specify how it should be provided.*

RESPONSE: For FA1 and FA2 Attachment S-5, part B, please complete the table provided in the RFP. For the required format for Response Attachment S-1, please see the response to Question #39

104. *Functional Area Questionnaires:*
On the FA1 & FA2 documents, Q. 86 and Q. 95 answer options have Yes/No drop downs and the question requires text. Should responses be listed in the explanations section? Q. 86 as an example below.

RESPONSE: Q-86 has been updated. Q-95 should be answered using the Yes/No and "Other" fields provided. Please see Amendment 2.

105. *We are seeking clarity on the requirements for prescription lenses/frames and contact lenses. We need to understand the language for single/bifocal/trifocoal lenses coverage. Do the amounts listed represent the amount the member pays for those items or is that the amount that the health plan will discount towards the purchase of those items? We are posing the same question with regard to contact lenses. With regard to the "no limits for children under 18" provision, does this mean they can get multiple pairs of eyeglasses/contacts at no cost and no limit to frequency?*

RESPONSE: The limits indicated are the limits paid by the plan.

106. *If we were to propose a MBE subcontractor that performs cleaning services for an operations center that would handle the State of Maryland contract, how would we count those expenditures towards the MBE goal?*

RESPONSE: Please refer to RFP Section 1.33.3:

Section 1.33.3.2 states: "When preparing **Attachment D-1**, the Offeror must consider and include ***only those MBE payments that are attributable to the State's contract***."
Section 1.33.3.3 states: "The **Attachment D-1** is to be completed using only the amount of the MBE participation that is attributable to the State's Contract. The Attachment D-1 shall indicate the percentage (%) of the Contract to be subcontracted to each MBE firm."

Therefore, as long as your proposed MBE's participation includes only payments that are attributable to the State's contract, those payments to that MBE will be counted towards meeting the MBE goal commitment.

107. *Is there any restriction on the number of primes that an MBE can support for this opportunity?*

RESPONSE: As long as there is no conflict of interest, there is no limit set by the State to the number of contracts that a MBE subcontractor (or any subcontractor for that matter) can work on.

108. *Would the State consider letting Offerors quote the wellness and disease management programs on a per participant basis, rather than a per employee per month basis?*

RESPONSE: As stated in the RFP, the State is requesting the wellness and disease management programs be quoted on a per employee per month basis.

109. *In section 3.1, the Contractor would be required to staff "130 or more quarterly wellness fairs throughout the State each year." Can you confirm this is a total of 130 for the whole year, rather than 130 each quarter?*

RESPONSE: Please see response to Question #68.

110. *Regarding the Geo Access Worksheets (S-5, S-6, S-7, S-8):*

a. *Should the first set of reports run on FA-1 (PPO), be based on just members in the census noted as "PPO", or as both "PPO and POS"? The instructions at the top of the worksheet say the later, but Section B says the former.*

RESPONSE: Please see response to Question #103a.

b. *Should the Geo Access Reports in these worksheets be run on all lines in the census (i.e. all members), or should we just run them on the members noted as "Self" (i.e. employees only).*

RESPONSE: The Geo Access Reports should be run on all Employees and Retirees, not dependents, as stated in the Instruction for Attachments S-5, S-6, S-7 and S-8. In the census information the members are designated as "Self." Please also refer to the definition of Member as defined in Section 1.2 Abbreviations and Definitions, gg.

c. *Can the State let us know how it arrived at the "Total Number of Employees/Retirees" in Section B? We are unable to arrive at these numbers based on the census provided.*

RESPONSE: Please see the response to Questions # 110 a and b above. In addition, the Offerors must use the date of birth to determine those retirees that are over 65 and eligible for Medicare.

d. *If the "Total Number of Employees/Retirees" in the worksheet is off, should we just use the numbers that the census and Geos access provides? (These cells are locked, so we are not able to update, but they would be reflected in our report).*

RESPONSE: The total number of Employees Matched and Employees Not Matched entered by the Offeror should equal the Total Number of Employees/Retirees included in the locked cells of the RFP. The locked cells should not be changed.

e. *Can you confirm you will accept Geo Access County definitions of Counties if they differ from the State's County definitions? These can sometimes be slightly off if a zip code falls within two counties.*

RESPONSE: Geo Access County definitions are acceptable. Please also see response to question 100d above.

111. *To clarify section 4.2.1, is it acceptable to the State to receive one box for each Functional Area, then within that box, that would be two separate sealed and labeled packages- one being the Technical Proposal, and the other being the Cost Proposal?*

RESPONSE: That is correct/acceptable.

