# Amendment of Solicitation

**Date of Issuance:** 3/1/2017 **Solicitation No.** 0900000252

**Requisition No.** 0900008599 **Amendment No.** 1

Hour and date specified for receipt of offers is changed: ☐ No ☒ Yes, to: March 20, 2017 3:00 PM CST

Pursuant to OAC 260:115-7-30(d), this document shall serve as official notice of amendment to the solicitation identified above. Such notice is being provided to all suppliers to which the original solicitation was sent.

Suppliers submitting bids or quotations shall acknowledge receipt of this solicitation amendment prior to the hour and date specified in the solicitation as follows:

(1) Sign and return a copy of this amendment with the solicitation response being submitted; or,

(2) If the supplier has already submitted a response, this acknowledgement must be signed and returned prior to the solicitation deadline. All amendment acknowledgements submitted separately shall have the solicitation number and bid opening date printed clearly on the front of the envelope.

**ISSUED BY and RETURN TO:**

**U.S. Postal Delivery:**
OMES Central Purchasing
5005 N. Lincoln Blvd., Ste. 300
Oklahoma City, OK 73105
or
**Personal or Common Carrier Delivery:**
OMES Central Purchasing
5005 N. Lincoln Blvd., Ste. 300
Oklahoma City, OK 73105

Leanna Edmonds
Contracting Officer

405 - 521 - 2133
Phone Number

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E-Mail Address

**Description of Amendment:**

a. This is to incorporate the following:

**The Response Due Date of this Solicitation has been changed to: 3:00 PM ON MARCH 20, 2017.**

Questions received regarding this solicitation and their answers are below.

**Q.1.** Are companies from outside the USA allowed to submit a proposal?

**A.1.** Per Section B.34. Offshore Services - No offshore services are provided for under this Contract. State data shall not be used or accessed internationally, for troubleshooting or any other use not specifically provided for herein without prior written permission, which may be withheld in the State's sole discretion, from the appropriate authorized representative of the State.

**Q.2**. What are the requirements for attending meetings?

**A.2.** Per Section C.15.4. Attendance at Meetings - The Supplier shall provide representation at periodic meetings or functions as requested by EGID which include quarterly Board meetings at EGID. The Supplier must be available upon request at monthly Committee meetings or any other special meetings.

**Q.3.** Can we perform the tasks (related to this RFP) outside the USA?

**A.3.** Per Section B.34. Offshore Services - No offshore services are provided for under this Contract. State data shall not be used or accessed internationally, for troubleshooting or any other use not specifically provided for herein without prior written permission, which may be withheld in the State's sole discretion, from the appropriate authorized representative of the State.

**Q.4.** Can we submit the proposals via email?

**A.4.** No. Please reference Sections A.2 and E.3.8 regarding submission requirements.

**Q.5.** Can you provide the list of services provided by the current administrator and the rates for those services?

**A.5.** The list of services are similar to the scope of services for this RFP. The rates for 2017 are $13.66 per member per month for administrative services.

**Q.6.** Section E.1.2. Paragraph 2, second sentence: "The Supplier shall specifically document experience in administering the Redirection and Member Advocacy administration for a minimum of three (3) YEARS AS OF 1/1/2017." Can you please clarify the expectation of this section?

**A.6.** EGID requires the TPA, or their subcontractor, to have experience performing the functions described in Section C.9.4 for a minimum of three years as of 1/1/2017.

**Q.7.** As per Section C.9.4. "…being a relatively new program", does the EGID intend to allow-, or plan for-, further enhancements that could be advantageous to both the Plan and Members? If proposer has another more meritorious option or approach taking the Select program into a demonstrably more effective and efficient model, would it be considered?

**A.7.** EGID will consider suggestions to the Select program to increase its efficiency.

**Q.8.** How many pre-certifications were done in 2015 and 2016 for inpatient services? Outpatient?

**A.8.** 2015 Inpatient services = 22114

2015 Outpatient services= 9557

2016 Inpatient services= 22406

2016 Outpatient services= 9012

**Q.9.** What is the average number of members in case management on a monthly basis?

**A.9.** Effective January 1, 2017 EGID has retained a vendor for care coordination for its Pre-Medicare population. Based upon the effectiveness of this program, it may be provided to all of EGID's population in future years. EGID's internal Health Care Management primarily performs certifications for certain procedures rather than case management.

**Q.10.** Do all pricing items need to be provided within Attachment 3 or can we include additional pricing documents?

**A.10.** Attachment 3 must be provided but additional pricing documents may be included.

**Q.11.** Re: E.1.2.1. "Supplier shall disclose the percentage of its full service book of business…" relates solely to those medical plan administered lives, correct? Not any other specialized, ancillary, or care/case lives?

**A.11.** Correct. The percentage should apply only to medical plan administered lives.

**Q.12.** Re: Are all contracts (primary and any sub-contractors) currently serving EGID available publicly? If not, we would respectfully request direction on how to apply for those contracts including contracted parties, terms, duties and responsibilities, and rates paid.

**A.12.** The Central Purchasing Division of the Office of Management and Enterprise Services is the central repository for state contracts. Any vendor who might be interested in contracting with any state agency for a specific type of goods or service may contact Central Purchasing and ask that it be notified of any new solicitation within its area of expertise.

**Q.13.** Please provide a list of the services that require preauthorization in the current plan, as well as guidance on future requirements. If the cert list varies by population (employee/prison) please provide the requirements by population.

**A.13.** Please refer to the member handbooks at www.ok.gov/sib for a list of services that require certification for the employee population. The DOC performs an internal preauthorization process using its own criteria. The TPA will not be involved in this process. Preauthorization is not considered when adjudicating DOC claims.

**Q.14.** Pricing for medical management services is driven by the volume of activity. Please provide the employee/prisoner counts and utilization data by completing the table below. If the requested data is not available, please provide alternative data and specify the time period for the data.

