



Amendment of Solicitation

Date of Issuance: 5/24/17

Solicitation No. 0900000264

Requisition No. 0900009141

Amendment No. 1

Hour and date specified for receipt of offers is changed: ☒ No ☐ Yes, to: _____ 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

Richard Williams
Contracting Officer
405 - 522 - 1040
Phone Number

Personal or Common Carrier Delivery:

OMES Central Purchasing
5005 N. Lincoln Blvd
Ste. 300
Oklahoma City, OK 73105 -

Richard.Williams@omes.ok.gov
E-Mail Address

Description of Amendment:

a. This is to incorporate the following:

Deadline for Questions will be May 31st @ 3:00 PM. Submit Questions to Richard.Williams@OMES.OK.GOV

Please look for Attachments 23 and 24.

Answers to all questions received are below.

Q.1. Will OMES/CP consider proposals for Medicare PPO plans in lieu of Medicare HMO plans?

A.1. The Supplier may submit either a Medicare HMO response or a Medicare PPO response, but not both.

Q.2. In E.1.3.3, you ask us to include the rates and copays for the HMO and Medicare Supplement under separate cover from the proposal. Is it acceptable to include this CD in the same shipment box as the technical proposal, but within a separately sealed envelope, or should it be a total separate box?

A.2. Yes. This is acceptable. Please make sure everything is labeled correctly.

Q.3. Can you please provide the latest employer contribution schedule for the group? If not, can you please provide us with the average employer contribution per member per month?

A.3. For the categories Medicare Retiree and Pre-Medicare-Retiree, the retirement system contribution ranges from \$101 to \$105 per month for the primary member only. There is no dependent contribution. For commercial employees, contribution levels vary widely. In the majority of cases, the employer contribution for the employee will be at least equal to the HealthChoice High Option Premium. In the majority of cases, there is no employer contribution towards the cost of dependent coverage

Q.4. Can you please provide the most up to date plan designs and corresponding rates for all Medicare supplement and MAPD plans offered to members?

A.4. The Retiree Option Period guide for plan year 2017 is attached. (Attachment 24)

Q.5. Can you please confirm that section H.2. titled "Risk Adjustments" does not apply to MAPD plans. We do not believe the risk adjustment mechanism as described is appropriate for Medicare Advantage. The vast majority of revenue for Medicare Advantage comes from CMS and is risk adjusted at a member level based on each member's claim and diagnostic history. Risk adjustment of the supplemental premium paid by the employer and/or retiree is therefore not necessary and arguably inappropriate.

A.5. Confirmed. Risk Adjustments will not apply to Medicare Advantage.

Q.6. Can you provide the most recent 24 months of medical claims experience (on a monthly basis) for Medicare retirees - containing allowed, retiree cost share (copays, ded, etc) and plan paid claims with corresponding monthly membership? Please include plan design changes and dates of plan design changes.

A.6. EGID will not be providing this data.

Q.7. Can you provide the most recent 24 months of prescription drug claim experience (on a monthly basis) for Medicare retirees- containing allowed, retiree cost share (copays, ded, etc) by month and plan paid claims with corresponding monthly membership? Please include plan design changes and dates of plan design changes

A.7. EGID will not be providing this data.

Q.8. Section H.3. titled "Administrative Assessment" states that the quotes rates should include an administrative cost adjustment (\$4.624 pmpm) to reimburse EGID for administrative activities including, but not limited to enrollment, record keeping, accounting and employee communication functions. Can you please confirm that this should be included in the rating? We were requested to remove it from our initial offer for a 1/1/2017 effective date.

A.8. Yes, the \$4.624 pmpm "Administrative Assessment" should be included in the rates.

Q.9. A member level RX claim file for all Medicare retirees for each RX plan. We will need one file that contains claim level information. The information should be provided in summary as well as in detail format. The detail format file should be in delimited text format, inclusive of a header row. The data should be provided for the Medicare eligible population we are quoting. Such as both Medicare eligible pre- and post-65's, including disabled.

The File should include:

- a. Unique Member ID
- b. Pharmacy ID
- c. NDC-11
- d. AWP
- e. Dispense Date
- f. Retail vs. Mail Indicator
- g. Days supply
- h. Quantity or Units Dispensed
- i. Duplicate records and originals/reversals should be removed

A.9. EGID will not be providing this data.

