MARYLAND
DEPARTMENT OF
BUDGET & MANAGEMENT

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Deputy Secretary

QUESTIONS AND RESPONSES # 1
PROJECT NO. F10B6400003
Audit Services for State Employee and Retiree Health and Welfare Benefits Program
January 28, 2016

Ladies/Gentlemen**:**

This List of Questions and Responses #1 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 of 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.

Please note that many vendors submitted questions that were significantly similar or requested the same information. Duplicate questions of this type are not repeated in this Q&A. Therefore, a vendor may not see its question reproduced here exactly. Please read through all the Q&As carefully before re-submitting a question. Thank you.

1. **QUESTION:** In Section 1.33, could you clarify if there is a % of revenue MBE/WBE requirement which varies by service category plus an additional 1% of revenue for VSBE for each service category?

RESPONSE:

As stated in RFP Section 1.33.1, each Service Category has its own MBE subcontractor participation goal for the total contract value. As stated in RFP Section 1.41.3 each Service Category has its own VSBE participation goal for the total contract value which is in addition to the stated MBE goal in RFP Section 1.33.1.

2. **QUESTION:** If we should work with a vendor partner that is both a MBE/WBE and a VSBE, what are the required revenue percentages for each service category?

RESPONSE:

The Offeror would make good faith efforts to commit to the MBE subcontractor participation goal for the applicable Service Category and the VSBE subcontractor participation goal for the applicable Service Category. The vendor partner you reference would need to be certified by the Maryland State Department of Transportation (MDOT), Office of Minority Business Enterprise as an MBE to do the contract work and verified by the Center for Verification and Evaluation (CVE) of the United States Department of Veterans Affairs as a VSBE to do the contract work.

So by way of example, if proposing for Service Category 1- Medical Benefit Plans which has a 20% MBE goal and a VSBE Subcontracting Goal of 1%, the total commitment to the MBE/VSBE subcontractor for Service Category 1 would be 21%. Review RFP §1.33, §1.41 and Attachments D and M including Instructions for Attachments D-1A and D-1B and M-1 carefully as some errors on Attachment D cannot be fixed after submission.

3. **QUESTION:** In Section 3.1.5, could you provide clarification on the number of medical plans to be audited? There appears to be conflicting information between Section 3.1.5 and Attachment H. Audits of Clinical Processes.

RESPONSE:

There are eight medical plans; three PPO plans, three EPO plans, one POS plan, and one IHM. See Amendment #1 for revised Attachment H. Attachment H originally reflected six (6) medical plans. Carefirst PPO and EPO included consolidated enrollment for both regular State and SLEOLA Plans. The breakout of the two SLEOLA plans adds two more plans bringing the total to eight (8) medical plans.

4. **QUESTION:** Could you provide a more detailed explanation on the requirements for Section 3.2.1.A (6)-Audits of PBM's inflation protection plan and savings achievement?

RESPONSE:

Our PBM recently offered an inflation protection plan that caps brand name drug inflation at a certain percentage. We are asking the Offeror to audit this program against what the PBM self-reports.

5. **QUESTION:** Could you provide the exact standards that are being referenced in 3.2.1 D -"generally accepted auditing standards"?

RESPONSE:

Generally accepted auditing standards means the general, field work, and reporting standards (the 10 standards) approved and adopted by the membership of the American Institute of Certified Public Accountants (AICPA), as amended by the AICPA Auditing Standards Board (ASB). The RFP will be amended to include this definition. See Amendment #1.

6. **QUESTION:** Are there performance guarantees in place with the medical plan vendors that will require a random sample methodology be used to determine claims processing accuracy and claims financial accuracy?

RESPONSE:

The auditors are to apply the appropriate methodology to confirm the performance guarantees.

7. **QUESTION:** On page 36 under Section 3.2.3, Audit of Administrative Procedures/Operational Audits, bullets 4 and 5 reference is made to ensuring remittances have been paid or debited to the State's account or adjustments have been made and paid to the State. Does the State expect the Contractor to review accounting ledgers, electronic statements, etc.? Or, will the state allow that as long as validation is done that claims have been adjusted this would feed directly back to the State's funds?

RESPONSE:

Yes. Both instances could be applicable. Bullets 4 and 5 require the Contractor to verify that, ultimately, the State received any additional funds it was owed. These additional funds could be related to recovery of erroneous payments or claims errors that were identified in a previous audit report that the Vendor Contractor was required to repay the State of funds and payments that the Vendor Contractor received in connection with the administered plan. Bullet 4 also requires the Contractor to verify that systematic errors have been corrected by the Vendor Contractor, and that any related retroactive adjustments were made and paid to the State. For certain instances, the Contractor's review of internal vendor records will be required to validate this and could be tested in its simplest form to see if a valid cancelled check was sent to the State. Other instances require that the Contractor validate adjustments to the claims files.

