Washington State Health Care Authority

Solicitation Amendment

PEBB Medicare Advantage plus Prescription Drug (MA-PD)

RFP No. 3872

Amendment No. 1

Date Issued: August 7, 2019

Purpose: Answer all questions received. Amend the RFP as follows. Redline RFP documents provided as separate attachment.

Amendment need not be submitted with Proposal. All other Terms, Conditions, and Specifications remain unchanged. The above referenced solicitation is amended as follows:

1. Appendix 5 – *Provider Network Adequacy* and all references within the RFP of Appendix 5, have been deleted in their entirety.
2. NEW - Appendix 6 - *PEBB 834 Companion Guide* has been added to the RFP.
3. Exhibit D – *Reference Form*, has been deleted and replaced with Exhibit D-1 – Reference Form REGIONAL, and Exhibit D-1 – Reference Form NATIONAL.
4. Exhibit E – *Operations*, question 7.3.5 has been amended as follows:

   7.3.5 Inform the HCA account manager(s) of federal law changes within thirty (30) Days of notification, which the Bidder will be obligated to do.

5. Exhibit G – *Pharmacy Management*, question 4.1.10.3 has been amended to be renumbered as question 4.1.11. All remaining previously existing numbers have been subsequently renumbered.

6. Exhibit H – *Clinical Management*, question 2.3 and sub-questions 2.3.1 and 2.3.2 have been amended and renumbered as question 2.2.2 and sub-questions 2.2.2.1 and 2.2.2.2, respectively. All remaining previously existing numbers have been subsequently renumbered.

7. Exhibit H – *Clinical Management*, question 6.3 has been deleted and replaced as follows:

Number of clinical and non-clinical case management staff, their qualifications, and the criteria they use to assign case management.

8. Exhibit H – *Clinical Management*, question 6.5 has been deleted and replaced as follows:
Number of clinical specialists who perform clinical consultations for complex case management, their qualifications, and the criteria used to assign complex case management to clinical specialists.

9. Exhibit I (REGIONAL) – Provider Network & Access, question 1.9, has been deleted and replaced by:
Network adequacy (according to CMS network adequacy regulations for Medicare Advantage Organizations) in Washington State.

10. Exhibit I (NATIONAL) – Provider Network & Access, question 1.10, has been deleted and replaced by:
Network adequacy (according to CMS network adequacy regulations for Medicare Advantage Organizations) in Washington State.

11. Exhibit J – Technical Data Requirements, question 4.2.2 has been amended to reference Appendix 6 as follows:

4.2.2. Accept and process PEBB Program eligibility files daily in the format outlined in the PEBB Program Eligibility File Format. See Appendix 6 – *PEBB 834 Companion Guide*.

12. Exhibit K – *Cost & Plan Design*, has been deleted and replaced, to amend cells within WS2 and WS3, with Exhibit K-1 – Cost & Plan Design. See separate attachment.

13. Section 3.1 of the RFP has been amended as follows, to include Exhibit D – Reference Form:

National PPO plan proposals will be scored against other National PPO plan proposals only. Regional PPO plan proposals will be scored against other Regional PPO plan proposals only. For Bidders submitting both a National and a Regional PPO plan proposal, the Bidder **must** submit unique responses for a National and a Regional PPO plan type for the below listed exhibits. All other exhibits only need to be submitted once.

1. Exhibit D – Reference Form;
2. Exhibit K - Cost & Plan Design; and
3. Exhibit I - Provider Network

In order to have its Proposal evaluated by HCA, Bidder must provide the items listed below following the specific instructions outlined in the Sections noted below:

1. Letter of Submittal (See Section 3.4)

2. Evaluation Elements (See Section 3.5)

3. Additional Proposal Documents (See Section 3.7)

14. Section 3.6, Additional Proposal Documents (Mandatory Not Scored) subsection 4. Exhibit D – Reference form has been amended as follows:

4. Exhibit D – Reference Form (if HCA elects to move forward with Oral Presentations, these Reference Forms will be used for the Oral Presentation Reference requirement).

Amendment 1 RFP 3872 - MA-PD - Questions and Answers			
#	**RFP Section**	**Bidder Questions**	**HCA Response**
1	1.2	Per the schedule, proposals are due on August 23 by 2 pm (PT). Is it possible to email our response, per the instructions, to meet that deadline and then follow with overnight delivery of the hard copies?	No. Per Section 3.3 of the RFP, Bidders should allow sufficient time for delivery to ensure timely receipt of their Proposals by the RFP Coordinator. This applies to both the required electronic copy and physical copies.
2	Appendix 5	In order to provide results for the requested Appendix please provide us with a list of zip codes you would like us to use. Without this information we are unable to complete the attached Appendix.	Per Amendment 1, Appendix 5 has been deleted from the RFP.
3	Appendix 5	It states that we should use state network adequacy guidelines however due to the RFP being a request for Medicare the Medicare network adequacy standards would be per CMS, not state. Please let us know which guideline we should use (time or distance) as well as provide an updated Appendix 5.	Per Amendment 1, Appendix 5 has been deleted from the RFP.
4	Appendix 5	Upon review it appears that the providers listed are more commercial providers and not Medicare providers. Please provide an updated Appendix 5 with Medicare providers.	Per Amendment 1, Appendix 5 has been deleted from the RFP.
5	Data	Based on the advanced date in receiving answers and our ability to provide competitive rates within the RFP timeline I felt it was important to ask if a census of the retiree population will be provided with gender, DOB, ZIP and spouse indicator? The RFP didn't mention a census so I wanted to ask if it was an oversight. Census info is very important in rating Medicare Advantage plans since CMS reimburses based on where the retiree/spouse resides.	HCA is continuing to evaluate this question. An answer will be provided within a future amendment by August 16, 2019.
6	Data	The data received seems to only be for the UMP Classic Plan. Will we be receiving more experience information around other plans?	No further information will be provided.

