

July 19, 2018

Reference Request for Proposals #3000010732 soliciting Proposals from any qualified Louisiana Health Maintenance Organization (“HMO”) approved by the Centers for Medicare and Medicaid Services that meets the criteria set forth in La. R.S. 42:802.1 (C), to offer one or more fully-insured Medicare Advantage HMO medical plan(s), on a statewide or regional basis, for Medicare eligible OGB retired Plan Participants.

Addendum #1 provides clarification to the RFP and includes responses to written inquiries received by the deadline stated in the Request for Proposals.

THIS ADDENDUM IS HEREBY OFFICIALLY MADE A PART OF THE REFERENCED REQUEST FOR PROPOSALS.

INQUIRIES AND RESPONSES

No	Inquiry	Response
1	<p><u>Term of Contract, Section 1.4, Page 5</u> there is the statement that “OGB may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms, and conditions of the initial Contract term.” On page 36 of the RFP under section 2.4 it states, “One hundred and twenty days (120) prior to January 1, 2020, and January 1, 2021, respectively, for the initial Contract period and 120 days prior to January 1, 2022, and January 1, 2023, respectively, for any renewal option period, the Contractor shall provide OGB with a renewal report that shows how the indicated rate adjustment for the renewal year was calculated.” Similar language is provided on page 73.</p> <p><u>Question:</u> Given the potential conflict in these sections, could OGB clarify that Contractors may adjust fully insured premium rates for each year of the potential 5 years the contract may run?</p>	<p>The Contractor may adjust the Fully-Insured Medicare Advantage premium rates for each calendar year of the potential five (5) year contract in conformance with the requirements listed in RFP Attachment IV: Cost Proposal and RFP Section 1.9 (H).</p> <p>Reference amendment to RFP Section 1.4 Term of Contract, and Attachment II: Sample Contract, Section 3.1 Term of Contract included in this addendum.</p>
2	<p><u>1.8.1 Mandatory Qualifications, Page 7</u> – states that “Proposers must meet or exceed the below listed Mandatory Qualifications prior to the deadline for receipt of proposals. Proposers should</p>	<p>Proposers should supply the listed supporting documentation provided in Section 1.8.1 in their proposal submission due on August 1, 2018, at 4:00 PM.</p>

No	Inquiry	Response
	<p>supply the below listed supporting documentation <u>prior</u> to the deadline for receipt of proposals.</p> <p>Question: What is the due date for the supporting documentation and how is this to be delivered to OGB?</p>	
3	<p><u>1.9 Proposal Response Format, C. Executive Summary, Page 8</u></p> <p>Question: Several items in the Proposal Response Format section require Proposer to provide “confirmation statements” or a “positive statement of compliance.” Will a statement in the RFP response suffice, or do you want Affidavits of any specific Proposer personnel included in the RFP response?</p>	<p>“Confirmation statement” and a “positive statement of compliance”, as referenced in RFP Section 1.9 (C) Executive Summary denotes that the Proposer should include a written statement confirming the criteria listed in Section 1.9 (C) Executive Summary in the Proposer’s RFP response. No Affidavits of any specific Proposer’s personnel is required to be included in the RFP response.</p>
4	<p><u>1.9 Proposal Response Format, H. Cost Proposal, Page 12, 1.35.1 Payment Terms, Page 27, and Phase 2 – Cost, Page 38</u></p> <p>The RFP requires the Contractor to pay the OGB an administrative fee of “not less than \$10.00 per Primary Plan Participant per month.” The \$10.00 admin fee referenced in the proposal is new.</p> <ol style="list-style-type: none"> 1. What is the fee for and how was the amount (\$10.00) established? 2. Is there any authorizing legislation or regulation related to the admin fee that currently exists or will be sought? 3. Has the admin fee been authorized by CMS in connection with its oversight authority for MA plans? 4. Can plans recapture any part of the admin fee through its rates structure or other mechanism? 	<p>The administrative fee referenced in the RFP is an administrative fee due OGB for the services OGB provides to plan participants, including but not limited to, eligibility and enrollment services for the Fully-Insured Medicare Advantage Plans. This fee is borne by the Contractor as part of their cost of doing business and is not passed along to the plan participant. The minimum administrative fee cost of \$10.00 is the minimum amount that will cover the administrative costs for services rendered by OGB.</p> <p>Pursuant to La R.S. 42:802 (D)(1), OGB will seek final approval by the appropriate standing committees of the legislature having jurisdiction over agency rules by the Office of Group Benefits or the subcommittees on oversight of such standing committees, and the Office of State Procurement of the Division of Administration.</p>

