DEPARTMENT OF
BUDGET & MANAGEMENT

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QUESTIONS AND RESPONSES # 2

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

January 17, 2014

Ladies/Gentlemen**:**

This Questions and Responses #2, including questions #148 through #170, 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.

Responses to Questions remaining from Q&A #1:

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: Below is a legend for the Lettered Service Codes. The Numbered Codes are standard for all carriers.

AT	ALCOHOL TREATMENT CENTER
CL	CLIENT-SPECIFIC LOCATION/CLINIC
FS	FREE STANDING EMERGENCY CENTER
OL	OTHER LOCATION
RX	PHARMACY/MEDICAL SUPPLIER

99. *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). Apply the following percentages to "**Paid Retiree Claims**" to calculate the amount of **paid claims** for Medicare Retirees.

Time Period: July 2011 – June 2012

EPO – 37% Medicare

PPO – 39% Medicare

POS – 49% Medicare

Time Period: July 2012 – June 2013

EPO – 37% Medicare

PPO – 45% Medicare

POS – 53% Medicare

Responses to new Questions, continuing from Q&A #1:

148. General

a. What is the reimbursement level for PPO and POS plans for all carriers?

RESPONSE: That information is considered propriety for the current carriers and will not be provided.

b. From the RFP Wrap document, Section 3.5 In the paragraphs describing Retirees, Direct Pay Enrollees and Satellite Account Employees, there is reference that the "…State will send a payment to the Contractor once a month." Please confirm that this payment will follow the same methodology described in 3.5.1. – Functional Area 1 & 2 will be payments of invoiced fees and weekly claim reimbursements. Functional Area 3 will be paid as fully insured monthly premiums.

RESPONSE: Confirmed.

c. From the RFP Wrap Document, Section 3.3.3 "Contractors must offer additional programs for participants with Chronic Conditions and Eligible for Disease Management Programs including but not limited to: diabetes, asthma, congestive heart failure (CHF) hypertension, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), hyperlipidemia, and depression." What additional programs and/or other conditions are being referred to?

RESPONSE: This list of conditions and programs is anticipated to be extensive and varied. This statement is merely providing examples; the Offeror must indicate what programs and conditions are included in its Proposal response.

d. Please provide clarification on the consecutive numbering. Does this need to be consecutive from beginning of binder to end or only consecutive between each main section?

RESPONSE: The request for consecutive numbering in an Offeror's Proposal is from beginning to end (i.e. the numbering should not restart for a different section in the Proposal). Please see RFP Section 4.2.4 and the Response to Question #8 in Q&A #1.

e. From FA1 Questionnaire – Q.199, FA2 Questionnaire – Q.199, FA3 Questionnaire – Q. 218 "Have you implemented, or do you plan to implement within the next 12 months, an Internet or other electronic connection available to providers for the following? - A physician chat line". Is this a physician/physician chat line or a member/physician chat line?

RESPONSE: FA1 Questionnaire – Q.199, FA2 Questionnaire – Q.199, and FA3 Questionnaire – Q. 218 refer to a physician to physician chat line.

f. Please sign the attached Non-Disclosure Agreement that allows us to release the proprietary discount information requested in RFP.

RESPONSE: The State will not sign the vendor's Non-Disclosure Agreement. Pursuant to RFP § 4.2.5 the "Proposals and any modifications to Proposals will be shown only to State employees, members of the Evaluation Committee, or other persons deemed by the Department to have a legitimate interest in them."

With regards to Public Information Act requests, pursuant to the RFP §§1.14 and 4.4.3.2, an Offeror should identify any portions of its Proposal that it considers proprietary or confidential. Offerors are advised that, upon request for this information from a third party, the Procurement Officer will independently determine whether the information must be disclosed.

g. From the Compliance Checklist FA1-Q#CC-100-e, FA2-CC101-e, FA3-CC-95-e "(11) Prescriptions for controlled substances from more than 3 providers", this requirement applies to the pharmacy management program. Please confirm that pharmacy is not a part of this RFP and that this requirement still applies to the medical RFP.

RESPONSE: Confirmed. Data is fed from the PBM to the medical carriers for the purposes of wellness and disease management.

h. The RFP states that the "Offeror agrees to provide at least one fully insured conversion plan option." Please provide detail of the current conversion plan.