Q.10. Will there be any additional time provided to review this RFP and to submit additional questions? The format is different from previous commercial RFP's and there are new items to review. In past years, at least five business days or more were allotted.

A.10. Deadline for Questions will be May 31st @ 3:00 PM. Submit Questions to Richard.Williams@OMES.OK.GOV

Q.11. C.1.3 – Please confirm it is acceptable to offer both a commercial rate for active employees and a Medicare Advantage rate for retirees, and that a Medicare Supplement plan is not required to be offered. We are trying to clarify C.1.3 "Suppliers may not offer a MAPD or a Medicare Supplement on a standalone basis for this RFP."

A.11. Suppliers may offer a commercial rate for active employees and a Medicare Advantage rate for retirees. However, state law under 74 O.S. §1366.1 requires that "if the participating health maintenance organization offers a Medicare supplement plan to other entities within this state then it shall be required to offer a Medicare supplement plan."

Q.12. C.6.7.4.1 – How shall bidders handle the situation where a Medicare eligible retiree signs up for the MAPD offering, and the retiree has a dependent that is not Medicare eligible? Only Medicare eligible members may enroll in an MAPD employer group plan offering; will plans be required to offer commercial plans with identical benefits to MAPD plans for dependents of Medicare-eligible enrollees, or will such dependents be required to enroll in a separate commercial offering?

A.12. When there is a retiree situation where the primary and the dependent are not both Medicare eligible, the Medicare eligible member is enrolled in an MAPD/Medicare Supplement and the other covered individual is enrolled in the commercial offering from the same Supplier with the appropriate non-Medicare rate applied. So long as there is a dependent relationship both individuals must be on plans offered through the same Supplier.

Q.13. C.9.5.9 – Please specify how the actuarial equivalence needs to be calculated for the prescription drug plan. In particular, how do Federal Reinsurance, Low Income Cost Sharing, and Coverage Gap Discount Program amounts need to be reflected in the actuarial equivalence calculation? How should drug rebates be considered? Is the calculation as simple as (total allowed – cost sharing) / total allowed? Does actuarial equivalence have a range (+/- 2%), or does it mean as good as or better than the comparison plan? How should membership and morbidity mix be reflected, if assumed to be different from the comparison plan?

A.13. Actuarial equivalence is defined as (Total Pharmacy Allowed – Member Pharmacy Cost Sharing)/Total Pharmacy Allowed. Federal reinsurance, Low Income Cost Sharing, Coverage Gap Discount, and Rebates should not be reflected in the actuarial equivalence calculation. The actuarial equivalence will need to be within a reasonable range or better than the comparison plan, which is the HealthChoice SilverScript High Option Medicare Supplement plan benefits. Membership and morbidity mix should not be reflected, it should be based on the population as a whole.

Q.14. C.9.6.2 – The RFP specifies the MAPD pharmacy plan must be actuarially equivalent to the HealthChoice SilverScript High Option Medicare Supplement Plan. How should we demonstrate this actuarial equivalence? Should we estimate the plan responsibility under each benefit design and demonstrate that the proposed plan design is expected to pay as much or more than the HealthChoice SilverScript High Option Medicare Supplement Plan? Is this actuarial equivalence calculated in total (both medical and pharmacy)? How do Federal Reinsurance, Low Income Cost Sharing, and Coverage Gap Discount Program amounts need to be reflected in the actuarial equivalence calculation? How should drug rebates be considered? For both the medical and pharmacy benefits, does actuarial equivalence have a range (+/- 2%), or does it mean as good as or better than the comparison plan?

A.14. OMES will review the proposed plan design to ensure it meets the actuarial equivalence. The actuarial equivalence will need to be within a reasonable range or better than the comparison plan, which is the HealthChoice SilverScript High Option Medicare Supplement plan benefits. Actuarial equivalence is defined as (Total Pharmacy Allowed – Member Pharmacy Cost Sharing)/Total Pharmacy Allowed. It is based only on pharmacy claims. Medical claims are not considered. Federal reinsurance, Low Income Cost Sharing, Coverage Gap Discount, and Rebates should not be reflected in the actuarial equivalence calculation. As a point of comparison, the estimated 2017 actuarial equivalence for the HealthChoice SilverScript High Option Medicare Supplement plan benefits is approximately 78.5%.