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		<p>The contractor and OGB will seek authorization from CMS for the proposed administrative fee rate, should CMS' approval of the administrative fee become a requirement for the additional payment to OGB for administrative services.</p> <p>The contractor shall not recapture any part of the administrative fee through its rate structure, and the administrative fee shall not be passed on to OGB plan participants. As provided in RFP Section 3.1 Phase 2-Cost, Contractor shall pay a monthly fee directly to OGB of no less than \$10.00 per each Primary Plan Participant enrolled, and the fee shall not be included in the proposed monthly premium. The administrative fee is in addition to the monthly premium.</p>
5	<p><u>1.9 Proposal Response Format, J. Outsourcing of Key Internal Controls, Page 13</u> - Related to SOC 1, Type II and/or SOC 2, Type II Reports:</p> <p>Question: Will Proposer subcontractors, performing key administrative functions, be required to provide a SOC 1, Type II and/or SOC 2, Type II report resulting from its most recent Statement on Standards for Attestation Engagements No. 18 (SSAE 18) audit. And if so, will Proposer's subcontractors, as an alternative to a SSAE 18 engagement and resulting SOC 1, Type II and/or SOC 2, Type II report, provide a quality control plan [such as third party Quality Assurance (QA), an Independent Verification and Validation (IV & V)], or any other independent Contractor project or performance review or independent internal audit report?</p>	<p>In regards to the proposal submission, a SSAE 18 report or alternative report as provided in RFP Section 1.9 (J) is not required to be submitted for the proposer's subcontractor(s).</p> <p>However, note that RFP Attachment II: Sample Contract, Section 19 Independent Assurances, requires that the contractor submit to and cause its subcontractors who perform key internal controls to submit to a SSAE 18 or an alternative report approved by OGB.</p>
	<p><u>2. Scope of Services, 2.2 Tasks and Services, Pages 34 and 35, Task (3):</u></p>	

No	Inquiry	Response
6	<p><u>Fully-Insured Medicare Advantage HMO Plan Services</u></p> <ul style="list-style-type: none"> • Prepare and distribute, at a minimum, the following required membership materials to each new Plan Participant within thirty (30) days of receipt of confirmation from OGB as to the validity of the enrollment application: <ol style="list-style-type: none"> 1. A member handbook, which includes information on all covered services, including, but not limited to: benefits, limitations, exclusions, copayments, coinsurances and deductibles, policies and procedures for utilizing clinical and administrative services, conditions under which an individual's membership may be terminated, procedures for registering complaints or filing grievances against the Contractor or any providers participating in a contractual agreement with the Contractor. 2. Directions to access an online directory of providers, which includes all physicians, hospitals and specialty facilities. Hard copies of provider directories and certificates of coverage must be available upon request. 3. One identification card to each Plan Participant for individual coverage or two cards for all other classes of coverage. Additional cards for family members or replacement cards shall be provided upon request and at no additional charge to OGB or the Plan Participant. 4. Summary of Benefits and Coverage and Uniform Glossary, as required by the federal Patient Protection Affordable Care Act (PPACA) and/or applicable state law and/or rules and regulations promulgated pursuant 	<p>The listed Incentive Tracking Capabilities service has been removed from the RFP. Reference amendment to RFP Section 2.2 Tasks and Services, Task (3): Fully-Insured Medicare Advantage HMO Plan Services included in this addendum. OGB will not rephrase any other requirements listed under RFP Section 2.2 Tasks and Services, Task (3): Fully-Insured Medicare Advantage HMO Plan Services.</p>

No	Inquiry	Response
	<p>thereto, and including PPACA Section 1557. Provide printed SBC documents to OGB for distribution to eligible but not enrolled employees/retirees.</p> <p>5. The following notices and any other notices required by applicable laws:</p> <ul style="list-style-type: none"> ▪ <u>Women’s Health and Cancer Rights Act Notices.</u> Contractor will provide a notice to Primary Plan Participant(s) under the Women’s Health and Cancer Rights Act of 1998. ▪ <u>HIPAA Authorized Delegate Form.</u> Contractor will provide a HIPAA Authorized Delegate Form to Primary Plan Participant(s). ▪ <u>HIPAA Privacy Notice.</u> Contractor will provide each Primary Plan Participant(s) with Contractor(s) HIPAA privacy notice, in the event that Primary Plan Participant(s) need to contact Contractor’s Privacy Department. OGB will prepare and Contractor will provide OGB’s HIPAA privacy notice to Primary Plan Participant(s). ▪ <u>Balance Billing Disclosure Notice.</u> Contractor will provide a Balance Billing Disclosure Notice to Primary Plan Participant(s). <ul style="list-style-type: none"> • Provide a Wellness Program that includes, at a minimum, the following components: <ul style="list-style-type: none"> ▪ 24/7 online program for plan participants and OGB ▪ Preventive care tracking ▪ Biometric data collection – onsite and PCP ▪ Health coaching capabilities ▪ Incentive tracking capabilities 	