RESPONSE: Please see the Response to Question #118 in Q&A #1: 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.

i. The RFP states that the "Contractor agrees that the only compensation to be received by or on behalf of its organization in connection with this Plan shall be that which is paid directly by the State and limited to premium, administrative fees, claims, shared savings and/or other incentive payments." How does the State categorize Cost Containment programs?

RESPONSE: Cost containment savings are independent of this category. 100% of cost containment savings shall be paid to the State.

j. Please confirm that members who are eligible for Medicare are not eligible for FA3 (IHM), but are eligible for FA1 (PPO) and FA2 (EPO)?

RESPONSE: Please see the Responses to Questions #33 and #82 in Q&A #1: 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." 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).

k. There are 225 Employees on the census that are not currently enrolled in any plan. For purposes of the GEO analysis, which plan should we include them?

RESPONSE: The employees in the census without a health plan designation should only be included in the GEO analysis for "all Employees & Retirees."

l. The RFP states that we should cover "custom plan design changes." Please clarify the intent of these custom plan design changes.

RESPONSE: These changes could include, but are not limited to, deductibles, co-insurances, and copays. Plan design changes that may occur throughout the contract will not impact the financial proposal as accepted during this RFP process.

149. Network

a. From FA1 Questionnaire - pg. 20, FA2 Questionnaire - pg. 18, FA3 Questionnaire - pg. 17 Participating Physicians: Should physicians counts be given at the unique level, or at the multiple specialty/address detail?

RESPONSE: In response to FA1, FA2, and FA3, Attachments S-4: Participating Physician counts should be given at the unique level.

b. From FA1 Questionnaire - pg. 97, FA2 Questionnaire - pg. 94, IHM Questionnaire - pg. 77 "If yes, please indicate the percentage of RBRVS it represents for primary codes and for secondary codes." Please define what is considered primary codes and what is considered secondary codes.

RESPONSE: Primary codes are those that are used in determine the primary diagnosis. Secondary codes are designated for secondary conditions also requiring treatment.

150. Medicare

Is this a true Medicare supplement plan that covers some or the entire remaining amount after Medicare pays and covers what Medicare approves and allows? If it is not, do you want to receive quotes for this product?

RESPONSE: Program plans automatically pay secondary to Medicare upon the retiree becoming Medicare eligible due to age or disability. Please respond only to the plans requested in the RFP.

151. Vision

a. Please provide vision experience.

RESPONSE: Vision experience is included in the medical claims data provided.

b. The IHM vision plan design states the routine exam is covered at 100% after $15 copay (PCP) and $30 copay (Specialist). However, the rest of the plan is identical to the CareFirst and UHC vision plans. The UHC and CareFirst vision plan offer the routine exam at up to $45. Please confirm if the routine vision plan should indeed be up to $45 and not the copay by PCP and Specialist.

RESPONSE: Please refer to Amendment 2 and Questions and Responses #1.

152. Repricing

The RFP document shows $2,225,905,993.59. Our calculations after running disruptions have a difference of over $465k. Could you please confirm data on financial workbooks is accurate?

RESPONSE: Please refer to Amendment 2 and Question # 119 in Questions and Responses #1.

153. *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..." One of our proposed sub-contractors is a third party administrator with many other clients. If a state employee enrolls in, for example, a spouse's plan and that plan happens to be administered by our sub-contractor, this provision seems to indicate that the state wants that to be disclosed. Please advise regarding the intent of this provision.*

RESPONSE: Please see the Response to Question #5 in Q&A #1: 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.

154. *Regarding subcontractors, several of our 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 see the Response to Question #153, and Question #5 in Q&A #1: 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.

155. *Section 3.7.4 on page 42 states that Certificates of Insurance are due within five business days of contract execution; however, 4.4.3.6.e. pages 51-53 Certificates of Insurance are to be provided with the response. Please clarify when Certificates of Insurance are to be submitted.*

RESPONSE: Note that RFP Sections 4.4.3.6.e (and 4.4.3.12) requests the Offeror's *current* certificate(s) of insurance, as of the time of proposal submission (which may possibly not meet the requirements of Section 3.7 at that time). RFP Section 3.7 (and 5.6.g) requests updated copies of the recommended awardee's certificate(s) of insurance meeting the prescribed limits set forth in Section 3.7, and naming the State as an additional insured, if applicable.