7	Data	Can you provide pharmacy information – NABP, or NPI for pharmacies – on the detailed claim file?	No further information will be provided.
8	Data	Can you provide “date filled” information in the pharmacy file?	No further information will be provided.
9	Data	We received the claims files and other pertinent data from Milliman but have not yet seen a census. Is the census going to be provided by Milliman? Does HCA know yet when that will be?	Please see response to Question #5.
10	Data	We have received the data files from Milliman. The census file does not include critical pieces of information that help Medicare Advantage plans estimate CMS revenue to determine price, or to confirm network adequacy to permit a carrier to offer a National Group Medicare Advantage PPO plan. Could we please have a census issued that includes either the age or the date of birth along with the gender and zip code for every Medicare-eligible retiree, spouse and dependent?	Please see response to Question #5.
11	Data	Please provide a member level census that includes DOB, Gender, Zip Codes, and current plan indicator for all Medicare Eligible Retirees and for all plans.	Please see response to Question #5.
12	Data	If a full census will not be provided, could the HCA provide the split of membership for the Kaiser WA Classic and Kaiser WA MA?	As of August 2019, there are 3,628 members in the Kaiser Permanente of Washington (KPWA) Original Medicare plan, and 20,762 members in the KPWA Medicare Advantage plan.
13	Data	Please provide the latest 12-24 months of medical claims, including corresponding member counts by month for the Kaiser WA Classic and Premera Medicare Supplement plans.	No further information will be provided.
14	Data	For the UMP Classic Medical claims provided, is it possible to update the data to include monthly claim amounts along with monthly member counts?	No further information will be provided.
15	Data	For the UMP Classic RX claims provided, is it possible to provide Pharmacy information (NABP or NPI) as well as Drug Type (Retail or Mail Order) • If no, could the State provide the utilization report	No further information will be provided.

		by pharmacy and/or the mail order utilization information?	
16	Data	For the Kaiser WA Medicare Advantage and Kaiser NW Senior Advantage, please provide: • The latest 12-24 months of medical claims, including corresponding member counts by month. • The corresponding 12-24 months of CMS revenue totals for each of the Medicare Advantage plans • The 2018 full year MA only risk score for each of the Medicare Advantage populations. • Please describe whether the 2018 MA risk scores include any mid-year reconciliation estimates or final reconciliation estimates.	No further information will be provided.

17	Data	For the Kaiser NW Senior Advantage, Kaiser WA Medicare Advantage, Kaiser WA Classic and Premera Medicare Supp Plan F, please provide :• 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's. The File should include:• Unique Member ID• Pharmacy ID• NDC-11• AWP• Dispense Date• Retail vs. Mail Indicator• Days' supply• Quantity or Units Dispensed• Duplicate records and originals/reversals should be removedNot required, but useful information:• Current Formulary Tier• Low Income Status (Yes/No indicator)• Member months: Could we receive Rx member months for the same year claims have been provided (by month if possible). This should be provided for Medicare eligible members only and will be used to convert insured pricing to a PMPM basis.• Please provide a second Rx file that contains member information:• Member ID• Risk Score• DD/MM/YYY Y of risk score• Zip code• It is very useful to provide a formulary and network disruption report. We can use the member level information to produce a formulary and network disruption. This can be used with pre-effective date transition activities.• If member level utilization data is not available, please provide the generic dispense rate (GDR) for the current Rx plan.	No further information will be provided.

18	Data	Please provide a census for all Medicare eligible retirees/spouses/dependents. At minimum, please include the below information. This should only be for Medicare eligibles retirees. • Date of birth • Gender • Zip code • Current plan selection • Relationship indicator	Please see response to Question #5.
19	Data	So that carriers may better understand the current plan offerings, please provide detailed SPDs for all the current plan options for Medicare eligibles retirees. • For the plans that are secondary to Medicare, please also include a detailed description of how the plans coordinate with Original Medicare.	Plan design summaries and Certificates of Coverage for current PEBB Program Medicare Retiree Health Plans are available to the public through HCA's website (www.hca.wa.gov). See response to Question #82.
20	Data	Please provide the most recent 24 months of claims data for the Premera Plan F and Kaiser Classic Medicare supplemental plans similar to the claims provided for the UMP Classic Medicare plan. Claims should be separate by plan offering. Please note if the claims are incurred or paid and the paid through date of the data.	No further information will be provided.
21	Data	Please provide the most recent 24 months of Medicare Advantage claims for the Kaiser Senior Advantage and Kaiser MA plans. Claims should be separate by plan offering. Please note if the claims are incurred or paid and the paid through date of the data. Additionally, please note if the claims include or exclude amounts for clinical/quality programs not covered by Original Medicare.	No further information will be provided.