No	Inquiry	Response
	<p>Question: Certain of the listed tasks and services are required by law for OGB’s commercial health coverage but are not normally part of a Medicare Advantage product offering. Please confirm that only tasks and services required by CMS are applicable to the insured OGB Medicare Advantage product and the RFP response.</p>	
7	<p>2.3 Deliverables / Top of Page 36 states “the Contractor shall provide OGB with a renewal report that shows how the indicated rate adjustment for the renewal year was calculated. The renewal report shall include, at a minimum, the base period incurred claims on which the renewal projection is based, the annual trend factors used to project claims costs, the administrative fees included in the renewal calculation, adjustments due to credibility, adjustments for stop-loss premium, premiums at current rates, and the indicated rate adjustment”</p> <p>Question: Fully Insured Medicare Advantage does not have Stop-Loss Premium that is not something that cannot be included. Additionally, this section details how to process rate adjustments annually and contradicts p.5 (1.4 Terms of Contract), “With all proper approvals and concurrence with the successful Contractor, OGB may also exercise an option to extend for up to twenty-four (24) additional months at the same rates...” Clarify that the Fully Insured Medicare Advantage rates annual renewal rating process of section 2.3 takes precedence over contradiction of section 1.4 as noted.</p>	<p>The reference of stop-loss premium has been removed from this RFP. Reference amendment to RFP Section 2.3 Deliverables included in this addendum.</p> <p>Additionally, reference amendment to RFP Section 1.4 Term of Contract, and Attachment II: Sample Contract, Section 3.1 Term of Contract included in this addendum.</p>

No	Inquiry	Response
8	<p><u>2.4 Performance Guarantees, Page 36:</u></p> <p>Question: It appears that some of the performance standards do not align with the performance standards that a Medicare Advantage organization must meet under its contract with CMS. Please reconcile the discrepancy between CMS required service level requirement and the RFP. In addition, please explain how the OGB intends to assess financial performance penalties on the Contractor related to Service Level requirements found at Section 2.4? That is, given that this is a fully-insured MA product, for which there will be a Regional Premium, and an Administrative Fee paid to the OGB by the Contractor, upon what amount will the fee be assessed against?</p>	<p>OGB will not rephrase the requirements listed in RFP Section 2.4 Performance Guarantees.</p> <p>The OGB will assess performance guarantee penalties as provided in RFP Attachment II: Sample Contract section 3.6, RFP Section 2.4 Performance Guarantees. Twenty-five (25%) percent of Contractors total annual premium payment will remain at risk, and Contractor will be subject to per day and per occurrence fees for certain performance guarantees.</p>
9	<p><u>2.4 Performance Guarantees, Page 36</u></p> <p>Question: Under the fees at risk per calendar year, how is the 6.25% applied or to what funding is it tied to?</p>	<p>The performance guarantees listed in RFP Section 2.4 Performance Guarantees are tied to the total annual premium payment.</p> <p>The listed performance guarantees are each measured at 6.25% annually, not including the Independent Assurance Reporting and Annual Enrollment Meeting performance guarantees. The individual performance guarantees measured at 6.25% add up to a total of twenty-five (25%) percent, and that is the percent of total annual premium payment that remains at risk.</p>
10	<p><u>4.2 Performance Measurement/Evaluation/Monitoring Plan, Page 39</u></p> <p>Question: Clarification on the 25% percent total annual contracted cost at risk? Since this is a Fully Insured Medicare Advantage product, upon what amount will the fee be assessed against?</p>	<p>The performance guarantees listed in RFP Section 4.2 Performance Measurement/Evaluation/Monitoring Plan are tied to the total annual premium payment. See RFP Attachment II: Sample Contract Section 3.6 which provides the manner in which Performance Guarantees are applied.</p>