**A.14.**

**Employees/Dependents**

| | Calendar Year 2015 | Calendar Year 2016 |
|---|---|---|
| # of employees | 127,006 | 125,322 |
| # of dependents | 60,149 | 60,055 |
| # of Inpatient admissions pre-certified | 13,168 | 13,477 |
| # of Inpatient admissions denied | 8,946 | 8,929 |
| # of Admits/1000 | 62.1* | 69.5* |
| # of Outpatient cases pre-certified (all case types.) If possible, please provide a list of the types | 5,545 | 5,470 |
| # of cases opened to Case Management for the year | N/A | N/A |

*Active and Pre-Medicare Admits/1000

**Prisoners**

The TPA is not responsible for providing Certification or Utilization Management for the Department of Corrections. Therefore, please see below.

| | Calendar Year 2015 | Calendar Year 2016 |
|---|---|---|
| # of prisoners | NA | NA |
| # of Inpatient admissions pre-certified | NA | NA |
| # of Inpatient admissions denied | NA | NA |
| # of Admits/1000 | NA | NA |
| # of Outpatient cases pre-certified (all case types.) If possible, please provide a list of the types | NA | NA |
| # of cases opened to Case Management for the year | NA | NA |

**Q.15.** Will you provide enrollment counts for 2015 and 2016 to assist us in developing pricing? (H.1.3 Pricing and Compensation Attachment 3)

**A.15.** Yes, please see Attachment 1.

**Q.16.** What are the administrative duties involved in the Life Insurance Program? Do you simply provide advice to pay to the TPA? (C.8.1 Claims Administration)

**A.16.** Prior to paying the life claim, the TPA shall determine that all supporting documentation including, but not limited to the death certificate, beneficiary designation form, funeral home assignment, police or fire department reports, guardianship papers, trust papers, and life insurance claim form has been provided. In addition, the TPA shall verify the eligibility, the amount of coverage and that the premiums have been paid in full. The TPA shall be able to pay multiply payees.

**Q.17.** Does the dental plan have a PPO and fee schedule we will load or do you pay at a percentage of U&C? (C.8.1 Claims Administration)

**A.17.** The HealthChoice dental plan has a fee schedule for dentists and a separate fee schedule for endodontists. DRS has a separate dental fee schedule. Typically, there is an annual update to the fee schedule and quarterly updates if necessary.

**Q.18.** Will you provide customer service phone stats for 2015 and 2016? (C.10.1.5 Call Center)

**A.18.** Total calls for 2016 were approximately 335,000.

**Q.19.** Would submission of the proposal on Flash Drives instead of CDs be acceptable? (E.3.8 Proposal Process)

**A.19.** Yes, proposals will be accepted on flash drives.

**Q.20.** The Health TPA Vendor would like additional clarification on the two questions in Section B.38 within the solicitation document regarding "High Technology System Performance and Upgrades". It is not clear to us if these questions are pertinent to the Health TPA Vendor.

**A.20.** This provision is no longer applicable.

**Q.21.** Please also provide additional clarification for question C.11.2.3 below.

C.11.2.3. Describe in detail the Supplier's system capabilities to administer the limiting charge of the allowed amount for non-Network Medicare providers.

**A.21.** The provision in C.11.2.3. applies specifically to claims processed for members in any of the EGID Medicare Supplement Plans. The Medicare limiting charge is the highest amount a provider who does not accept Medicare assignment can charge for certain services. The Supplier must be able to integrate any applicable limiting charge when adjudicating relevant claims without manual intervention.

**Q.22.** Section A.2.4. Bid Submission on page 5 of the RFP the requirement states: In addition to a hard copy submittal, the bidder will also be required to submit an electronic copy. Please confirm this requirement does not apply to this RFP as requirement E.3.8 (pg 38) states the bidders are to submit response in electronic format on CDs only.

**A.22.** Correct, Section A.2.4. does not apply, electronic format on CDs are to be submitted per Section E.3.8.

**Q.23.** Sections A.24 Termination of Cause and A.25 Termination of Convenience on page 10 of the RFP. Based on the language in sections B.7.2 "This paragraph contradicts and supersedes General Provisions at A.24.1. And A.25." and B.7.3 "This paragraph supersedes General Provisions Section A.24.1 and A.24.2." Would there be instances in which the RFP language pertaining to section A.24 and A.25 would still apply?

**A.23.** No, Section B.7.2. supersedes Section A.24.1. and A.25. Section B.7.3. supersedes Section A.24.1 and A.24.2.

**Q.24.** Section C.3.1. page 20 of the RFP. Regarding the State of Oklahoma Information Security Policy, Procedures, and Guidelines; the links provided are for two versions of the same manual (updated 2008 and 2015). What is the link for the current State of Oklahoma Security Policy, Procedures, and Guidelines?

**A.24.** Section C.3.1 on page 20 of the RFP is not referring to the State of Oklahoma Information Security Policy, Procedures and Guidelines. Sections B.33.1. and B.37. refer to the State of Oklahoma Information Security Policy, Procedures and Guidelines. The correct link is on Section B.33.1.
http://www.ok.gov/cio/documents/InfoSecPPG.pdf

**Q.25.** Section C.8.1. Claims Administration on page 21 of the RFP. This requirement references the HealthChoice benefits Member Handbook and states the TPA will use its usual processing procedures for claims administration, unless EGID issues written instructions to the contrary. Please provide bidders with all Operational Directives EGID wants the TPA to follow so that a complete and accurate configuration of the Claims Administration System can be accomplished for HealthChoice, Select and any other plans.

**A.25.** EGID will work with the successful bidder during the implementation phase to ensure that current benefit/plan designs are programmed correctly. EGID is open to suggestions for processes that need to be changed to meet industry standards.

**Q.26.** Section C.8.2. Eligibility on page 23 of the RFP. Per this reference the TPA is to provide "daily Eligibility files". Please confirm if daily includes weekdays only.

**A.26.** The current export goes to the TPA Sunday through Thursday evenings for EGID. DOC and DRS send separate eligibility to the TPA Monday through Friday.

**Q.27.** Sections C.8.5 Network Providers; C.8.5.2 on page 23 of the RFP. The requirement references a "separate and distinct EGID, DRS and DOC provider files". Is it the intent to provide separate provider files?

**A.27.** No, it is not the intent to provide separate files. EGID currently sends all three networks (HC, DRS and DOC) to the TPA in a single file.

**Q.28.** Section C.10.2 Special Services on page 28 of the RFP. Please clarify what non-English speaking languages are required?

**A.28.** The Supplier should know ACA requirements for providing services to Limited English Proficiency (LEP) members. The ACA requirements are not changed by this response. For information purposes only, EGID understands that services to LEPs are controlled by 45 CFR 155.205 (C). Any non-english LEP group that exceeds 10% of a county's population must be provided translation and interpreting services. It is EGID's understanding that Texas County, located in the Oklahoma panhandle has a Hispanic population of over 10%.

**Q.29.** Section C.11.1 Encryption on page 29 of the RFP. Requirement states "EGID policy dictates that all files at rest must be encrypted." Would you clarify all files? Or is this just for confidential files (such as PHI, PII, etc.)?

**A.29.** All files (exports and reports) that are currently received or transmitted between EGID and the TPA contain either PHI or PII. This ranges from member eligibility to provider banking information. It is the intent to encrypt all transmitted files to minimize the risk should a breach occur.