156. *Section 4.2.4 on pp 47 states numbering within the proposal must be consecutive from beginning to end. Can we ID each section and number consecutively within the sections? Also, for the questionnaire portion the format makes it difficult for numbering purposes and would require creation of a PDF with manual application of page numbers. Is that acceptable to the State or otherwise are we able to submit our reply in the actual format provided?*

RESPONSE: See the Response to Question #148.d. The request for consecutive numbering in an Offeror's Proposal is from beginning to end (i.e. the numbering should not restart for a different section in the Proposal). Please see also RFP Section 4.2.4 and the Response to Question #8 in Q&A #1. Manual application of page numbers is acceptable to the State. For pages preceding the response Word attachment (i.e., the title page, table of contents, claim of confidentiality, transmittal letter, executive summary) it is acceptable to use small Roman numerals (e.g., i, ii, iii, etc.)

157. *Claim file format - Will we need to include only medical claims paid by the vendor or would other vendor-paid claims (dental , vision, Rx, behavioral health) need to be included as well?*

RESPONSE: The medical plan covers Vision, Behavioral, and Medical claims. The medical contractor must report on each. The State has separate procurements for both Dental and Rx.

158. *The plan design outlined in the benefit does not include Rx. Please confirm that Rx benefits are not included in this RFP.*

RESPONSE: Rx benefits are not included as part of this RFP. The State has a separate contract/procurement for Rx benefits (see http://dbm.maryland.gov/contractors/contractlibrary/Pages/PharmacyBenefits2012.aspx).

159. *Please provide the website that identifies Federally-certified veteran companies.*

RESPONSE: The U.S. Department of Veterans Affairs website that includes verified veteran business information is located at http://www.vetbiz.gov/ . Veteran business may be searched using the following website: https://www.vip.vetbiz.gov/ .

160. *Please provide clarification on what deviations need to go into the Executive Summary (per Sections 1.24 and 4.4.3.4). Should we just include deviations to Attachment A (Contract), since the Compliance Checklist section of the RFP includes space to allow bidders to spell out any deviations to particular Compliance Checklist items?*

RESPONSE: Any and all exceptions or proposed deviations to any RFP requirement, including Attachments (ex. Attachment A, the Contract), should be included in the Executive Summary. Any deviations to the Compliance Checklist should be noted in both the Compliance Checklist's spaces for deviations and in the Executive Summary.

161. *The state provides six separate sub-contractor questionnaires (S11 a-f). However, we will be using seven subcontractors. How would we provide this information for the seventh? Would it be acceptable to respond to their questions in a Word document, and put it after the other six*?

RESPONSE: Additional Word documents, utilizing the same format and including the same questions as the subcontractor questionnaires, can be created and submitted after the first six, titled with the next letter suffix (e.g., "g," "h," "i," and so forth as needed). Number the additional pages using the page number of sixth subcontractor plus Part 2, Part 3, etc. (e.g., Number the 7th subcontractor questionnaire page 87-Part 2; If there is an eighth subcontractor number it page 87-Part 3).

162. *We previously asked a question about the disruption data (#42). We have a similar request regarding the re-pricing files provided by the State. Specifically, please provide revised re-pricing files containing the following fields:*

Tax ID (TIN)
Name
Full Address, including Zip code
In or Out of Network indicator
Place of Service Indicator

Procedure Code
Billed Charges

Please note that, if we do not receive a revised re-pricing file as requested, then we will proceed with re-pricing these claims using weighting and distribution of services consistent with our experience administering claims for the State's population.

RESPONSE: Repricing files include all data that is currently being received for each data field. The data fields provided in the repricing files include Provider TIN, Name, Zip, POS Indicator, Procedure Code, and Net Billed Charges. No additional information will be provided.

163. *We have concerns with the large number of fields in the re-pricing file that have 99999 for the zip code. This would technically be an Alaska zip code on a 3-digit basis. It's our belief that the 99999 indicator was used as a placeholder in instances where the claim record did not have a zip code. Is that correct?*

RESPONSE: The data that is currently received uses 99999 as a placeholder for claim records that do not have a zip code attached.

164. *Can the State please confirm that all capitated services to be provided should be expressed on a PEPM basis and included in the administration fee (i.e., these services should not be billed through a claim wire)?*

RESPONSE: There is no capitation in the EPO and PPO as these are self-insured plans. Rates provided for the IHM should be quoted on a fully-insured basis encompassing all costs of care.