No	Inquiry	Response
11	<p><u>Attachment IV, Cost Proposal, Page 73</u> states that “Note: Premium rates proposed for each twelve (12)-month period must be approved by the Centers for Medicare and Medicaid Services (CMS).”</p> <p>While individual rates are specifically approved by CMS, EGWP rates are set outside of the bid process and do not receive explicit CMS approval. The EGWP product is filed annually with CMS, but it is not specific to any group.</p> <p><u>Question:</u> Is there a specific document OGB requires from CMS, or is approval of the general EGWP product through the bid process sufficient?</p>	<p>RFP Section 1.8.1, Mandatory Qualifications, provides that proposers should supply a copy of the contract between Centers for Medicare & Medicaid Services and the proposer authorizing a Medicare Advantage plan offering by Proposer in Louisiana prior to the deadline for receipt of proposals.</p> <p>RFP Section 1.9 (H), Cost Proposal and Attachment IV: Cost Proposal provides that for each twelve (12)-month period, the Contractor must document, through a written certification from its actuary, that the proposed rates for each twelve (12)-month period is calculated on the basis of sound actuarial principles, reasonable in relation to the benefits provided and the population anticipated to be covered, and that the rates are neither excessive nor deficient.</p> <p>As it relates to RFP Attachment IV: Cost Proposal, there is no specific CMS document that OGB requires from the Contractor. Note: The contractor must maintain a contract with CMS for the duration of the Medicare Advantage Plans contract.</p>
12	<p>Will Tower Watson’s OneExchange/Via Benefits Medicare Advantage contract continue for 2019? In previous discussions with OGB, the OneExchange contract was under review.</p>	<p>OGB currently has a solicitation (i.e., RFP) for an Individual Market Medicare Exchange Broker with Health Reimbursement Arrangement (“IMMHRA”) to obtain competitive proposals from qualified proposers who are interested in providing an Individual Market Medicare Exchange for OGB’s Medicare retirees, together with administrative services for a Health Reimbursement Arrangement (“HRA”) for those retirees who utilize the Exchange for a contract effective January 1, 2019 through December 31, 2021, with an option to extend the contract for up to</p>

No	Inquiry	Response
		<p>twenty-four additional months at the same rates, terms and conditions of the initial contract term.</p> <p>OGB currently provides the IMMHRA program as an additional option for its Medicare retirees. The current IMMHRA emergency contract administered by Via Benefits, formerly known as OneExchange is effective from January 1, 2018 through December 31, 2018.</p>
13	<p><i>Section 2.2 Task 3: Fully-Insured Medicare Advantage HMO Plan Services-Summary of Benefits and Coverage and Uniform Glossary, as required by the federal Patient Protection Affordable Care Act (PPACA) and/or applicable state law and/or rules and regulations promulgated pursuant thereto, and including PPACA Section 1557. Provide printed SBC documents to OGB for distribution to eligible but not enrolled employees/retirees.</i></p> <p>The Summary of Benefits and Coverage (SBC) and Uniform Glossary documents are applicable only to Commercial and ACA-compliant plans, not Medicare Advantage plans. However, Vantage makes the OGB Medicare Advantage Plan Finder brochure available by request, online and at OGB’s open enrollment meetings as a summarized plan description. Please acknowledge that the Plan Finder and other plan documents are sufficient for material needs.</p>	<p>OGB will not rephrase this requirement.</p>
14	<p><i>Section 2.2 Task 3: Fully-Insured Medicare Advantage HMO Plan Services-Provide a Wellness Program that includes, as a minimum, the following components:</i></p> <p>... <i>Incentive tracking capabilities</i></p>	<p>The listed Incentive Tracking Capabilities service has been removed from the RFP. Reference amendment to RFP Section 2.2 Tasks and Services, Task (3): Fully-Insured Medicare Advantage HMO Plan Services.</p>

No	Inquiry	Response
	<p>Wellness and participation incentives are not allowed for Medicare Advantage plans, per CMS guidelines. Please clarify the “incentive tracking capabilities” language on page 34 as it pertains to Medicare Advantage OGB plans.</p>	
15	<p><i>Sections 2.4 and 4.2 of the Scope of Services and Section 3.6 of the sample Contract describe the “Performance Guarantees.” Section 4.2 states: “The Contractor will be subject to negotiated performance standards subject to a penalty of twenty-five (25%) percent of the total contracted cost, plus per day and per occurrence fees for certain performance guarantees.”</i></p> <p>Please clarify the meaning of “total contracted cost” in this context. Vantage must meet Medical Loss Ratio requirements, (i.e., 85% of premiums received are required to be used for claims and other quality costs). The remaining 15% of premiums are used for plan administration and margin. This plan is a fully-insured Medicare Advantage plan, and Vantage bears all risks associated with plan benefits. As a result, the penalty calculation for Vantage could be substantially higher if it is based on total premium dollars.</p> <p>Please confirm “total contracted cost” is referring to the 15% of premium used for administration and margin.</p>	<p>“Total contracted cost” as referred to in Section 2.4 and 4.2 of the Scope of Services and Section 3.6 of the Sample Contract indicate twenty-five (25%) percent of Contractors total annual premium payment will remain at risk, and Contractor will be subject to per day and per occurrence fees for certain performance guarantees.</p>
16	<p><i>Section 3.1, Phase 2 – Cost; Cost Proposal and 1.9 Section H – Cost Proposal and 1.35.1 Payment Terms</i></p> <p>In the past, OGB has not implemented a monthly administrative fee to OGB’s Medicare Advantage plans. Please confirm that the administrative fee applies to Medicare Advantage plans and is in addition to the monthly premium.</p>	<p>The administrative fee applies to the Medicare Advantage Plans and is in addition to the monthly premium.</p>