**Q.30.** Performance Guarantees/Quality/Plan Design/Benefit Changes – How frequent are these type of requests? How many are received at one time? How are the effective dates determined? How much lead time is provided for these requests?

**A.30.** Plan design changes, such as deductibles/out-of-pocket max, are annual and are provided in late August for a January 1st implementation. Benefit changes, such as coverage of a new procedure, can occur throughout the year. Sixty day notice is required to be given to providers prior to such changes. Typically, there are approximately 2-3 benefit changes a month.

**Q.31.** Please provide the last 12 months of call volume statistics (daily call volume and average handle time) for call members and providers

**A.31.** Total calls for 2016 were approximately 335,000.

**Q.32.** What is the percentage paper vs. electronic claims?

**A.32.** 89% electronic and 11% paper

**Q.33.** Please provide Exhibit K – Performance Guarantees. PDF in Word format.

**A.33.** Exhibit K is provided in Excel format, please see Attachment 2. A Word format is not available.

**Q.34.** Please provide copies of reports outlined in Exh L - EGID Required Reports.PDF.

**A.34.** The report formats developed and maintained by the current TPA are proprietary. EGID will work with the successful bidder during the implementation process to ensure the reporting requirements are met or changed to meet industry standard.

**Q.35.** Please provide list of current vendors and services performed by each vendor.

**A.35.** Hewlett Packard Enterprise - Claim administration, UM, Certification, Redirection, Customer Service

McAfee&Taft – Subrogation

American Fidelity – Flexible Spending Account

Evolution Benefits – Flex Benefit Card

Healthcare Highways – Care Coordination for HealthChoice pre-Medicare population

**Q.36.** Please provide current administrative contract and associated pricing.

**A.36.** The list of services are similar to the scope of services for this RFP. The rates for 2017 are $13.66 per member per month for administrative services.

**Q.37.** A.2.4. All bids shall be legible and completed in ink or with electronic printer or other similar office equipment. Any corrections to bids shall be identified and initialed in ink by the bidder. Penciled bids and penciled corrections shall NOT be accepted and will be rejected as non-responsive. In addition to a hard copy submittal, the bidder will also be required to submit an electronic copy. Electronic responses must be submitted in the identical format contained in the solicitation (for example Microsoft Word, Microsoft Excel, but not Adobe PDF). In the event the hard copy of the price worksheets and electronic copy of the price worksheets do not agree, the electronic copy will prevail.

E.3.8. Bidders are to submit two (2) electronic copies of their completed response, to include scanned images of the required completed and signed forms. Electronic copy can be in Word, Excel, or PDF format; but, is to be an unprotected document provided on a CD. Faxed or emailed responses will not be accepted. Hard copies of the solicitation are not needed. This requirement overrides A.2.4 of the General Provisions.

**Q.37.1.** Based E.3.8 ("Hard copies of the solicitation are not needed. This requirement overrides A.2.4 of the General Provisions."), it is our interpretation that a hard copy is not needed. Please confirm.

**A.37.1.** Correct, a hard copy is not needed.

**Q.37.2.** Is it an option to provide the completed response on a flash drive rather than a CD?

**A.37.2.** Flash drives will be accepted.

**Q.38.** B.2.1. The Contract shall be awarded for a one (1) year term to be effective January 1, 2018 or the date the Third Party Administrator has passed an implementation audit and given authority by EGID to begin processing claims. The implementation audit and authority for the TPA to begin claims processing is determined at EGID's discretion based on meaningful claims adjudication and run of corresponding check cycle.

B.2.2. The Contract includes a provision to renew for four (4) consecutive, one (1) year options.

B.4. Firm Fixed Price

Unless this Solicitation specifies otherwise, a Bidder shall submit a firm, fixed price for the term of the Contract.

**Q.38.1.** Is the expectation to have a firm, fixed price for the entire 5 year period (1 year initial term and 4 consecutive, 1 year options)?

**A.38.1.** Each year of the contract is to have a firm, fixed priced. The price does not need to be the same for all 5 years of the contract. Submit pricing on Attachment A as stated in Section H.1.5.

**Q.39.** C.3.1. EGID was established by, and operates pursuant to, the Oklahoma Employees Insurance and Benefits Act, 74 0.S. § 1301, et seq., hereinafter (Act). The Act was established for the benefit of state and education employees, employees of other state governmental entities and quasi-state governmental entities authorized by the Act to participate in the insurance plans offered by EGID. The health, dental and life insurance plans offered by EGID are known as the HealthChoice plans. EGID makes decisions on all policy matters affecting the group insurance plans, including member benefits, premium rates and the investment of premiums. EGID serves over 900 employer groups with multiple retirement systems. See www.ok.gov/sib/ for more information about EGID and plans offered.

**Q.39.1.** Is the expectation that the HealthChoice name will remain?

**A.39.1.** Yes. The name will remain HealthChoice.

**Q.40.** C.4.1. For informational purposes, the census data for the members in EGID Health Plans as of January 1, 2017 is identified in Exhibit A, sorted by Plan. The primary member count referenced is 125,364. The total HealthChoice participation is 187,180.

**Q.40.1**. Please explain the column Total Children in Exh A - Census Data.PDF. It is not the sum of Child column and Children column.

**A.40.1.** EGID has a four-tier rating for premiums. Members with two or more children are in the "Children" column and represent the unique billing units. The "Total Children" column represents covered lives. The total lives are the sum of the Primary, Spouse, and Total Children columns.

**Q.41.** C.4.2. DOC participation is approximately 22,000 inmates. DRS participation is approximately 1,800 clients.

**Q.41.1.** Please explain/define "clients."

**A.41.1.** A "client" is an individual the DRS has determined is currently eligible for health and dental coverage.

**Q.42.** C.9. Utilization Management, Certification and Redirection

C.9.1. General. Currently, EGID's internal Health Care Management (HCM) performs certification for home health, durable medical equipment, outpatient mental health, outpatient substance use disorder and other evolving categories such as genetic testing. The Supplier handles inpatient hospital admissions, sub-acute and long-term acute care admissions, skilled nursing facility, day/residential treatment, transplants, certain outpatient hospital surgical procedures, and certain diagnostic imaging procedures. EGID and the Supplier shall collaboratively determine the medical services requiring certification.

EGID implemented a bundled payment initiative effective January 1, 2016 and continually adds new CPT/HCPCS/MS-DRG procedures to the Select Program as well as to the standard HealthChoice benefit plan. See Exhibit E for a list of the bundled procedures on the Select Program as of October 1, 2016 and the bariatric bundled pricing on the standard HealthChoice benefit plan as of January 1, 2017. Some of the procedures identified for the bundled payment shall require certification. EGID will be adding new procedures to this list throughout the length of the contract. It is the responsibility of the Supplier to adjudicate all claims for bundled procedures per the contracted rates. Due to the Select provider being a relatively new program, EGID anticipates the need for active redirection for members to Select providers for the first two (2) to three (3) years of the contract. Once the program becomes known and more providers/procedures are available on the Select provider/Select procedures, the procedures for active redirection may change.