8. **QUESTION:** On page 37 under Section 3.2.4 section A, Audit of Claims Processing, the last bullet also refers to confirming that overpayments identified in prior audits have been paid to the State. I have the same questions as I posed under #7 above.

RESPONSE:

See response to Q7.

9. **QUESTION:** On page 39 Section 3.2.9, Review of Internal Audits– I have the same questions about how to verify that payments or recoveries due to the State have been paid from prior audits (items 2 and 5 in their list).

RESPONSE:

Section 3.2.9 refers to reviewing the Vendor Contractors Internal Audits. The State is asking that the Contractor review the Vendor Contractors' Internal Audit and verify receipt of all payments and liquidated damages due under the previous audit with the Vendor Contractor (copy of the cleared check, etc.) based upon the results of the Vendor Contractors' Internal Audit.

10. **QUESTION:** On page 56 under Section 4.4.2.7, reference is made to "letters of intended commitment to work on the project." I take it that these are letters from the Key Personnel named to the project, that must be provided in addition to their resumes?

RESPONSE:

Yes, per Section 4.4.2.7, Letters of intended commitment to work on the project should be provided for key personnel and the key personnel of any proposed subcontractor(s).

11. **QUESTION:** Under what circumstances would proposed exceptions to terms and conditions to the State contract (exhibit A), be cause for it being deemed unacceptable?

RESPONSE:

Per Section 4.4.2.4, Exceptions to terms and conditions may result in having an Offeror's proposal deemed unacceptable or classified as not reasonably susceptible of being selected for award. If an Offeror declines to meet an RFP requirement or a term or condition to the State contract, it would be provided at least one opportunity to fix a deficient proposal. If the deficiency is not resolved, a proposal could be declared not reasonably susceptible of being selected for an award, not responsible or simply ranked lower than other proposals that would meet requirements. We should point out mandatory RFP and contract terms are driven by law, regulation and best procurement practices. The State has little flexibility on matters of law and regulation and limited flexibility elsewhere although we would consider the reasons for your exception and respond.

12. **QUESTION:** Should we assume that whenever the term "State" employees is used that it is always inclusive of SLEOLA?

RESPONSE:

No, while SLEOLA members are State employees, the RFP distinguishes between plans for general State employees other than SLEOLA and plans for SLEOLA members only. In the RFP, the term State employee varies in terms of referencing SLEOLA members or members of the general State plan depending on the specific context.

13. **QUESTION:** Could you provide how many claims were processed by vendor in the latest year?

RESPONSE:

In CY 2015 the State paid approximately 4.8 million medical claims and 3.8 million prescription drug claims.

14. **QUESTION:** Please confirm that these are the plans included in the Solicitation (based on the statement at the Pre-Proposal conference that there are 8 required medical plan audits each year):

CareFirst: Two PPO Plans (one for the State; one for SLEOLA); Two EPO Plans (one for the State; one for SLEOLA) One POS Plan (for SLEOLA only) = 5 plans
UHC: One PPO Plan for the State; One EPO Plan for the State = 2 plans
Kaiser: One IHM Plan for the State =1 plan

RESPONSE:

Yes. See the response to Q3 above.

15. **QUESTION:** Does the State want one audit report for each administrator (one for UHC, one for CareFirst, one for Kaiser) or does the State want separate reports for each plan audited (five for CareFirst, two for UHC, one for Kaiser) or does the State want one report for each administrator with audit results and reports combined (one report with combined results for the 5 CareFirst plans; one report for UHC with combined results for PPO and EPO and one report for Kaiser).

RESPONSE:

The State requires separate reports for each plan, i.e., five reports for CareFirst, two for UHC, one for Kaiser. Typically, some report duplication may exist (i.e. audit of administrative procedures may be the same with all plans under one vendor) however, each report should be separate and stand on its own with specific findings, recommendations, etc. The RFP § 3.3.1 A will be amended to clarify this point. See Amendment #1.

16. **QUESTION:** Re RFP 3.2.8, Audit of Clinical Processes. Please clarify which of the first four bullet points apply to dental and flexible benefit plans. (From our experience, none of these requirements would apply to an FSA plan.)

RESPONSE:

The bullets listed in RFP 3.2.8 are intended to be broadly applied as appropriate to the Service Category to which an Offeror is proposing. For example, pre-certifications and claims appeal processes would occur in dental plans as well as medical plans; claims appeals would apply under FSA plans. The RFP will be amended to clarify this point. See Amendment #1.

Remember Proposals are due on March 31, 2016 no later than 2:00 p.m. If there are questions concerning this solicitation, please contact me via e-mail at joy.epstein@maryland.gov or call me at (410) 260-7570 as soon as possible.

Date Issued: February 23, 2016 By

Joy Epstein
Procurement Officer