Section Reference RFP 1.4 Term of Contract

Original Text:

The initial term of any Contract resulting from this RFP shall begin on or about January 1, 2019, and is anticipated to end on December 31, 2021. With all proper approvals and concurrence with the successful Contractor, OGB may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms, and conditions of the initial Contract term. Prior to the extension of the Contract beyond the initial thirty-six (36)-month term, all prior approvals required by applicable law shall be obtained. Written evidence of required approval shall be submitted by OGB, along with the Contract amendment, to the Office of State Procurement (OSP) to extend Contract terms beyond the initial 3-year term. The total Contract term, with extensions, shall not exceed five (5) years. The continuation of the Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract.

Revised Text:

The initial term of any Contract resulting from this RFP shall begin on or about January 1, 2019, and is anticipated to end on December 31, 2021. With all proper approvals and concurrence with the successful Contractor, OGB may also exercise an option to extend for up to twenty-four (24) additional months at the same administrative fee, terms and conditions of the initial Contract term. Prior to the extension of the Contract beyond the initial thirty-six (36)-month term, all prior approvals required by applicable law shall be obtained. Written evidence of required approval shall be submitted by OGB, along with the Contract amendment, to the Office of State Procurement (OSP) to extend Contract terms beyond the initial 3-year term. The total Contract term, with extensions, shall not exceed five (5) years. The continuation of the Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract.

Section Reference RFP Attachment II: Sample Contract, 3.1 Term of Contract

Original Text:

The term of any Contract resulting from this RFP shall begin on or about January 1, 2019, and is anticipated to end on December 31, 2021. With all proper approvals and concurrence with the successful Contractor, OGB may also exercise a one-time option to extend the Contract for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial Contract term. Prior to the extension of the Contract beyond the initial thirty-six (36)-month term, all prior approvals required by law shall be obtained. Such written evidence of these approvals shall be submitted, along with the Contract amendment, to OSP to extend Contract terms beyond the initial three (3)-year term. The total Contract term, with extensions, shall not exceed five (5) years. The continuation of this Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract.

Revised Text:

The term of any Contract resulting from this RFP shall begin on or about January 1, 2019, and is anticipated to end on December 31, 2021. With all proper approvals and concurrence with the successful Contractor, OGB may also exercise a one-time option to extend the Contract for up to twenty-four (24) additional months at the same administrative fee, terms and conditions of the

initial Contract term. Prior to the extension of the Contract beyond the initial thirty-six (36)-month term, all prior approvals required by law shall be obtained. Such written evidence of these approvals shall be submitted, along with the Contract amendment, to OSP to extend Contract terms beyond the initial three (3)-year term. The total Contract term, with extensions, shall not exceed five (5) years. The continuation of this Contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the Contract.

Section Reference RFP 2.2 Tasks and Services, Task (3): Fully Insured Medicare Advantage HMO Plan Services

Original Text:

- Provide a Health Maintenance Organization (HMO) Physician and Hospital Provider Network to OGB Plan Participants, including but not limited to inpatient and outpatient hospital services (including hospital based ancillary services), ambulatory surgical services (including ASC based ancillary services), physician services, mental/behavioral health, substance abuse services, prescription drugs, utilization management and medical management, and disease management (including but not limited to the five chronic diseases of focus to OGB: Asthma, Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease and Chronic Heart Failure).
- Provide at least 45 days advance written notification to OGB and its participants of any change in provider networks that will effect a 1% or greater change in the number of providers in the network or a disruption that would impact 3% or greater of participants.
- Provide a network of primary, specialty, and ancillary care providers within sixty (60) miles of a participant's address.
- Process premium refunds to Low Income Subsidy (LIS) members enrolled in Medicare Advantage Part D plans on behalf of OGB.
- Responsible for reconciling Part D claims payments, subsidies, and rebates on an annual basis.
- Provide 21-day disenrollment notices to Plan Participants as required by CMS.
- Consult with OGB with regard to benefits provided under the Plan. No changes to said plan design shall be made during the term of the resulting Contract without the written consent of OGB.
- Accept enrollment information daily from OGB in electronic format and enroll Plan Participants, including COBRA beneficiaries, to receive benefits in accordance with OGB requirements and plan provisions.
- Staff and maintain a dedicated toll-free customer service unit and phone line to assist plan participants with questions on claims, benefits, and networks in compliance with PPACA Section 1557 and any other applicable laws. Furnish a toll-free telephone number for incoming customer service calls, including telephone technology for the hearing impaired and multi-lingual support. The customer service unit must be available for annual and any special enrollment periods.
- Provide knowledgeable staff to attend state-wide annual and special enrollment meetings within the proposed parishes for which the Contractor is authorized to provide coverage and informational meetings as scheduled by OGB.
- Design, update, print, and/or mail all plan participant communication materials (i.e., provider directories, summary plan documents, Plan Participant education materials, etc.),