**Q.42.1.** It is our understanding that the new UR vendor will only be required to perform precertification for the following inpatient and outpatient /diagnostics procedures. Please confirm.

**A.42.1.** Please refer to the handbooks at www.ok.gov/sib for a list of the current procedures requiring precertification. The list may change upon direction for EGID.

**Q.42.2.** All inpatient hospitalizations and the following surgical/diagnostic procedures.

Surgical Procedures:

Blepharoplasty – Correction to the eye lid;

Rhinoplasty – Reconstruction of the nose;

Breast implant removal – Removal of breast implants;

Scar revision – Removal of scar tissue;

Breast reduction – Reduction in breast size;

Panniculectomy – Reduction in abdomen size;

Surgical treatment of varicose veins;

Spinal cord stimulator (neurostimulator) placement; and

Correction of lid retraction.

Diagnostic Imaging

Sinus CT / MRI;

Head / Brain CT / MRI;

Chest CT including spiral CT (RAD);

Spine CT / MRI;

Shoulder MRI; and

PET Scans.

Will any additional procedures (list above) be required for precertification by UR vendor?

**A.42.2.** The list may change upon direction from EGID.

**Q.42.3.** In the Solicitation it states EGID's internal Health Care Management (HCM) performs certification for home health, durable medical equipment, outpatient mental health, outpatient substance use disorder and other evolving categories such as genetic testing. Will the HCM unit need access to our system to coordinate patient certifications? If so, how many will need access?

**A.42.3.** Yes, EGID's HCM would need access to the certification system to document certifications for both the claims processor and the certification administrator. We currently have eight nurses, one physician, and three clerks with access to the certification system.

**Q.43.** C.9.4. Redirection. In order to avoid a certification penalty, providers are required to certify all services/procedures that are indicated as requiring certification. Providers are encouraged to notify TPA of services/procedures designated, or possibly designated, as Select. The Supplier shall provide member outreach and education for purposes of actively redirecting members to Select providers for no out-of-pocket cost to the member though members enrolled in the HealthChoice High Deductible Health Plan (HDHP) must meet their deductible before any benefits, except for preventive services, are paid by the plan. Due to the Select provider being a relatively new program, EGID anticipates the need for active redirection for members to Select providers for the first two (2) to three (3) years of the contract. Once the program becomes known and more providers/procedures are available on the Select provider/Select procedures, the procedures for active redirection may change.

**Q.43.1.** Please describe the current workflow the HealthChoice Select team performs in coordinating, educating and redirecting members to selected providers.

**A.43.1.** HealthChoice members can be redirected to Select facilities by any EGID employee, claims representative, or by a referral coordinator. Members can also self-refer. HealthChoice Select Referral Coordinators are notified of the certification of Select procedures and will assist the member in locating a HealthChoice Select facility. The HealthChoice Select facility will contact the member to schedule the appointment for applicable procedure/service. Members have been educated by newsletters, public meetings, handbooks and by word of mouth.

**Q.44.** C.10.1. Call Center. The Supplier shall maintain a toll-free customer service call center. Toll-free numbers shall be provided for EGID, DRS, DOC, and a Fraud Hotline.

C.10.1.14. Describe in detail the Supplier's Fraud Hotline services including the Supplier's ability to research and provide all supporting documentation to EGID.

**Q.44.1.** Please explain the current process once a matter has been reported.

**A.44.1.** EGID Compliance opens a case on all reports of suspected FWA. If the report is of provider FWA, Compliance notifies EGID's Network Management department and a request is sent to EGID's Chief Medical Officer for summary claims data for the date span in question or two years (whichever is greater). Claims are analyzed for patterns, frequency, billing provider type appropriateness, claim/provider outliers (depending on suspected FWA) and a determination is made regarding requesting medical records for further review. When medical records are requested and received, a review is performed by the Chief Medical Officer and Compliance staff. If records do not substantiate billings, then a request is sent to the TPA to adjust claims to deny due to specified reason(s). A notification letter is sent to the provider of record. Providers may also receive a separate notification letter in situations where their billing has been identified as an outlier. In some cases, such as where a DME company is the subject of an investigation, members have been surveyed to gather information and identify patterns, opportunities, etc. If a plan participant is being investigated, medical and pharmacy claims history may be reviewed for patterns, doctor shopping, stockpiling pills, etc., depending upon the type of FWA suspected.

Depending on the outcomes, relevant enforcement authorities may be notified.

**Q.45.** Utilization Management Data Request: Please provide the following information to assess current utilization patterns.

**Q.45.1** Total number of inpatient admissions certified in 2016

**A.45.1.** Total number of inpatient admissions certified in 2016 = 8,242

**Q.45.2.** Total number of inpatient days certified in 2016

**A.45.2.** Total number of inpatient days certified in 2016 = 41,354

**Q.45.3.** Total number of Admissions noncertified in 2016

**A.45.3.** Total number of Admissions noncertified in 2016 = 5,161

**Q.45.4.** Total number of inpatient days noncertified in 2016

**A.45.4.** Total number of inpatient days noncertified in 2016 = 16,735

**Q.45.5.** Inpatient Utilization - Top Ten Diagnosis Groups by Admissions for 2016

**A.45.5.**
1. Normal newborn
2. Vaginal delivery w/o complicating diagnoses
3. Major joint replacement or reattachment of lower extremity w/o MCC
4. Cesarean section w/o CC/MCC
5. Cesarean section w/ CC/MCC
6. Neonate w/ other significant problems
7. Septicemia w/o MV 96+ hours w MCC
8. Vaginal delivery w/ complicating diagnoses
9. Esophagitis, gastroent & misc digest disorders w/o MCC
10. Spinal fusion except cervical w/o MCC

**Q.45.6.** Inpatient Utilization - Top Ten Diagnosis Groups by Days for 2016

**A.45.6.**
1. Normal newborn
2. Vaginal delivery w/o complicating diagnoses
3. Major joint replacement or reattachment of lower extremity w/o MCC
4. Cesarean section w/o CC/MCC
5. Septicemia w/o MV 96+ hours w MCC
6. Cesarean section w/ CC/MCC
7. Degenerative nervous system disorders w/o MCC
8. Extreme immaturity or respiratory distress syndrome, neonate
9. Neonate w/ other significant problems
10. Aftercare, musculoskeletal system & connective tissue w/ CC