22	Data	Please provide the most recent MMR file for the two current MA plans. If MMR files are not available, please provide the most recent risk score for each plan. Please note the date of the risk score (CY, specific month, etc.) and if it includes any actual or estimated amounts for CMS mid-year or final accruals. If neither MMR nor risk scores can be provided, please provide the most recent CMS revenue for each MA plan. Please note the date of the payment (CY, specific month, etc.) and if it includes any actual or estimated amounts for CMS mid-year or final accruals.	No further information will be provided.
23	Data	Please provide total monthly enrollment counts by plan offering for the past 24 months.	HCA, through its contracted actuary Milliman, provided summary data for the last three years of enrollment for the Uniform Medical Plan -- Classic Medicare. Enrollment by carrier is included in RFP Section 1.4 -- Background. No further information will be provided.
24	Data	Please provide updated detailed Rx data to also include the 7 digit NCPDP/NABP Number (Pharmacy ID) or NPI. Also please include the actual fill date. Additionally, please provide the same data for the other currently offered Rx plans.	No further information will be provided.
25	Data	Bidder requests census information for all Medicare-eligible retiree plans in place today.	Please see response to #5.
26	Data	If census information cannot be made available, please provide the out-of-state membership by state and county similar to what was provided for members in Washington State(on pages 12 and 13 of the RFP)?	Please see response to #5.
27	Data	If census information cannot be made available, what data should Bidder's use to complete the network adequacy attachment required by HCA?	Per Amendment 1, Appendix 5 has been deleted from the RFP.
28	Data	Regarding the members who are out of country, what is the HCA's expectation for addressing the health plan benefits for these members? Can the HCA provide additional information as to where these members reside?	HCA referenced UMP Classic-Medicare international enrollment for informational purposes only. The RFP does not require Bidders to cover Retirees who reside outside of the United States; however, it is within the Bidders' discretion to decide what coverage limitations if would like to propose. Exhibit K offers Bidders the opportunity to include up to four Enhanced Supplemental Benefits, which may include international coverage.

29	Data	Would it be possible for the HCA to resend the drug claims information with a mail/retail indicator included?	No further information will be provided.
30	Data	Regarding the drug claim file labeled "UMP Medicare Detailed Claims Sample.xlsx", were all claims incurred during the months provided included? Considering that the file appears to be a sample, will full data be supplied at some point?	The file is a representative sample and no further information will be provided.
31	Data	Is the member month information in the "UMP Classic - Medicare Experience Summary.xlsx" applicable for both the medical experience provided and the drug experience provided?	Yes.
32	Exhibit B	Does the RFP require we utilize a Diverse Business Enterprise? If so, will there be a specific percentage requirement that we need to meet in order to fulfill a future evaluation criterion?	Exhibit B is for information purposes. To be named an ASB, a Bidder would not be required to use a Diverse Business Enterprise, nor are there any specific percentage requirements.
33	Exhibit D	Please clarify if the Bidder is quoting both a National and Regional solution, does HCA wish to receive 5 unique references for each proposed solution, or would a total of 5 references representative of our total experience be sufficient. If 10 references are required, can we use some references more than once since they fall in both network descriptions?	Per Section 3.4 of the RFP, Bidders must submit separate references for each plan type (Regional and/or National) for which they are submitting a Proposal. A reference may be used more than once if the Bidder currently offers, or has offered, both plan types through that reference. Please see Amendment 1 for revised Exhibit D, in which separate Exhibit Ds have been created for REGIONAL and NATIONAL.
34	Exhibit D	After reviewing the RFP we did not see a request for termed reference, is it HCA's intent to have termed references provided? If yes, how many are required.	Per Section 3.4 of the RFP, termed references are not required. However, Section 3.4 of the RFP does not preclude the use of termed references.
35	Exhibit E	7.3.5: Inform the HCA account manager(s) of federal law changes within fifteen (30) Days of notification, which the Bidder will be obligated to do. o Clarify if 7.3.5 is asking about a 15 day or 30 day notification	Please see Amendment 1 of the RFP, which clarifies that the number of days in question 7.3.5 of Exhibit E is thirty (30).
36	Exhibit E	Section 1, table 1.1. Regarding the request for the number of subscribers in the bidder's largest account; we treat each enrollee as a separate beneficiary per Medicare guidelines. We do not	No. Section 1, table 1.1 is specifically describing experience for employer accounts the Bidder is contracted with to provide fully-insured MA-PD plans.