advertisements and marketing materials. All such materials will be subject to OGB's approval prior to distribution and shall be in compliance with all applicable laws, including but not limited to PPACA Section 1557. The cost of preparation and distribution of any and all Plan Participant communications or promotional materials must be included in the quoted premium.

- Facilitate management of the health care services afforded OGB's Plan Participants under the plan, including but not limited to authorization services, discharge planning, verification of provided services, utilization management, and quality assurance.
- Maintain website for Plan Participant access to their claims information, benefits, order replacement ID cards, provider directories, self-care information, and other program information necessary to manage their health care needs, in compliance with all applicable laws, including but not limited to PPACA Section 1557.
- Provide 24/7 access to online portal for Plan Participants and plan sponsor for activities such as claim submission, account monitoring, reporting, communications requested and approved by OGB, etc., in compliance with PPACA Section 1557 and any other applicable laws. This portal must include adequate encryption to guarantee protection of the Plan Participant's privacy and confidential data (e.g., PHI, personal data, and banking information, as applicable). All outages in excess of one (1) hour must be reported to the OGB Contract Supervisor.
- Maintain a service disruption plan or procedure to continue customer service, portal access, and other business operations when existing service is temporarily unavailable because of scheduled or unforeseen events.
- Medical Claims Administration to include, but not limited to, the following, in compliance with all applicable laws: process claims and remit timely payment to providers; furnish to any claimant notices of payment, explanation of benefits, and/or denials for claims; provide review of plan participants' appeals and grievances; maintain medical and carved out pharmacy claims for integrated Medical/Rx out-of-pocket maximum accumulation; adjudicate and process all claims with service dates prior to termination date.
- Submit standardized reports and/or data to OGB for the purpose of evaluating Plan Participant demographics and utilization, financial experience, and other aspects of the Contractor's performance. Format and layout must be approved by OGB.
- Prepare and distribute, at a minimum, the following required membership materials to each new Plan Participant within thirty (30) days of receipt of confirmation from OGB as to the validity of the enrollment application:
 1. A member handbook, which includes information on all covered services, including, but not limited to: benefits, limitations, exclusions, copayments, coinsurances and deductibles, policies and procedures for utilizing clinical and administrative services, conditions under which an individual's membership may be terminated, procedures for registering complaints or filing grievances against the Contractor or any providers participating in a contractual agreement with the Contractor.
 2. Directions to access an online directory of providers, which includes all physicians, hospitals and specialty facilities. Hard copies of provider directories and certificates of coverage must be available upon request.

3. One identification card to each Plan Participant for individual coverage or two cards for all other classes of coverage. Additional cards for family members or replacement cards shall be provided upon request and at no additional charge to OGB or the Plan Participant.

4. Summary of Benefits and Coverage and Uniform Glossary, as required by the federal Patient Protection Affordable Care Act (PPACA) and/or applicable state law and/or rules and regulations promulgated pursuant thereto, and including PPACA Section 1557. Provide printed SBC documents to OGB for distribution to eligible but not enrolled employees/retirees.

5. The following notices and any other notices required by applicable laws:

- Women’s Health and Cancer Rights Act Notices. Contractor will provide a notice to Primary Plan Participant(s) under the Women’s Health and Cancer Rights Act of 1998.
 - HIPAA Authorized Delegate Form. Contractor will provide a HIPAA Authorized Delegate Form to Primary Plan Participant(s).
 - HIPAA Privacy Notice. Contractor will provide each Primary Plan Participant(s) with Contractor(s) HIPAA privacy notice, in the event that Primary Plan Participant(s) need to contact Contractor’s Privacy Department. OGB will prepare and Contractor will provide OGB’s HIPAA privacy notice to Primary Plan Participant(s).
 - Balance Billing Disclosure Notice. Contractor will provide a Balance Billing Disclosure Notice to Primary Plan Participant(s).
- Provide a Wellness Program that includes, at a minimum, the following components:
 - 24/7 online program for plan participants and OGB
 - Preventive care tracking
 - Biometric data collection – onsite and PCP
 - Health coaching capabilities
 - Incentive tracking capabilities