**Q.45.7.** Inpatient Utilization - Top Ten Facilities by Admissions for 2016

**A.45.7.**
1. Norman Regional Hospital ID:129863120698 State of OK
2. Mercy Hospital Oklahoma City ID:139903173100 State of OK
3. OU Medical Center ID:190123172994 State of OK
4. Saint Francis Hospital ID:182583173109 State of OK
5. Integris Baptist Medical Center ID:178253120556 State of OK
6. St John Medical Center ID:148493173103 State of OK
7. St Anthony Hospital ID:195023120580 State of OK
8. Comanche County Memorial Hospital ID:167293120704 State of OK
9. Oklahoma Heart Hospital ID:151303141946 State of OK
10. St Marys Regional Medical Center ID:172843173055 State of OK

**Q.45.8.** Inpatient Utilization - Top Ten Facilities by Days for 2016

**A.45.8.** 1. OU Medical Center ID:190123172994 State of OK

2. Saint Francis Hospital ID:182583173109 State of OK
3. Integris Baptist Medical Center ID:178253120556 State of OK
4. Norman Regional Hospital ID:129863120698 State of OK
5. Mercy Hospital Oklahoma City ID:139903173100 State of OK
6. St John Medical Center ID:148493173103 State of OK
7. St Anthony Hospital ID:195023120580 State of OK
8. Comanche County Memorial Hospital ID:167293120704 State of OK
9. Integris Southwest Medical Center ID:115803120451 State of OK
10. Parcway ID:121311260645 State of OK

**Q.45.9.** Inpatient Utilization - Top Ten Physicians by Admissions for 2016

**A.45.9.** 1. Sous , Ziad

2. Hightower , R B
3. Ponder , Corey E
4. Tkach , Thomas K
5. Elkington , Mark W
6. El Raheb , Morad L
7. Mittal , Yogesh
8. Chickasaw Nation Health System ,
9. German , Robert A
10. Browne , Christopher A

**Q.45.10.** Inpatient Utilization - Top Ten Physicians by Days for 2016

**A.45.10.** 1. Elkington , Mark W

2. Sous , Ziad
3. Hightower , R B
4. Bisson , Albert J
5. Smith , Michael S
6. Jarman , Yana
7. El Raheb , Morad L
8. Scaunasu , Adrian A
9. Martin , Harvey C
10. Feldman , Michael L

**Q.46.** What is the current claims processing platform?

**A.46.** Hewlett Packard Enterprise uses the MetaVance application.

**Q.47.** Are there expected auto adjudication goals and if so what is the current Auto Adjudication rate?

**A.47.** There is not an “expected” goal. We will work with the TPA to maximize auto-adjudication rates. This would include a collaborative review of current benefits and other requirements that may limit auto-adjudication. Current adjudication rate varies depending on claim type ranging from 71% to 83%.

**Q.48.** The 2017 Employee Benefit Guide contains many different plans. Are all of these plans in scope?

**A.48.** The Oklahoma Employees Insurance and Benefits Board (OEIBB) oversees the HealthChoice plan and alternative plan offerings such as HMOs. The scope of this RFP is limited to all the HealthChoice health, dental and life plans only.

**Q.49.** Would network claims be re-priced prior to submission to TPA?

**A.49.** No. The TPA is required to load our contractual rates.

**Q.50.** Would we be responsible for run in claims? If so would run in claim interest payments mentioned in C.8.9 be waived?

**A.50.** EGID does not anticipate the TPA to be responsible for run in claims.

**Q.51.** Who will we receive Enrollment and Eligibility from?

**A.51.** All enrollment and eligibility information for HealthChoice comes only from EGID. DOC and DRS send separate eligibility files to the TPA.

**Q.52.** It appears that we would be supporting three unique provider networks (HealthChoice, DOC and DRS) and that the three would be submitted separately, is this correct?

**A.52.** There are three separate networks with considerable overlap and EGID currently sends all three network providers (HC, DRS and DOC) to the TPA in a single file.

**Q.53.** Please provide a census including the following identifiers: home zips, date of birth, gender, enrollment tier, active vs. pre or post 65 retiree vs. COBRA, product, plan, state grouping, amount of basic life, AD&D, supplemental life and supplemental AD&D and indicate if the employee has dependent life and amount.

**A.53.** This information contains PII and will not be released.

**Q.54.** What are the current administrative fees being charged for the services falling under this RFP?

**A.54.** The rates for 2017 are $13.66 per member per month for administrative services.

**Q.55.** Please provide the number of covered employees and pre-65 retirees residing outside of Oklahoma.

**A.55.** There are 767 HealthChoice members and 272 dependents who reside outside of Oklahoma, primarily in Arkansas, Texas and Kansas.

**Q.56.** Please provide the current administrative fee (percentage of savings or PEPM) for out of state claims fee negotiation services.

**A.56.** The current TPA retains a percentage of savings for out of state claims fee negotiation services.

**Q.57.** In order to provide the State with the best financial value for claims incurred outside of the State of Oklahoma, please provide the number of claims, as well the associated billed and paid charges (in aggregate), which were incurred and paid outside of Oklahoma (non-HealthChoice provider contracts) on a monthly basis for the last two years?

**A.57.** Typically, only 6% of medical payments are to non-network out-of-state Providers. Due to the low volume, this information is not being provided on a monthly basis for the last two years. Refer to Exhibit B for paid claims history.

**Q.58.** Who are the FSA and debit card vendors?

**A.58.** Evolution Benefits for State employees only.

**Q.59.** Requirement C.16.4 – please explain what is meant by 'warrant number'.

**A.59.** These are the unique numbers assigned to each paper check and EFT, i.e. check number.

**Q.60.** We would require indicators on the demographic file of the reimbursement schedule that would be applied to each provider. How many different reimbursement schedules does this involve?

**A.60.** Reimbursement is driven by contract type which is driven by provider specialty/type. The contract types are as follows:

**Professional contracts**

Dental
Dietician
Clinical Nurse Specialist
Nurse Practitioner
Oral Surgeon
Pharmacist
Physician
Physician Assistant
Provider

**Facility Contracts**

Ambulance/Air Ambulance
Ambulatory Surgery Center
Durable Medical Equipment
Facility Contract
Hearing Aid Vendor
Home Health Care Agency
Hospice
Independent Diagnostic Testing Facility
Infusion Therapy
Laboratory
Long-Term Acute Care Facility Contract
Pathology Group Contract
Wig/Scalp Prosthesis

**Q.61.** Please clarify/define the bundle indicator on the demographic layout?

**A.61.** Additions, terminations, and changes are transmitted five nights a week via an incremental update sent via FTP. A quarterly, full reconciliation file is also provided. These files contain user defined indicators for the providers that have agreed to provide bundled services under the Select program.