		identify members on a subscriber, spouse or dependent level. Therefore, is it acceptable to provide the total number of enrollees?	
37	Exhibit E	Section 7, question 7.3.5 - The timeframe is not consistent – it spelled out fifteen but put (30) as the numerical figure. Please confirm 15 or 30.	Please see response to Question #35.
38	Exhibit E	In regards to retention (Question 1.1), is HCA looking for group retention or individual retention within the plan?	Question 1.2 in Exhibit E refers to employer group account retention.
39	Exhibit E	In reference to question 4.4 & 4.5 , is HCA referring to an EOC or COC?	The PEBB Program uses the term Certificate of Coverage (COC), but this is equivalent to an Evidence of Coverage (EOC) document used by CMS for Medicare plans.
40	Exhibit E	Please clarify the number of days noted in question 7.3.5 (15 or 30). Is notification based on when a federal law is passed or enacted?	Please see response to Question #35.
41	Exhibit G	Section 2- Benefit Design and Experience. For a MA-PD plan offered by the Bidder in 2018 to an employer group with 10,000 or more members, describe: o Please confirm that HCA is requesting that the bidder answer all questions within #2 Benefit Design and Experience (2.1-2.12) on a case specific basis on one MAPD customer from 2018 with more than 10,000 members. If not, please specify which items (2.1.-2.12) should reported on book of business (BOB) or case specific	Yes. Per Exhibit E, Section 2 all questions in this Section are describing one MA-PD employer group customer from 2018 with 10,000 or more members.
42	Exhibit G	Section 2, question 2.1 - For this question, is the co-pay accumulator tool referring to Medical or Pharmacy or both?	Question 2.1 of Exhibit G is referring to a copay accumulator for pharmacy benefits.
43	Exhibit G	Does HCA want to offer Gap coverage as a part of the benefit?	It is within the Bidder's discretion to propose medical and prescription coverage levels that it considers competitive and that meet the requirements of the RFP. Under Exhibit K, Bidders must propose one (1) but may propose up to three (3) Enhanced Alternative Pharmacy plans with enhanced coverage over the Defined Standard Part D benefit. WS8 requires a description of each Enhanced Alternative Pharmacy plan design, including any gap coverage and cost-sharing.

44	Exhibit G	Section 2 - This section is prefaced with "For a MA-PD plan offered by the Bidder in 2018 to an employer group with 10,000 or more members, describe." Considering that the minimum qualification that Bidder's proposing regional coverage have experience with an employer group with a minimum of 10,000 members has been removed, does this requirement for this section no longer apply as well?	Section 2 of Exhibit G is Mandatory Scored. Per Exhibit G, all questions are Mandatory Scored (unless otherwise specified).
45	Exhibit G	Question 4.1.10.3 - Is HCA requesting the estimated quantifiable savings linked to allowing prior authorization overrides at the point of service or to the UM programs outlined in Section 4.1 as a whole?	Question 4.1.10.3 of Exhibit G is requesting quantifiable savings realized as a result of UM tools/programs in general. Please see Amendment 1, which corrects the formatting for this question to provide clarity.
46	Exhibit G	Questions 2.4 & 2.4.1 - Please provide a drug-level list of the current formulary to support our review and response to this question.	The UMP Preferred Drug list is publically available through the HCA website (www.hca.wa.gov) and directly at www.modahealth.com/PreferredDrugList
47	Exhibit H	2.3 Whether or not a current methodology is in place, is the Bidder willing to provide a report following the methodology provided by HCA, if awarded a Contract? o What is the HCA methodology intending to measure and what is the methodology? (prior question is about primary care spend, but the rest of question 2.3 appears to be about BH)	Please see Amendment 1 to the RFP, which reformats question 2.3 of Exhibit H to clarify that it is referencing question 2.2 on reporting for primary care spending. The methodology that will be provided by HCA is currently under development. A template will be provided to ASB(s) during the contract negotiation to provide information about primary care spend, which will include the definition of primary care providers and services to capture claims data, and information about non-claims-based payment (value based incentives, etc). The methodology will be similar to that currently used statewide in Oregon.
48	Exhibit H	6.3. Number of and criteria for clinical case managers and non-clinical staff members. o Is this asking about the qualifications for clinical managers and non-clinical staff members working on complex case management?	Please see Amendment 1 to the RFP, which clarifies that Question 6.3 of Exhibit H is asking for the number of clinical and non-clinical case management staff, their qualifications, and the criteria they use to assign case management.
49	Exhibit H	6.5 Number of and criteria for clinical specialists for clinical consultations, including physicians and behavioral health practitioners. o Is this asking about the qualifications for clinical specialists? Or the criteria for a clinical specialist to outreach to a member?	Please see Amendment 1 to the RFP, which clarifies that Question 6.5 of Exhibit H is asking for the number of clinical specialists who perform clinical consultations for complex case management, their qualifications, and the criteria used to assign complex case management to clinical specialists.