165. *In Responses to Questions #11, #43, and #63, the State noted its plans to provide its own Health Risk Assessment, which would be revealed to Offerors during implementation. We ask that the State reconsider its decision not to release this HRA to Offerors at this time for the following reasons:*

a. By not releasing the HRA the State intends to use, vendors will not be able to adequately assess how they will identify lifestyle risks and chronic conditions. This could significantly impact participation assumptions and clinical measure or ROI projections that could impact each vendors ability to meet performance guarantees.

b. By not releasing the HRA and its technical specifications, vendors are not able to determine the costs or technological specifications that will be required with this HRA. Issues such as mailing and production costs are also unable to be estimated without standard information such as the number of questions included, pages required, or font requirements. This obviously creates significant challenges for those vendors not familiar with the desired HRA.

RESPONSE: Please see the Response to Question #11 in Q&A #1. The State's HRA will be a comprehensive HRA that accurately reflects an individual's health risk profile.

The vendor will not be responsible for the distribution or production of the HRA, and therefore should not build in any additional administrative costs for these processes.

166. *In Question #60, the State noted it will only use paper HRAs, rather than telephonic or online HRAs. By not releasing the HRA or the details related to paper distribution requirements, the State is putting each vendor unfamiliar with the HRA in a significantly disadvantaged position regarding costs for paper distribution, assumptions regarding population completion percentages and associated identification and impact targets, and may negatively impact other more efficient and effective HRA distribution and completion models. Will the State reconsider this and accept electronic HRAs?*

RESPONSE: Please see the Response to Question #11 in Q&A #1 and #165 above. The State will not be releasing an electronic or telephonic HRA at this time.

167. *Our experience has indicated that providing on-line and telephonic access for members provides significantly better response rates than HRA's in paper format by mail. Will the State consider allowing chosen vendors to use alternative methods to obtain completed HRA results if we use the HRA preferred by the State?*

RESPONSE: Please see the Response to Question #11 in Q&A #1 and #165 and 167 above.

168. *In Questions #29 and #59, the State noted it will not provide a baseline for the "A13: Performance Metrics" until post award. By not releasing the baseline performance metrics until after the award, the State is putting each vendor unfamiliar with the baseline in a significantly disadvantaged position regarding how to measure the risk/reward equations related to the State's desired clinical metric performance standards. By asking for a commitment to pricing and performance against a 10-year contract without knowledge regarding current performance, the State is not allowing vendors to accurately project their potential for success. This may also end up increasing cost assumptions as vendors assume worst case scenarios to protect their ability to compete and profitably participate in the contract. Please reconsider this decision and release these baseline metrics as part of the RFP process.*

RESPONSE: Each Contractor will be required to develop their baseline metric using data collected during the first year of the contract. This baseline for each contractor will be used to measure their performance against the target goals listed in the RFP. Please see section 3.3.4 of the Health Plan RFP Wrap "Performance Management Program."

169. *If baseline clinical performance metrics are not available across the entire population, would the State consider allowing each vendor chosen to establish baseline metrics using 12 months of historical data and 6 months of data post implementation. This would then allow the establishment of realistic performance metrics for subsequent years of the program using consistent methodologies across all partners.*

RESPONSE: Please see response to question # 168 above.

170. *There is a Process Implementation Schedule in RFP Section 3.2 on page 29 of the wrap document. What date in 2014 is the starting date for generating and reporting minority and veteran spend directly attributable to the State of Maryland contract?*

Is it based on a fixed date in section 3.2 or based on the date of the contract award by the Board of Public works?

RESPONSE: As the MBE and VSBE goals are based on either administrative fees or premiums paid to a Contractor, depending on the Functional Area awarded (see RFP Section 1.33.1), and no administrative fees or premiums will be paid to a Contractor until actual coverage begins (anticipated January 1, 2015), MBE and VSBE spend attributable to the contract should be reported starting when actual coverage begins (anticipated January 1, 2015), though these initial reports may include payments made to MBE and VSBE subcontractors from the startup period of the contract, prior to the actual coverage start date.

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

Date Issued: 01/17/2014

By: Gabriel Gnall
Procurement Officer