**Q.62.** How many providers, physicians and hospitals are within the State's proprietary networks?

**A.62.** The number of active providers is listed below. Please note that this does not include counts for terminated providers who can still submit claims for network services from prior to their termination date.

| | |
|---|---|
| HealthChoice – | 2,094 active facilities at 2,940 locations |
| | 19,999 practitioners at 40,501 locations |
| Department of Corrections (DOC) - | 335 facilities at 553 locations |
| | 3,557 practitioners at 6,717 locations |
| Department of Rehabilitation Services (DRS) - | 521 facilities at 820 locations |
| | 4,125 practitioners at 6,442 locations |

**Q.63.** What types of pricing methodologies are used for the State's proprietary networks?

**A.63.** HealthChoice utilizes MS-DRG, LTCH-MS-DRG, per diems, fee schedules, certain codes at a percentage of billed charges and bundled payments.

**Q.64.** On the HealthChoice Basic and Basic Alternative plans, are there any "out-of-network" benefits (similar to the High and High Alternative Plans), or are these plans strictly In-Network only benefit plans?

**A.64.** The Basic and Basic Alternative plans have out-of-network benefits.

**Q.65.** Pertaining to section C.8.7, specifically the requirement for out of state providers to receive payment at the same level as in-state providers, please clarify that this means at the same member benefit level.

**A.65.** State Statute 74 Section 1304.1.M.19 and Section1307.3 requires out-of-state providers receive payment at the same level as in-state providers unless an Administrative Exception has been granted or the claim meets certain thresholds and criteria. The member benefit level is based upon whether the out-of-state provider is network or non-network.

**Q.66.** Will you consider our network vs. Health Choice?

**A.66.** The scope of this RFP is for claims administrative services so the TPAs network services will not be considered.

**Q.67.** What is the reason for going out to bid? Is it a requirement, or are there pricing or service issues?

**A.67.** Oklahoma Statute requires services to be competitively bid every five (5) years. EGID has determined it is in the best interest of the State to go out to bid prior to the full expiration of the current contract due to new programs being implemented by EGID.

**Q.68.** Does the no offshore requirement apply to back office situations as well, or just for situations where the member would be directly impacted? Please clarify offshore services.

**A.68.** The no offshore requirement applies to direct contractual obligations, i.e., obligations that go directly to the purpose of the contract.

**Q.69.** Are we required to bid on all three services: Health, Dental and Life; or would we have the opportunity to bid only on the health TPA services, or possible only the health and dental TPA services?

**A.69.** All three services must be bid by the vendor or its subcontractor.

**Q.70.** Can we see a sample purchase agreement?

**A.70.** Attached is a sample Purchase Order (Attachment 3). The Supplier must provide a sample invoice prior to the Purchase Order.

**Q.71.** B.7.4 – requires us to turn over all phone numbers, PO box addresses, etc. at the termination of the contract. Please verify this would be at the conclusion of the run out administration as we will need to maintain our contact info during this time.

**A.71.** All phone numbers, PO Box addresses, etc. will be turned over to the new TPA at the termination of the contract. The new TPA would then forward to the previous TPA all calls, claims, and other information required to perform run-out requirements.

**Q.72.** C.3.3 – Subrogation is carved out. What data is required by the carved out vendor?

**A.72.** The current subrogation vendor receives pharmacy and medical claims information as well as member eligibility. The current file layouts will be supplied to the successful bidder.

**Q.73.** C.11.5 – Requests a weekly paid claims file. What data requirements or layout is required?

**A.73.** The data requirements include but are not limited to:

- Claim identifying information
    - Unique claim identification number
    - Claim type e.g. Hospital, Professional, Dental, etc.
    - Adjudication sequence e.g. original, reversal, adjustment
- Subscriber and patient
    - Subscriber contract ID
    - Benefit package or coverage ID
    - Plan ID including member tier i.e. High Plan/Active/2+ Children coverage
    - Subscriber first and last name

- Subscriber sex
- Subscriber date of birth
- Subscriber zip code
- Subscriber employer/group identifier
- Patient first, middle, and last name
- Person code
- Patient relation to subscriber
- Patient sex
- Patient age at date of service (calculated)
- Patient date of birth
- Flexible spending account indicator

- Provider information
  - Tax identification number
  - NPI
  - Any system-assigned identifying numbers
  - Network indicator
  - Name
  - Address including zip code
  - Contract type
  - Specialty code
- Claim header and service lines
  - Receipt date
  - Source e.g. electronic, scanned paper, Medicare crossover
  - Type of bill code
  - Place of service
  - Paid date
  - Service span dates
  - Discharge status code
  - Operator ID
  - Precertification information
  - Service line number
  - Service date
  - MS-DRG assigned
  - Primary and secondary procedure codes billed
  - Modifiers billed
  - Diagnosis codes billed
  - Diagnosis code POA indicator
  - POA text string from 837 inbound record
  - Surgical procedures billed
  - Units billed

- Units paid
- Any pricing method codes
- Explanation codes for allowed, denied, paid, subrogation, adjustment reason, other carrier liability, special handling, etc.
- Dental
  - Tooth number or range
  - Surface indicator
- Anesthesia
  - Units
  - Minutes count

- Financial fields
  - Total charges (header)
  - Total paid (header)
  - Interest paid (header)
  - Tax levy
  - Patient responsibility
  - Service line
    - Charged
    - Allowed
    - Denied
    - Non-covered
    - Paid Deductible
    - Copay
    - Coinsurance
    - Patient private room responsibility
  - COB amounts
  - Amounts applied or available to be applied to negative balances
  - Payment type
  - Payment identification number

**Q.74.** A.18 invoicing - invoices will be paid in arrears after products have been delivered or service provided. Does this apply to claims and claim like charges? Our care coordination fees under VBC are prospective and settled annually with ACO and future years are adjusted based on prior years' performance.

**A.74.** The current TPA only invoices for administrative services provided. The current TPA issues daily claim payments on an OMES-EGID bank account. EGID funds the bank account daily based on daily check registers provided by the TPA.

**Q.75.** C.8.14. How are underpayments handled? Will they be treated similarly as overpayments?

**A.75.** The provisions in C.8.14. apply to overpayments that result from Supplier paying too much to a member or provider. Such overpayments are caused by a number of reasons in the ordinary course of business and result in amounts owed back to EGID. Underpayments are ultimately obligations of EGID no matter the cause or whether identified by any Supplier or not during the term of the contract.