50	Exhibit H	9.1 For an MA-PD plan offered by the Bidder in 2018 to an employer group with 10,000 or more members, describe: … o Should we answer this question based on a case specific basis for one MAPD customer from 2018 with more than 10,000 members or should we answer for all customers in our MAPD book in 2018 with more than 10,000 members? (specifically for 9.1-9.6.1) If it is a combination of both, please specify which items (9.1.-9.6.1) should reported on book of business (BOB) or case specific.	Please see the response to question #41.
51	Exhibit H	Section 9.1, question 9.1.3.1 - What does health care services reviewed mean in this context? The actual procedures? We ask this since this item already mentions the volume of reviews at the beginning of the question.	The use of "health care services" in question 9.1.3.1 of Exhibit H refers to the types of health care services, which may include procedures that were reviewed.
52	Exhibit H	Section 9.1, question 9.1.3.3 - Please clarify what IROs are.	Question 9.1.3.3 of Exhibit H refers to Independent Review Organizations (IRO). IROs are entities that conduct independent external reviews of adverse determinations involving appropriateness of care, medical necessity criteria, level of care, and effectiveness of a requested service.
53	Exhibit I	Will the denominator of the scores for Exhibit I be adjusted appropriately to score bidders not providing a Regional PPO quote?	Per Section 3.1 of the RFP, For Bidders submitting both a National and a Regional PPO plan proposal, the Bidder must submit unique responses for a National and a Regional PPO plan type for the below listed exhibits. All other exhibits only need to be submitted once.1. Exhibit K - Cost & Plan Design; and2. Exhibit I - Provider NetworkAmendment 1 has amended the above list to include, Exhibit D - Reference Form.
54	Exhibit I	Section 1, question 1.18 - In order to more accurately respond to the percentage of Medicare-participating providers that are outside the plan's network but accept the plan, we request a claims file with provider TINs.	Question 1.18 of Exhibit I is requesting Medicare-participating providers outside of the Bidder's MA-PD network, not outside of the networks for the current PEBB Program Medicare Retiree Health Plans. A claims file with provider TINs will not be provided.

		If unable to provide a claims file, please confirm if physicians and hospitals are acceptable as the "providers" as we are unable to provide a list of non-par ancillary or facilities.	
55	Exhibit I	REGIONAL - Question 2.1.1.1 - Is the HCA looking for an administrative service fee (i.e., do we have separate administrative rates for the specialty pharmacy service)?	There is no Question 2.1.1.1 in Exhibit I. Question 2.1.1. of Exhibit I asks whether the Bidder has any requirements related to mandatory mail order prescription services for specialty drugs. If the Bidder is referencing Question 2.1.2.2 in Exhibit I, the question is not specifically asking for administrative service fees. It is asking for the rate impact as a result of the Bidder's subcontracting of specialty pharmacy services, which may be impacted by separate administrative or other fees.
56	Exhibit I	REGIONAL - Question 2.1.1.2 - Is the HCA looking for an administrative service fee (i.e., do we have separate administrative rates for the specialty pharmacy service)?	There is no Question 2.1.1.2 in Exhibit I. Question 2.1.2. of Exhibit I asks whether specialty pharmacy is managed in-house, through a subsidiary contract, or an external subcontract. If the Bidder is referencing Question 2.2.1.2 in Exhibit I, the question is not specifically asking for administrative service fees. It is asking for the rate impact as a result of the Bidder's subcontracting of mail order pharmacy services, which may be impacted by separate administrative or other fees.
57	Exhibit J	Section 4, question 4.2.2 - Question references PEBB Program Eligibility File Format. Is there a template or sample file format file available for review?	Please see Amendment 1, Appendix 6, PEBB 834 Companion Guide.
58	Exhibit J	Section 4, question 4.2.4 - Please confirm if HCA would pass a separate SSN for employees and their dependents or if one SSN would be passed per family. Could another unique identifier be provided since employee and dependents are tracked individually (i.e. MBI number)?	HCA uses an SSN for each Member. There is no other unique identifier for employees and dependents in the 834 file.

59	Exhibit K	We are wondering if the Washington State Health Care Authority would be willing to facilitate a call with Milliman to help gain clarity about the following: In our experience, when our Group Medicare Advantage PPO plan is added as an additional option without any existing plans being removed or members auto-enrolled, very few members elect the plan (approximately .5%). This amount of membership would very likely not be credible which creates concerns with the level of detail being requested in the pricing workbook, Exhibit K. How would Milliman/Washington State Health Care Authority like us to handle Exhibit K given this scenario?	No, a meeting with Milliman will not be hosted for the Bidders. Exhibit K allows Bidders discretion when determining pricing decisions for input into the pricing workbook. Bidders are provided the option of using an experience-based projection, or substituting a manual projection if the Bidder deems this preferable. Exhibit K is Mandatory Scored. Appendix 3 requires Bidders to submit an actuarial memorandum documenting data, methodology, and assumptions underlying all proposed bid rate assumptions for Exhibit K. Bidders should provide support for all plans within their Proposals in a single memorandum, and note any differences between plans in the relevant sections.
60	Exhibit K	We are wondering if the Washington State Health Care Authority would be willing to facilitate a call with Milliman to help gain clarity about the following: We have typically structured our plans to have fixed dollar amounts for items such as administrative costs and retention. Exhibit K does not allow for this, nor does it allow for any variation among plans which could create significant differences in these costs from one plan to another. Are there any alternate ways or flexibility within the pricing terms to allow the carriers to better control these costs between plans?	Please see response to Question #59.
61	Exhibit K	We are wondering if the Washington State Health Care Authority would be willing to facilitate a call with Milliman to help gain clarity about the following: The Exhibit K instructions make several references to Membership Tiers and how these were created. We do not feel this is applicable to a Medicare Advantage quote as all rates are quoted on a pmpm basis vs. pepm or pspm. Please advise.	No, a meeting with Milliman will not be hosted for the Bidders. Although rates may be quoted on a PMPM basis to CMS, rates are applied on a tiered basis in the PEBB Program. Tiers in the PEBB Program are defined equivalent to a PMPM basis, with the exception of children, which should be very rare in the Medicare risk pool.Exhibit K is Mandatory Scored, and Bidders are required to complete all sections per the instructions in Appendix 3.