112. *Section 4.2.2 asks offerors to submit two electronic copies of the proposal on CD-Rom, in MS Word format. Can the State confirm that it would only be the Functional area response documents that are required in Word (the original format they came in)? Certain requested and supplement files might be in other formats (such as Geo-Access downloads in Excel, Org Charts in PowerPoint, Sample Brochures in pdf, etc.).*

RESPONSE: While the State prefers that all response documents be in MS-Word format when possible, if certain additional files are unable to be adequately converted to MS-Word form, the State will accept those documents in editable Excel or PDF format (editable for the purposes of copying information and/or editing/redacting for purposes of Public Information Act requests).

113. *Can the State confirm that the Financial and Technical redacted proposals requested in 4.2.3, can be together on the same CD and/or package?*

RESPONSE: No. The Technical and Financial redacted proposals are to be on separate CD/DVDs, enclosed with the appropriate package (Technical or Financial package).

114. *Is it acceptable for offerors to restart the consecutive page numbering in each new response section/tab (as discussed in 4.2.4)?*

RESPONSE: Please refer to the response to Question #8: No. Numbering each section sequentially leads to confusion when referencing specific page numbers that may be used in other sections. Per RFP Section 4.2.4, "All pages of both proposal volumes shall be consecutively numbered from beginning (Page 1) to end (Page "x")."

115. *Do offerors need to actually return the Attachment R (Proposal Submission Checklist) with the proposal response, or is this just provided for vendor preparation assistance?*

RESPONSE: Offerors are not required to submit Attachment R, Proposal Submission Checklist, with their Proposal. This document is simply provided to assist Offerors in preparing their Proposal(s).

116. *Regarding Attachment S-13, Performance Metrics, would the State of Maryland consider requiring that each vendor commit to contributing 75% of any earned incentives to a "physician bonus pool?" Physicians, as trusted advisors, play a very important role in working with their patients to improve health status and address health risks. We see the carrier's role as supporting physicians in these efforts and believe that physicians, not the carrier, should receive the bulk of any earned incentives.*

By requiring that each carrier contribute a fixed percentage of any earned incentives to a physician bonus pool, the State would be ensuring that physicians are rewarded for the improvements in clinical metrics that the State desires. Additionally, it would be to the State's advantage to combine these incentives into a single pool as that would maximize the payments that physicians would receive, thereby further encouraging physicians to take actions in support of the State's clinical program objectives.

RESPONSE: Contributing to a "physician bonus pool" is not currently a requirement of the State; however the mechanisms to incentivize the physicians to meet the State's program objectives are between the Offeror and the contracted physicians.

117. *Would the State allow offerors to place larger files (such as the full disruption results, full geo access files download) only on CD-ROM, rather than printing them?*

RESPONSE: See the Responses to Questions 39 and 40. The State will accept certain larger reports provided electronically on CD/DVD. The State's preference is that the CD/DVD include a PDF file generated from the system and an Excel file. Please see Amendment 2.

118. *In light of the fact that the Maryland Insurance Administration has repealed their Conversion requirements, effective 1/1/2014, and carriers have filed to remove the Conversion Provision from their filings; thus, the fully insured Conversion product cannot be supported in Maryland, will the State be removing this Compliance Checklist Item #2: Contractor agrees to provide a post-COBRA fully insured conversion plan to terminated plans.*

RESPONSE: Yes, Compliance Checklist Item # 2 has been removed from FA-1 and FA2, and Compliance Checklist Item #3 removed from FA-3. Please see Amendment 2.

119. *Attachment T, TabT-5: We currently show a total of $1.760B however the exhibit shows $2.225B. Please provide a control total by product or file for the claims repricing.*

RESPONSE: A total of $1.760B is correct. Please see Amendment 2.

120. *Attachment S-12, PG-18: We noticed EPO states 30 days and the PPO state 54 days. Should the timing be consistent between the two programs? Please confirm the timing for both programs.*

RESPONSE: The Plan Description for both the EPO and PPO should be returned to the State within 30 calendar days of the carrier's receipt of the State's edits. Please see Amendment 2 for FA-1 Attachment S-12, PG-18.

121. *Attachment S-9 Compliance Checklist: CC-112 and CC-113 refer to P-13: Performance Metrics, please confirm that this document is Attachment S-13.*

RESPONSE: Yes, FA1 Attachment S-9 Compliance Checklist Items: CC-112 and CC-113 and FA2 Attachment S-9 Compliance Checklist Items: CC-113 and CC-114 refer to S-13: Performance Metrics. (Please see Amendment 2.)

122. *Does the State want disease management and wellness services provided to pre 65 retirees?*

RESPONSE: Yes, disease management and wellness services should be provided to pre 65 retirees.