**Q.76.** Please provide a proposal census in Excel format, by subscriber, with the following fields: Medical Benefit Plan, DOB, Gender, 5-digit zip code, Medical Coverage Tier, Dental Coverage, Dental Coverage Tier

**A.76.** This information contains PII and will not be released.

**Q.77.** If EGID/the State signs a Purchase Agreement after Board approval is obtained, would they please provide a sample of that Purchase Agreement so that we may review? Who signs the Purchase Agreement and/or is a party to it?

**A.77.** Attached is a sample Purchase Order (PO). The Supplier must provide a sample invoice prior to the Purchase Order. The PO is signed by an authorized buyer for Central Purchasing.

**Q.78.** Regarding B.19 on Page 15. Regarding our Industry Improvement, Research and Safety language (Section 21 of our ASA), would the State consent to the use of de-identified data and limited data sets in that manner? Or would prefer that we discuss this as a deviation in connection with the Statement of Compliance instead of posing the question now?

**A.78.** EGID consents to the use of de-identified data and limited data sets provided the requested data is approved by EGID's Compliance Officer prior to use.

**Q.79.** Regarding B.40, Page 18, what constitutes "customized software"?

**A.79.** Customized" refers to software that is developed exclusively or modified exclusively for the State.

**Q.80.** Regarding B.33.2 on Page 18, this does not appear to be applicable. Would like clarification of this on B.33.1, Page 17. What circumstances would this apply to?

**A.80.** This provision is no longer applicable.

**Q.81.** Can you provide clarification or a representative to address the requested audit, underwriting and subcontractors terms listed within the proposal?

**A.81.** EGID does not understand this request. If any clarification is needed to any of the contract terms, detailed specific questions need to be in writing to Central Purchasing.

**Q.82.** A.20.1 - "pertinent state or federal agency" is too broad. Can the state identify the agency that would have the right to audit?

**A.82.** The State cannot identify a particular agency who would have the right to audit. As the clause reads, any pertinent State or Federal agency will have the right to examine and audit all records. The State cannot anticipate which, if any, State or Federal agency might choose to exercise its right to audit.

**Q.83.** A.21 - How will the state handle run out claims if funds are not appropriated by the legislature? How much notice will the state give prior to termination under this clause?

**A.83.** EGID is a non-appropriated state agency which does not directly receive any State revenues. It is funded entirely by premiums paid on behalf of its members. In the extremely unlikely event there is a revenue shortfall the 60 day termination clause within Section A.25 of the RFP would control.

**Q.84.** A.24 and A.25 – Please confirm the state will reimburse run out and admin fees.

**A.84.** Should EGID determine that it would be in the best interest of the State to continue receiving these services, it would reimburse run out and admin fees incurred

**Q.85.** B.7.1. Would this include the Supplier's confidential and proprietary information?

**A.85.** It is not the intent of this clause to require any Supplier to release proprietary information, but any information necessary for EGID to continue its plans administration must be provided. The data which must be delivered to EGID would be extremely confidential.

**Q.86.** B.7.5 Confirm that the state would continue to pay for run out claims and admin fees.

**A.86** Should EGID determine that it would be in the best interest of the State to continue receiving these services it would reimburse run out claims and admin fees incurred.

**Q.87.** B.21 Is the state willing to hold the Supplier harmless and indemnify the Supplier from a claim arising from the state's plan design?

**A.87.** No. State law forbids state agencies from indemnifying Suppliers.

**Q.88.** B.46 Is provision applicable to the requested administration?

**A.88.** It is not anticipated that any Supplier will furnish products or deliverables which require warranty protection. If a Supplier does furnish products or deliverables, the provision would apply.

**Q.89.** Corporate Insurance - Can we get a copy of the purchase order document, as they often contain insurance requirements?

**A.89.** Attached is a sample Purchase Order. The Supplier must provide a sample invoice prior to the Purchase Order. See B.14.2 for insurance requirements.

**Q.90.** Corporate Insurance - B.14.1 – Fidelity Bonds: Is it possible for us to provide a letter of credit rather than secure the bonds?

**A.90.** EGID will consider letters of credit in lieu of fidelity bonds, but will look closely at the financial condition of the Supplier and the financial institutions involved.

**Q.91.** Network Management -How do you define a bundled payment? Is it inclusive of all services (prof, facility and ancillary) for a defined time period?

**A.91.** The bundled payment includes the fees for the facility, surgeon, anesthesia, laboratory, pathology, radiology, et al. related services provided on the date of the surgery or procedure. Standard clinical editing and all existing plan policy and provisions apply.

**Q.91.1.** Are you requesting that the vendor administer the current contracts already in place today for the bundled arrangements, or create these same type of arrangements for OMES under our TPA services?

**A.91.1.** Yes, the vendor will load our current contracts into their claim administration system and process claims accordingly.

**Q.92.** Network Management - What are the time periods for each bundled payment service and what codes are included within each service line? Please specify each bundle and the codes within the bundle.

**A.92.** Please see Exhibit E for the list of bundled procedures and the code or combination of codes for each bundle. Bundled payment is for all services associated with an encounter including the facility, physician, anesthesiologist, laboratory, and radiology services. For example, an outpatient surgery bundled payment typically spans the services provided in one day and an inpatient bundled payment spans the admit-through-discharge date. The facility submits one claim and receives payment for the bundled service. The billed service line(s) on the claim are matched to a bundled procedure and receive the associated allowable fee. Any other service lines billed on the facility claim, or any services billed by the physician, anesthesiologist, etc. on a separate claim, are considered part of the bundled procedure and do not receive additional reimbursement. Facility providers contract for specific groups of procedures (i.e. Arthroscopy) at their discretion and can terminate participation with 60 days notice.

**Q.93.** Network Management - Is it a prospective or retrospective payment?

**A.93.** All claims are processed retrospectively.

**Q.94.** Network Management - Does the payment under the bundle go to the provider contract holder or does the payment go to each provider who submits a claim under the bundle?

**A.94.** Payments for services provided under the Select program are paid to the participating Select facility. All ancillary providers should look to the Select facility for payment and do not file claims for their services with HealthChoice.

**Q.95.** Network Management - Please list the providers whom the bundled payment is with and service lines by provider for which the bundle applies?

**A.95.** The Select program is expanding and new services are added quarterly. The providers participating in Select may change at any time. For the most current list of participating providers and the bundles they have agreed to provide under Select, please reference our website at https://gateway.sib.ok.gov/providersearch/SelectProgram.aspx.

**Q.96.** Network Management - Please provide details as to the contracting methodology that is used with providers within the Health Choice network (facility, ancillary and professional) – DRGs – MSDRG or APRDRG, per diems, case rates, etc.