62	Exhibit K	We are wondering if the Washington State Health Care Authority would be willing to facilitate a call with Milliman to help gain clarity about the following: We understand that we are being asked to quote rates for a 1/1/2021 effective date. For a Medicare Advantage product, a large portion of our pricing is contingent on the CMS Final Call Letter which won't be released until early April of 2020. This creates a large amount of uncertainty in our rates. We acknowledge the caveat that rates provided now would serve as a maximum and could be reduced at a later date however each carrier would have to make their own assumptions about what possibly may happen which could mean that rates amongst carriers are not being compared on the same baseline. How is Milliman planning to account for this uncertainty in each carrier's response?	Please see response to Question #59. HCA is responsible for scoring this RFP.
63	Exhibit K	We are wondering if the Washington State Health Care Authority would be willing to facilitate a call with Milliman to help gain clarity about the following: Will everything provided in Exhibit K be considered proprietary and confidential?	No, a meeting with Milliman will not be hosted for the Bidders. See RFP Section 2.5, Proprietary Information/Public Disclosure.
64	Exhibit K	Exhibit 3 – Worksheet 1: This worksheet provides inputs for Bidders to enter their projected medical allowed claims. These projections could be based on prior claims experience for PEBB Uniform Medical Plan Classic - Medicare or reflect the assumptions underlying the manual rate. PEBB UMP Classic - Medicare is a Coordination of Benefits (COB) plan that offers secondary coverage, with Medicare as the primary payer. The experience summary reflects the utilization for the Bidder's Baseline FFS Medical plan. This form also calculates the plan paid PMPM for evaluation of the mandatory Baseline FFS Medical plan, based on CMS defined Medicare cost sharing. o The RFP outlines number of members by type of Medicare plan and indicates there are 89,000 members in Washington state. Will the HCA	Please see response to Question #5.

		provide a breakdown of the number of members by state and country?	
65	Exhibit K	Exhibit K_WS3: How is “Paid Claim” defined? We would assume it’s net of DIR, reinsurance, CGDs and member cost share. Could you confirm?	Yes, "Paid Claim" in Exhibit K, WS3 is net of revenue from Direct and Indirect Remuneration, Reinsurance, the Coverage Gap Discount Program, and member cost-share.
66	Exhibit K	Tab WS2 - It appears that cells D26, C41-46, and C51-60 are meant to be editable by bidders, but they are locked. Please confirm these cells are meant to be edited and submit a revised worksheet with those cells unlocked.	This has been adjusted in Amendment 1, Exhibit K.
67	Exhibit K	How should projected Risk Scores be factored into the Baseline FFS Medical pricing?	Bidders may factor in projected risk scores as they deem appropriate in the cost and revenue projections in Exhibit K. Appendix 3 requires Bidders to submit an actuarial memorandum documenting data, methodology, and assumptions underlying all proposed bid rate assumptions for Exhibit K. Bidders should provide support for all plans within their Proposals in a single memorandum, and note any differences between plans in the relevant sections.
68	Exhibit K	How should the MA-PD county-level payment rates be factored into the Baseline FFS Medical pricing?	Bidders may factor in county-level payment rates as they deem appropriate in the revenue considerations in Exhibit K. Appendix 3 requires Bidders to submit an actuarial memorandum documenting data, methodology, and assumptions underlying all proposed bid rate assumptions for Exhibit K. Bidders should provide support for all plans within their Proposals in a single memorandum, and note any differences between plans in the relevant sections.
69	Exhibit K	WS2 tab – some input cells in rows 26 and beyond are locked. Can HCA provide an updated template?	Please see response to Question #66.