123. *Attachment S-9 Compliance Checklist 100r: Could the State clarify what you mean by "conform" or is this incorrect and should be the word "perform?"*

RESPONSE: FA1 Attachment S-9 CC-100 r., FA2 Attachment S-9 CC-101 r. and FA3 Attachment S-9 CC-95 r. should read "Contractor agrees to perform disease management and case management programs to facilitate cross referral and data integration to facilitate care and coordination." (Please see Amendment 2.)

124. *Attachment T: Please clarify how and when the CPI-U would be determined. For example, for policy year 2018, would it be the CPI-U for the month prior to the delivery of the renewal or average of the past 12 months?*

RESPONSE: The CPI-U would be determined based on an average of the previous 12 months.

125. *Please provide a history of all plans changes which have been implemented over the period of the experience period. Does the experience provided reflect the same plan designs for each carrier? Do the Actives, Direct Pay, and Satellite employees, as well as the Retirees, all currently have the same plans under all current carriers?*

RESPONSE: Each plan design is the same regardless of carrier. Additional information on the history of plan changes will not be provided.

126. *How long have the current carriers been with the State?*

RESPONSE: Please see the response to Question #51: Information regarding the current contracts for Health Plan Administration and Services may be found on the Department of Budget and Management's website, under the Contract Library: http://dbm.maryland.gov/contractors/contractlibrary/Pages/HealthPlanAdmin.aspx

127. *Why are these services out to bid? Are they due to the expiration of the current contract or for other reasons?*

RESPONSE: Services are being solicited because the current contracts are expiring.

128. *Is there anything you would like the new carriers to do differently, improve, and or provide additional services?*

RESPONSE: Any such information is already provided in the RFP.

129. *Could you please release the pre-proposal meeting's list of attendees?*

RESPONSE: The summary of the Pre-Proposal Conference, including the agenda and sign-in sheets, is available through the listing for this procurement on eMaryland Marketplace and on the Department of Budget and Management's website under "Procurements in Progress:" http://dbm.maryland.gov/agencies/procurement/Pages/health-plan-admin.aspx

130. *Would you be able to provide us with a summary of the pre-proposal meeting, including the questions raised and the answers given?*

RESPONSE: See the response to Question #129. The summary of the Pre-Proposal Conference, including the agenda and sign-in sheets, is available through the listing for this procurement on eMaryland Marketplace and on the Department of Budget and Management's website under "Procurements in Progress:" http://dbm.maryland.gov/agencies/procurement/Pages/health-plan-admin.aspx

131. *Please provide the annual and average monthly premium for the past three plan years.*

RESPONSE: No additional information regarding premiums will be provided.

132. *Please provide the claim utilization reports for the past three plan year.*

RESPONSE: Claim utilization that will be provided is included in Attachment U.

133. *Please provide enrollment history, by all eligibility/rate categories, for the past three plan years.*

RESPONSE: Please see the response to Question #14.

134. *Please provide any large claims (>$25,000) information.*

RESPONSE: Please see the response to Question #14.

135. *Have there been any benefit design changes during the past three plan years? If yes, please provide the effective date(s) and details of change(s).*

RESPONSE: Please see the Response to Question #51: Information regarding the current contracts for Health Plan Administration and Services may be found on the Department of Budget and Management's website, under the Contract Library: http://dbm.maryland.gov/contractors/contractlibrary/Pages/HealthPlanAdmin.aspx

Additional information regarding benefit design changes may be found in the contract modification documents included in the webpage linked above.

136. *In the event that there are two proposals with relatively equal technical and price scoring, and one proposal has meaningful professional service MBE participation and one does not, which proposal will receive more favorable consideration by the State?*

RESPONSE: The amount of proposed MBE participation does not affect the technical evaluation of an Offeror's proposal. However, note that an Offeror's proposed subcontractors are reviewed as part of the technical evaluation (see RFP Sections 5.2.2 and 4.4.3.13).

137. *Is there any MBE company(ies) currently working on the existing contract(s)? If yes, please provide the name(s) of the company(ies) and the types of services provided.*

RESPONSE: See the Response to Question #51: Information regarding the current contracts for Health Plan Administration and Services may be found on the Department of Budget and Management's website, under the Contract Library: http://dbm.maryland.gov/contractors/contractlibrary/Pages/HealthPlanAdmin.aspx

Any additional information detailed in the technical proposal portions of each of these contractors' selected proposals may be provided upon submission of a Public Information Act (PIA) request to the procurement officer for those specific contracts.

138. *What forms of benefits communications are currently provided to employees and retirees, i.e. print, e-mail, IVR, internet/intranet, employee self-service? How many employees have access to e-mail?*

RESPONSE: Various forms of communications, too numerous to detail here, are provided to participants including an annual Benefits Guide, direct mail notices, post cards, and website postings.