Q.15. C.10.1 – How should the low income premium subsidy amount be reflected in Attachment 8? Should Attachment 8 be the total premium required, with any low income premium subsidy amount subtracted from the stated rate? Note that the low income premium subsidy amounts may not be known until after the RFP deadline. For Attachment 8, how should the premium rate for a dependent be reflected based on Medicare eligible status? For example, we would have different rates for a dependent spouse if they are Medicare eligible compared to a dependent spouse that is not Medicare eligible.

A.15. When there is a retiree situation where the primary and the dependent are not both Medicare eligible, the Medicare eligible member is enrolled in an MAPD/Medicare Supplement and the other covered individual is enrolled in the commercial offering from the same Supplier with the appropriate non-Medicare rate applied. So long as there is a dependent relationship both individuals must be on plans offered through the same Supplier. As indicated in H.5.10, MAPD rates are to be expressed in a per covered individual rate, therefore there is no specific table format for the MAPD rate. Premiums are to be expressed as the total premium per covered person. Attachment 8 Table 2 is specifically for Medicare Supplement Plan rates.

Q.16. E.1.3.4 – The final MAPD rates are due by July 25. The federal rates may not be known by this time. Will the July 25 date be extended if the federal information has not yet been released?

A.16. Yes.

Q.17. H.5.4 – We plan to have one actuary develop the commercial HMO rates and a separate actuary to develop the MAPD rates. Is it acceptable to submit two separate signed statements from two actuaries certifying the statements in H.5.4? Please clarify what supporting documentation is required to accompany the certification (“...along with adequate supporting documentation.”)

A.17. It is permissible to have two different actuaries certify the rates. Supporting documentation is only required if the Supplier feels additional information may be necessary to qualify the assumptions.

Q.18. H.5.10.4 – For the MAPD premium quotes, does this include the entire Table 2 within Attachment 8? That is, the MAPD premium quotes due by July 25 also encompass the premium quotes for any dependents? How shall rates for dependents of MAPD enrollees be presented, as dependents not eligible for Medicare may not enroll in the MAPD? Do the rates in Attachment 8, Table 2 represent the combined employee and dependent premium? For example, should the Spouse rate represent the combined premium for an employee and spouse, or only for the spouse?

A.18. As indicated in H.5.9, Attachment 8, Table 2 is for Medicare Supplement Plan Rates. As indicated in H.5.10, MAPD rates are to be expressed in a per covered individual rate, therefore there is no specific table format for the MAPD rate. The MAPD rate for a spouse should not be combined with the primary. When there is a retiree situation where the primary and the dependent are not both Medicare eligible, the Medicare eligible member is enrolled in an MAPD/Medicare Supplement and the other covered individual is enrolled in the commercial offering from the same Supplier with the appropriate non-Medicare rate applied. So long as there is a dependent relationship both individuals must be on plans offered through the same Supplier.

Q.19. Attachments 15 and 16 indicate “\$100.000” at the top. Please confirm the correct threshold value is “\$100,000”.

A.19. The correct value is \$100,000.00.

Q.20. The header in Attachment 17 says "Early Retirees" while this exhibit normally includes active employees. Please confirm whether this exhibit should include early retirees only or should include active employees as well

A.20. This should include active employees as well as early retirees.

Q.21. Census: Last year - 2016, we received a file with 126,841 zip code lines prior to the expansion... this file included the three benefit types; Active Member, Medicare Retiree and Pre-Medicare-Retiree. This year – 2017, we received a file with 148,071 zip code lines prior to the expansion. This file included the three benefit types; Active Member, Medicare Retiree and Pre-Medicare-Retiree. Please confirm which benefit types should be included in the census for the HMO proposal and the MAPD separately. Please also confirm the approximately 17% increase in member data since last year.

A.21. The Commercial rate should take the Active Member and Pre-Medicare Retiree populations into consideration. Medicare Supplement and Medicare Advantage rates will utilize the Medicare Retiree information. The 148,071 number is correct.

Q.22. Attachment 20 - Please confirm that reports for the MAPD line of business are only required where ‘MAPD’ is listed with the report name in the column ‘Report Name’ (Column 3) If no ‘MAPD’ is listed then the report is only completed for the HMO line of business?