70	Exhibit K	WS2 tab – the Baseline FFS Medical pricing appears to reflect a plan design covering 100% of the member out of pocket costs for Medicare Covered Services. Is this the pricing intention?	Yes, the pricing intention in Exhibit K, WS2 is a plan design covering 100% of the member out-of-pocket costs for Medicare Covered Services. Cost-sharing for the Bidder's Baseline FFS Medical plan is determined by the Bidder's inputs on WS1, and is then passed through to the medical premium.
71	Exhibit K	What is the definition of a Health Education program?	Please see Appendix 3, which states that unless otherwise noted, definitions for benefits in Exhibit K are consistent with the CMS definitions for Medicare Covered Services and Supplemental Benefits. Please refer to the CMS definition of Health Education as a Medicare-approved Supplemental Benefit.
72	Exhibit K	What coverage level and cost sharing design should be priced for the minimum supplemental benefits? Please answer separately for each requested coverage: chiropractic care, acupuncture, massage therapy, routine vision exams and hardware, routine hearing exams and hearing aids, and gym membership.	It is within the Bidder's discretion to determine coverage level and cost-sharing for Minimum Supplemental Benefits in Exhibit K. Bidders must provide a description of coverage levels and cost-sharing for each Enhanced Alternative Medical Plan in WS7 of Exhibit K, as well as provide a sample COC (aka, EOC) per Section 3.6 of the RFP.
73	Exhibit K	WS3 tab – where should Specialty drugs be placed?	This has been adjusted in Amendment 1, Exhibit K.
74	Exhibit K	WS3 tab – what values are expected to be populated in row 6?	Irrelevant. This has been deleted in Amendment 1, Exhibit K.
75	General	Is it the intent of the HCA to implement the winning ASB as an option alongside current retiree plans? If so, will all retirees have to make a choice during open enrollment or will they have the option of staying in their current plan without having to make a choice? If the former, will the ASB have the opportunity to market their plan(s) to the retirees?	At this time, HCA does not intend to eliminate or consolidate existing PEBB Program Retiree Health Plans. Section 1.1 of the RFP defines Annual Open Enrollment, during which Subscribers **may** make changes to their plan enrollment for the following Plan Year. The PEBB Program does not currently require active enrollment (i.e., Subscribers who maintain eligibility for benefits are not required to make elections during open enrollment and may remain in their current plan). Per Section 1.4 of the RFP, the ASB(s) will be responsible for marketing, advertising, educating, or soliciting participation in their PEBB Program Medicare Retiree Health Plan(s) during Annual Open Enrollment. Any marketing efforts and materials must be approved by HCA, and plans are not permitted to market their plans independently of HCA. Per Question 3.3 of Exhibit E, Annual Open Enrollment support and resources may include, but are not limited to: trained staff to attend benefit fairs, written (paper, online) communications to explain the ASB(s)' MA-PD Health Plan offering(s), and webinar and video support as requested.

76	General	Is the future intent of the HCA to consolidate retiree options into one or several plans versus multiple carriers/options?	At this time, HCA does not intend to eliminate or consolidate existing PEBB Program Retiree Health Plans.
77	General	Is it the intent of HCA to have retiree education meetings during an open enrollment period?	Yes, HCA and ASB(s) will provide information to Retirees during Annual Open Enrollment at Benefits Fairs. Please see response to Question #75. HCA Outreach & Training staff also provide on-request presentations about PEBB Program Retiree Insurance Coverage to benefits administrators who work for PEBB-participating employers.
78	General	The HCA clearly values value based contracting based on the Healthier Washington and Value Based Roadmap initiatives. Are these initiatives in place currently with your incumbent plans or is this a forward projected initiative starting with the ASB MA PPO plans?	HCA includes VBP elements in all PEBB Program Health Plans as they come up for renewal, and includes these elements in new plans through the procurement process.
79	General	Per the RFP, the Health Care Authority will be implementing the School Employees Benefits (SEB) program, which will begin offering benefits to approx. 300k members beginning 1/1/20. Can you confirm out of the total 300k members; how many are Medicare Eligible?	Please see RFP Section 1.4, Background. The PEBB Program Medicare Retiree Health Plans **currently** serve school employees (future SEBB Program Members). Today, when a public employee **or school employee** retires and meets eligibility and procedural requirements, they may enroll in PEBB Program Retiree Insurance Coverage. Retirees who are not yet eligible for Medicare may select from health insurance options available to employees under the PEBB Program. When a Retiree becomes eligible for Medicare, they must disenroll from their existing PEBB coverage, and may enroll in a PEBB Program Medicare Retiree Health Plan. The pooling arrangement for Retirees could change during the term of any Contract(s) resulting from this procurement. As of July 2019, there are approximately 49,000 Medicare-eligible retired school employees and their eligible Dependents (i.e., Members) who are enrolled in PEBB Retiree Insurance Coverage. There are another ~4,000 retired school employees and their Dependents who are enrolled in PEBB Program benefits but are not eligible for Medicare.

80	General	Given only data for the 'UMP Classic Medicare' was initially provided, is it the intent of Washington State HCA to only replace this plan, with the new plan(s) being added as a choice to the remaining current plans? Or, is the State looking to potentially replace multiple plans and/or keep all current plans but add additional plans offerings?	Please see response to Question #76.
81	General	Please provide the projected membership for the Regional PPO and National PPO offerings in 2021.	This information is currently unavailable.
82	General	Please provide the average COB savings check amount (the average amount that members are sent at the end of the year to address COB savings) provided to members for 2018 and 2017.	PEBB Medicare Members have standard COB in UMP Classic--Medicare. The claim payments comply with the requirements of WAC 284-51. There is no end of year payment. COB savings are calculated and paid on a claim-by-claim basis and paid throughout the year as long as there is a balance of covered expenses and there is a COB savings reserve. The medical deductible and coinsurance may be covered by COB savings effectively paying up to 100% of the calendar year allowed expenses. UMP Classic--Medicare does not use Non-duplication of Benefits or Maintenance of Benefits methodology.
83	General	What subsidies or premium contributions does the HCA intend to make available to MA-PD beneficiaries?	Please see Section 1.4 of the RFP regarding the Medicare Explicit Subsidy. Per RCW 41.05.085, the Medicare Explicit Subsidy is set by the Legislature and adopted by the PEB Board. It has historically been made available to Medicare Retirees enrolled in a PEBB Medicare Health Plan that covers prescription drugs, as well as to individuals enrolled in a PEBB Medicare Supplement plan (which do not cover prescription drugs). Per statute, HCA must provide subsidies for health benefit premiums to all Medicare-eligible Retirees.
84	General	Can individual checks for the difference between what the plan pays and what Medicare pays (the deductible of $250 for the UMP Classic plan) be greater than the Medicare Part B deductible of $183?	UMP pays up to 100% of allowed amounts, which includes the plan deductible. Please see response to Question #82.
85	General	What is the expected retiree rate for the next five years?	This information is currently unavailable. PEBB Medicare Retiree enrollment increased 39.7% between July 2009 and July 2019.