139. *Please identify which of the following are currently in place and which the State would like to implement in the future:*

i. *Health risk assessment surveys*

ii. *Onsite Biometric Screenings*

iii. *Targeted Intervention/Health Coaching: Telephonic, Face to Face or Behavior Change,*

iv. *Mail based interventions, Online coaching*

v. *Self-Directed interventions (online and / or workbook)*

vi. *Gym membership discounts and Fitness*

vii. *Smoking cessation*

viii. *Nutrition education*

ix. *Disease prevention*

x. *Mental health programs, Hypertension education, Alcohol and substance abuse programs*

xi. *Stress Management*

RESPONSE: Health risk assessment surveys and on-site biometric screenings are not requirements of the current plan. The remainders of the services/programs are provided by the current carriers, however the State is seeking to standardize the provision of all of the services during the upcoming contract period.

140. *We understand from the pre-bid conference that certain documents that apply to all 3 Functional areas need not be duplicated. Please confirm the specific documents and/or responses and advise on how they should be packaged for delivery.*

RESPONSE: The specific Proposal response information that does not need to be duplicated for each Functional Area response is detailed in Section 4.4 (ex. 4.4.3.10; 4.4.3.11; 4.4.3.12; 4.4.3.14; 4.4.3.15.)

141. *There is a small population of the State's enrollment (SLEOLA) whose benefits differ from the larger population. Please advise if selected carriers will continue to offer a separate set of benefits for that population, or will they be part of the plan designs described in the RFP for all 3 Functional Areas.*

RESPONSE: This RFP does not include the SLEOLA population. An RFP for Health Plan Administration and Services including the requested plan designs for SLEOLA will be released in the near future.

142. *Besides submitting an Executive Summary with the Technical Responses, will the State of Maryland allow bidders to submit a "Financial Executive Summary" under Volume II for each Functional Area?*

RESPONSE: No. There is no need to submit a "Financial Executive Summary" with Volume II for each Functional Area.

143. *In the technical questionnaire, Centers of Excellence/Tiered Networks section (Q-95/96/130, for each functional area respectively), the following question asks:*

Please indicate high-risk and high-technology services coordinated with the Centers of Excellence.
-Disease Management
-Wellness

Please clarify what you are looking for with regard to DM and wellness Centers of Excellence. Are you asking if the DM and wellness programs provide referrals to COE, when applicable?

RESPONSE: The Offeror should indicate if the listed services are coordinated with and provided by the Offeror's Centers of Excellence.

144. *Will the State consider alternate reporting/PGs around performance metrics measurements to align with EBM measures considered best practice standards? For example, in some cases colorectal cancer screenings EBM "appropriate screenings" may be less frequent than every 2 years.*

RESPONSE: The State's required PGs and performance metrics are stated in the RFP for each Functional Area.

145. *Under Wellness Program Capabilities (Q-19 FA1 & FA2; Q-49 FA3) - Describe your ability to utilize retrospective episode-based payment (REBP). Question: is the State looking to carve something out and have the carrier pay the claims?*

RESPONSE: The State is interested in evaluating the Offeror's current capabilities related to REBP.

146. *As of today, January 2nd, we have not received answers to any of the bidder questions we submitted. Because of this, we ask that the State formally extend the deadline for bids until January 28th. Please confirm that an extension will be granted.*

RESPONSE: The proposal response due date has been extended to January 31, 2013. Please see Amendment #1.

147. *We have numerous concerns with the data files that the State provided to vendors so that disruption analysis could be conducted. Here are those concerns:*

· *Close to 30,000 records only contain Tax ID Numbers (TINs). A disruption analysis that relies only on TINs can result in inaccurate matches, since one provider may have several IDs and one TIN may cover multiple providers.*
· *Another large number of records contain just Name and Tax ID. This can also result in inaccurate matching.*

Given these concerns, here are our questions regarding the disruption data provided by the State:

a. *Are the records that contain just TIN-only all out-of-network providers?*

RESPONSE: The records that contain only the TIN are not only out-of network providers.

b. *To ensure greater accuracy in the results provided, will the State please provide an updated file containing Tax ID (TIN), Name, Full Address, and an In or Out of Network indicator?*

RESPONSE: Additional information will not be provided.

c. *Please also provide claim dollar amounts, as this would allow us to focus on potential recruitment of highly utilized out of network providers.*

RESPONSE: At this time additional information will not be provided.

Please remember that proposals are due by January 31, 2014, no later than 2:00 PM (see Amendment #1). If there are additional questions concerning this solicitation, please contact the Procurement Officer via e-mail at gabe.gnall@maryland.gov or by phone at (410) 260-7338 as soon as possible.

Date Issued: 01/09/2014 By: Gabriel Gnall
Procurement Officer