**A.96.** HealthChoice utilizes MS-DRG, LTCH-MS-DRG, per diems, set fee schedules for CPTs, HCPCS, ADA, certain codes at a percentage of billed charges and bundled payments.

**Q.97.** Network Management - Are there any gaps in provider access that would need to be filled by using a Supplier's wrap network?

**A.97.** HealthChoice utilizes its own network and does not need a wrap network. The vendor's network could be utilized in C.8.7 for non-network providers.

**Q.98.** Network Management - Can we have the participating provider list and 2016 claims to conduct a repricing as well as network comparison analysis? Please see the attached Milliman data layout requirements.

**A.98.** A provider list and claims repricing is not required. The scope of services for this RFP does not include network management by the TPA.

**Q.99.** Network Management - Please explain what is included in each of your episodes/bundles, their contracted rates and the providers they are associated with.

**A.99.** The contracted rates for the Select program are propriety. See the website for a list of providers. https://gateway.sib.ok.gov/providersearch/SelectProgram.aspx

**Q.100.** Network Management - Can you give use the volume (claim count) and dollars paid out over the last year for bundled payments?

**A.100.** 7,239 claims and $21 million plan paid.

**Q.101.** Network Management - Exhibit E contains a list of various codes. Please explain how these are expected to bundle into other procedures. For example, do you expect procedure code 19357 to always bundle into another line item on every claim?

**A.101.** Exhibit E – Bundled Procedures is the list of "primary" procedures which other services lines billed on a claim would bundle into. For example, if code 19357 is billed on a claim the allowable for that claim will be the bundled allowable for 19357 for a provider contracted for that Select bundle. If the claim has additional billed service lines for codes 88305 and J3010 those services lines will not receive any reimbursement. Additionally, any services billed for this encounter by physicians, anesthesiologists, etc. will not receive additional reimbursement.

**Q.102.** Network Management - Please explain the difference between a standard DRG methodology and the DRGs listed on your exhibit. Are you indicating all professional services rendered (e.g. surgeon, anesthesia) should be bundled into the facility claim?

**A.102.** DRGs on the Select Program are bundled payments that include the facility, professional and ancillary services for the procedure.

**Q.103.** Network Management - Would you be willing to do a retrospective review at the end of the year for bundled payments rather than a prospective payment?

**A.103.** The concept of the Select Program varies from Medicare's bundled payments where payment is made throughout the year and then a retrospective review is performed at year end. EGID does not anticipate changing the program to include a retrospective review at the end of the year.

**Q.104.** Network Management- Would the State be open to different payment methodologies?

**A.104.** EGID is always looking to improve its reimbursement and payment methodologies. Any suggestions by a vendor will be researched for potential impact.

**Q.105.** Network Management- Can you give us details on all of your provider contracts, including the reimbursement details for every contract? We need to know the pricing methodology for every type of contract. Examples include MSDRG, EAPG, APC, fee schedules, percent of billed charges, per diems, case rates, bundled pricing arrangements, etc….). We do not need the specific rates, just the methodologies and how many contracted providers are tied to each methodology.

**A.105.** HealthChoice utilizes MS-DRG, LTCH-MS-DRG, per diems, fee schedules, certain codes at a percentage of billed charges and bundled payments. The contract types are as follows:

**Professional contracts**
Dental
Dietician
Clinical Nurse Specialist
Nurse Practitioner
Oral Surgeon
Pharmacist
Physician
Physician Assistant
Provider

**Facility Contracts**
Ambulance/Air Ambulance
Ambulatory Surgery Center
Durable Medical Equipment
Facility Contract
Hearing Aid Vendor
Home Health Care Agency
Hospice
Independent Diagnostic Testing Facility
Infusion Therapy
Laboratory
Long-Term Acute Care Facility Contract
Pathology Group Contract
Wig/Scalp Prosthesis

**Q.106.** Network Management- Are we expected to support a customized Provider Finder?

**A.106.** No. EGID's website allows members to search for providers.

**Q.107.** Network Management- How would changes to the network (additions/deletions/changes, modifications to reimbursement) be communicated to the TPA Supplier?

**A.107.** Additions, terminations, and changes are transmitted five nights a week via an incremental update sent via FTP. A quarterly, full reconciliation file is also provided. Modifications to the fee schedules are currently communicated at least quarterly and as needed and sent via a separate Excel file as requested by the current TPA.

**Q.108.** Network Management- Will our standard ClaimsXTen rules apply?

**A.108.** EGID will work with the successful bidder to understand the TPA's clinical editing software and to determine if any rules need to be modified in accordance with the current provider contracts.

**Q.109.** Network Management- Would our pricing methodologies for things such as multiple surgery (100%, 50%, 50%, 50%), ASC (100%, 50%, 25%), anesthesia assistant, bi-lateral (100%, 50%) apply?

**A.109.** The TPA's pricing methodology will not apply. The TPA will follow all of EGID's reimbursement methodologies.

**Q.110.** Network Management- Do you expect the TPA Supplier's provider relations to support your network in any way?

**A.110.** No.

**Q.111.** Network Management - If the TPA Supplier is not notified in advance of a contract change, will we be required to implement that change retroactively and reprocess associated claims?

**A.111.** For each instance, EGID will provide a directive on whether to apply any change retroactively and will assist in identifying any claims that must be reprocessed.

**Q.112.** Claims Administration - What is the volume of claims?

**A.112.** Please see Exhibit B. 3,643,276 total claims processed including denied claims.

**Q.113.** Dental - Is the group interested in receiving full service ASO dental proposals? (i.e., using our network, etc.)

**A.113.** EGID utilizes its own network and the scope of services does not include a full service ASO dental proposal.

**Q.114.** Dental - Please provide the current dental enrollment breakdown for the existing Health Choice dental plans and the dental census information.

**A.114.** HealthChoice only offers one dental plan. The census at January 31, 2017 is 95,025 members, 24,181 spouses and 35,441 children for total covered lives of 154,647.

**Q.115.** What specific services are you requesting from vendors for the Life administration?

**A.115.** Prior to paying the life claim, the TPA shall determine that all supporting documentation including, but not limited to the death certificate, beneficiary designation form, funeral home assignment, police or fire department reports, guardianship papers, trust papers, and life insurance claim form has been provided. In addition, the TPA shall verify the eligibility, the amount of coverage and that the premiums have been paid in full. The TPA shall be able to pay multiply payees.

b. All other terms and conditions remain unchanged.

| Supplier Company Name (**PRINT**) | | Date |
|---|---|---|
| Authorized Representative Name (**PRINT**) | Title | Authorized Representative Signature |