Revised Text:

- Provide a Health Maintenance Organization (HMO) Physician and Hospital Provider Network to OGB Plan Participants, including but not limited to inpatient and outpatient hospital services (including hospital based ancillary services), ambulatory surgical services (including ASC based ancillary services), physician services, mental/behavioral health, substance abuse services, prescription drugs, utilization management and medical management, and disease management (including but not limited to the five chronic diseases of focus to OGB: Asthma, Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease and Chronic Heart Failure).
- Provide at least 45 days advance written notification to OGB and its participants of any change in provider networks that will effect a 1% or greater change in the number of providers in the network or a disruption that would impact 3% or greater of participants.

- Provide a network of primary, specialty, and ancillary care providers within sixty (60) miles of a participant's address.
- Process premium refunds to Low Income Subsidy (LIS) members enrolled in Medicare Advantage Part D plans on behalf of OGB.
- Responsible for reconciling Part D claims payments, subsidies, and rebates on an annual basis.
- Provide 21-day disenrollment notices to Plan Participants as required by CMS.
- Consult with OGB with regard to benefits provided under the Plan. No changes to said plan design shall be made during the term of the resulting Contract without the written consent of OGB.
- Accept enrollment information daily from OGB in electronic format and enroll Plan Participants, including COBRA beneficiaries, to receive benefits in accordance with OGB requirements and plan provisions.
- Staff and maintain a dedicated toll-free customer service unit and phone line to assist plan participants with questions on claims, benefits, and networks in compliance with PPACA Section 1557 and any other applicable laws. Furnish a toll-free telephone number for incoming customer service calls, including telephone technology for the hearing impaired and multi-lingual support. The customer service unit must be available for annual and any special enrollment periods.
- Provide knowledgeable staff to attend state-wide annual and special enrollment meetings within the proposed parishes for which the Contractor is authorized to provide coverage and informational meetings as scheduled by OGB.
- Design, update, print, and/or mail all plan participant communication materials (i.e., provider directories, summary plan documents, Plan Participant education materials, etc.), advertisements and marketing materials. All such materials will be subject to OGB's approval prior to distribution and shall be in compliance with all applicable laws, including but not limited to PPACA Section 1557. The cost of preparation and distribution of any and all Plan Participant communications or promotional materials must be included in the quoted premium.
- Facilitate management of the health care services afforded OGB's Plan Participants under the plan, including but not limited to authorization services, discharge planning, verification of provided services, utilization management, and quality assurance.
- Maintain website for Plan Participant access to their claims information, benefits, order replacement ID cards, provider directories, self-care information, and other program information necessary to manage their health care needs, in compliance with all applicable laws, including but not limited to PPACA Section 1557.
- Provide 24/7 access to online portal for Plan Participants and plan sponsor for activities such as claim submission, account monitoring, reporting, communications requested and approved by OGB, etc., in compliance with PPACA Section 1557 and any other applicable laws. This portal must include adequate encryption to guarantee protection of the Plan Participant's privacy and confidential data (e.g., PHI, personal data, and banking information, as applicable). All outages in excess of one (1) hour must be reported to the OGB Contract Supervisor.
- Maintain a service disruption plan or procedure to continue customer service, portal access, and other business operations when existing service is temporarily unavailable because of scheduled or unforeseen events.