86		Please confirm the current coordination of benefits methodology with Medicare that applies to the UMP Classic plan and the Kaiser WA Classic Plan for Medicare eligible retirees; COB (coordination of benefits, retiree comes out whole), MOB (maintenance of benefits, also called Carve-out and Non-duplication) or Government Exclusion (also called Medicare exclusion) basis: • COB – Coordination of benefits/ retiree comes out whole - Calculates what the plan would have paid as sole provider and adds what Medicare pays. If the total is more than 100% of the bill, the plan pays only enough to total 100%. The retiree often pays no deductible or coinsurance. • MOB - maintenance of benefits or also called Carve-out and Non-duplication - Calculates the plan's payment as if there were no Medicare coverage, applies the deductibles, coinsurance and other plan limits and pays the remaining amount minus what Medicare pays. • Government Exclusion (also called Medicare exclusion) - Determines the total expenses covered under the plan, reduces them by Medicare benefits and then applies the deductibles, coinsurance and other plan limits	Please see response to Question #82.
87		Please provide current plan designs for both Medical and RX for all plans.	Plan design summaries, Certificates of Coverage (COCs, aka EOCs), and premium rates for current PEBB Program Medicare Retiree Health Plans are available to the public through HCA's website (www.hca.wa.gov).
88		Please confirm if the current Rx plan has an open or closed formulary? Does the formulary exclude any part D drugs? Are generic drugs included on Tier 2 and Tier 3? Are non-Part D drugs such as Erectile Dysfunction drugs included?	The UMP Preferred Drug List excludes certain drugs, but it covers at least 2 drugs in all drug classes that are not excluded. Excluded drug classes include sexual dysfunction, infertility, cosmetic, and weight loss. Some generic drugs are covered in Tier 2, and some branded generics are covered in Tier 3. Please review the UMP Preferred Drug List (see Response to Question #46) for a complete list of covered drugs and tier levels. Additional coverage information is available through the HCA website (see response to Question #87).

89		Please confirm if the current supplemental plans are self-insured or fully insured.	The Medicare Supplement Plan F, and future Medicare Supplement Plan G (available 2020) are fully-insured.
90		Please confirm if the UMP Classic, Kaiser WA Classic, Kaiser WA MA, and Kaiser NW are commercial RDS RX plans?	Yes. The Kaiser WA Classic (Original Medicare COB) and Kaiser WA Medicare Advantage plans are grouped under the same Unique Benefit Option Identifier (UBOI) for RDS.
91		Please provide current RX premium rates.	Please see response to Question #87.
92		Please provide additional descriptions on what the following supplemental benefits cover?• Massage Therapy• Alternative Therapies• Counseling Services• OTC Drug Benefit• Post-Discharge In-Home Medication Reconciliation• Readmission Prevention	Please see responses to Questions #71 and #72. Bidders should refer to the CMS definitions for the Supplemental Benefits listed in Exhibit K.
93		Please confirm that the proposal should be setup as a tab for Letter of Submittal, a tab for Evaluation Elements (that section should include all documents noted in 3.5) and a tab for Additional Proposal Documents (include all documents noted in Section 3.7).	Please see RFP Section 3 - Proposal Contents, for instructions relating to proposal submissions.
94		Is it HCA's intention for the MA-PD contract to replace any or all of the current Medicare contracts? If yes, which Medicare contracts is the HCA looking to discontinue and effective what date?	Please see response to Question #76.
95		Will all members currently enrolled be offered the opportunity to enroll in the new offering? Is it an active selection process or will members default to their existing plan?	Please see response to Question #75.

96		Does the HCA have CMS MMR files for 2015 through 2018 that you can provide? If not, can the HCA please provide member eligibility by zip code (a census) with the following indicators for each member: • Zip Code • Date of Birth • Part B Eligibility Effective Date (or Community vs. New Eligible) • Part A Eligibility (please see question #2 below) • Institutionalized? • ESRD? • Hospice? • Dual Status Code (for Medicare and Medicaid)	No further information will be provided.
97		How many retirees today do not meet the 40-quarters-of-work requirement?	Tracking the 40-quarters-of-work requirement is a function of the Social Security Administration and HCA does not collect this information on Retirees. Per PEBB Program rules, eligible Retirees and their eligible Dependents who are entitled to Medicare must enroll (and maintain enrollment) in Medicare Part A and Medicare Part B to qualify and remain eligible for a PEBB Retiree Health Plan.
98		For those retirees who do not meet the 40-quarters-of-work requirement: a. Will they be eligible for the HCA PEBB Medicare Advantage plus Prescription Drug plan? b. If so, who will be responsible for paying their Part A premium?	Please see response to Question #97.