A.22. In addition to the reports specifically labeled MAPD, MAPDs should also provide the quarterly reports numbered 11, 12, and 13. MAPDs should also provide annual report numbers 14 and 15.

Q.23. C.7.11.22 - Attachment 5 lists four provider types; PCP, Specialists, Hospitals, Pharmacies. In the past RFPs, we have also provided Urgent Care locations. Please confirm that Urgent Care should be excluded. In the past RFPs, separate Geo Access mapping by provider type has been required. Please confirm that only employee data to each provider type is required in a map form.

A. 23. Please include Urgent Care locations. Under section C.7.14 Standardized Service Areas and Access Standards, reference C.7.14.3: “The Supplier shall provide a Geo Access report to show the network access strength.”

Q.24. Attachment 5 - A refresh of the entire directory is completed each quarter per the request of the State and the column ‘Record Status’ has been left blank per their request. Please confirm that we should continue to keep this column as blank in our data. Under ‘Type of Practice’ - should the format be revised to include NP-‘Nurse Practitioners’ and PA ‘Physician Assistants’.

A.24. Confirmed, please “refresh” the entire directory each quarter and leave the column “Record Status” blank. Under ‘Type of Practice’, include NP-‘Nurse Practitioners’ and PA ‘Physician Assistants’.

Q.25. C.7.14.2 - Attachment 3: How are the requirements for the zip code list for this question different from question C.7.11.18? Please explain.

A.25. Suppliers may disregard C.7.14.2 by providing the zip codes requested in C.7.11.18 in an Excel file in the format specified in Attachment 3 Standard Service Areas.

Q.26. Attachment 18 says it is for MAPD HMO but has no section for pharmacy. Should we use attachment 19 for the pharmacy information for our MAPD HMO plan?

A.26. For clarity, Attachment 23 has been created as the pharmacy response for MAPD HMO.

Q.27. Attachment 19 section Pharmacy Copay Structure for Network Benefits only lists 5 drug tiers. Where should we indicate additional pharmacy tier information?

A.27. Please insert a new row below the "Tier 5" row within the 30-day supply or the 31 to 90-day supply sections to include additional pharmacy benefit tier information.

Q.28. Responding Bidder Information, If a vendor has 2 filing numbers which one should they choose.

A.28. The vendor is responsible for determining which Vendor ID they want to submit their response under. The State cannot advise on this.

Q.29. Section H.2, Risk Adjustments, p. 40. Is there a cap on the Risk Adjustment?

A. 29. There will be no cap on the Risk Adjustment for 2018.

Q.30. Section C.9.8.1, Medicare Experience, p. 35. Do we need to include enrollment numbers for Medicare membership that were effective 1-1-2017?

A.30. Medicare enrollment is required for 2015 and 2016; however, it would be helpful if 2017 is provided.

Q.31. Section B.23.2, Subcontractors, p. 14. Please specify if subcontractor information should be provided for delegates that provide ancillary services (dental, mental health, etc.) or if subcontractor information is only needed in this section if a subcontractor is used for preparing the RFP?

A.31. Section B.23.2 refers to subcontractors who provide a significant operational component of the Supplier's administrative services. For instance, some Suppliers may subcontract out precertification, utilization review, provider credentialing, etc.

Q.32. Section C.6.19, Certificates of Coverage, p. 22. The U.S. Department of Health and Human Services sent guidance that Certificates of Coverage were no longer necessary since pre-existing condition exclusions were no longer allowed under any circumstances. Under what circumstances do you anticipate a member or dependent requesting a Certificate of Coverage?

A.32. These are usually being used by the former member to show proof of loss within 30 days so as to add coverage with another carrier. HealthChoice receives approximately 20 requests per year related to its population.

Q.33. Section C.7.12, Section 125, p. 27. Is the FSA requirement applicable to the HMO's? An HMO is unable to verify payment method on claims that are paid at the provider site and not through the HMO.

A. 33. OMES requests that the Supplier cooperate in this process to the extent that it may be possible under the particular HMO's arrangements.

b. All other terms and conditions remain unchanged.

Supplier Company Name (**PRINT**)

Date

Authorized Representative Name (**PRINT**)

Title

Authorized Representative Signature