- Medical Claims Administration to include, but not limited to, the following, in compliance with all applicable laws: process claims and remit timely payment to providers; furnish to any claimant notices of payment, explanation of benefits, and/or denials for claims; provide review of plan participants' appeals and grievances; maintain medical and carved out pharmacy claims for integrated Medical/Rx out-of-pocket maximum accumulation; adjudicate and process all claims with service dates prior to termination date.
- Submit standardized reports and/or data to OGB for the purpose of evaluating Plan Participant demographics and utilization, financial experience, and other aspects of the Contractor's performance. Format and layout must be approved by OGB.
- Prepare and distribute, at a minimum, the following required membership materials to each new Plan Participant within thirty (30) days of receipt of confirmation from OGB as to the validity of the enrollment application:
 1. A member handbook, which includes information on all covered services, including, but not limited to: benefits, limitations, exclusions, copayments, coinsurances and deductibles, policies and procedures for utilizing clinical and administrative services, conditions under which an individual's membership may be terminated, procedures for registering complaints or filing grievances against the Contractor or any providers participating in a contractual agreement with the Contractor.
 2. Directions to access an online directory of providers, which includes all physicians, hospitals and specialty facilities. Hard copies of provider directories and certificates of coverage must be available upon request.
 3. One identification card to each Plan Participant for individual coverage or two cards for all other classes of coverage. Additional cards for family members or replacement cards shall be provided upon request and at no additional charge to OGB or the Plan Participant.
 4. Summary of Benefits and Coverage and Uniform Glossary, as required by the federal Patient Protection Affordable Care Act (PPACA) and/or applicable state law and/or rules and regulations promulgated pursuant thereto, and including PPACA Section 1557. Provide printed SBC documents to OGB for distribution to eligible but not enrolled employees/retirees.
 5. The following notices and any other notices required by applicable laws:
 - Women's Health and Cancer Rights Act Notices. Contractor will provide a notice to Primary Plan Participant(s) under the Women's Health and Cancer Rights Act of 1998.
 - HIPAA Authorized Delegate Form. Contractor will provide a HIPAA Authorized Delegate Form to Primary Plan Participant(s).
 - HIPAA Privacy Notice. Contractor will provide each Primary Plan Participant(s) with Contractor(s) HIPAA privacy notice, in the event that Primary Plan Participant(s) need to contact Contractor's Privacy Department. OGB will prepare and Contractor will provide OGB's HIPAA privacy notice to Primary Plan Participant(s).

- Balance Billing Disclosure Notice. Contractor will provide a Balance Billing Disclosure Notice to Primary Plan Participant(s).
- Provide a Wellness Program that includes, at a minimum, the following components:
 - 24/7 online program for plan participants and OGB
 - Preventive care tracking
 - Biometric data collection – onsite and PCP
 - Health coaching capabilities

Section Reference RFP 2.3 Deliverables

Original Text:

The deliverables listed in this section are the minimum required from the Contractor.

Within fifteen (15) business days after the first of each month, Contractor shall submit reports which demonstrate Plan Participant demographics and utilization, financial experience, and other aspects of the Contractor’s performance identified by OGB to include, but not limited to, the following:

- **Financial Experience:** Premium Income and Claims Utilization Experience.
 - **Average Speed to Answer:** Average lag time to answer by live voice percentage of plan participants who wait over 60 seconds to speak with a live customer service representative.
 - **Abandon Call Rate:** Percentage of calls where the caller hangs up before speaking to a live voice.
 - **Inquiry Timeliness:** Percentage of inquiries answered within 7 business days.
 - **Claims Financial Accuracy:** Percentage of claims paid correctly – dollar amount only.
 - **Claims Accuracy:** Percentage of claims paid correctly the first time.
 - **Claims Process Time:** Percentage of electronic and non-electronic claims paid within 30 days of receipt.
 - **Eligibility Posting Timeliness:** Percentage of membership files updated within 2 business days of the receipt of the OGB enrollment file.
 - **ID Card Timeliness:** Percentage of new plan participants who have ID cards issued prior to their effective date of coverage.
 - **PCP Turnover Rate:** Percentage of PCPs leaving the network voluntarily or involuntarily during the month.
 - **Open PCP/Participant Ratio:** Ratio of open PCPs accepting new plan participants to actual plan participants.
- Submit annual Service Organization Control (SOC1),Type II report resulting from SSAE 18 engagement no later than September 30 of each Contract year and/or other independent assurances approved by OGB by January 15 preceding the report deadline.

- Submit quarterly report that captures operational performance guarantees on a client-specific basis and report OGB’s data within forty-five (45) calendar days after close of each quarter. All performance guarantees will be reconciled annually and any penalties owed to OGB shall be paid within ninety (90) days after the end of each calendar year.
- Provide client-specific ad hoc reports within thirty (30) days of OGB request that will include data related to Contractor’s operating performance and health outcomes of OGB’s Plan Participants.
- Within fifteen (15) business days after the first of each month, Contractor shall provide to OGB a report that shows by month, premiums paid, incurred claims, paid claims, and Plan Participants enrolled.
- One hundred and twenty days (120) prior to January 1, 2020, and January 1, 2021, respectively, for the initial Contract period and 120 days prior to January 1, 2022, and January 1, 2023, respectively, for any renewal option period, the Contractor shall provide OGB with a renewal report that shows how the indicated rate adjustment for the renewal year was calculated. The renewal report shall include, at a minimum, the base period incurred claims on which the renewal projection is based, the annual trend factors used to project claims costs, the administrative fees included in the renewal calculation, adjustments due to credibility, adjustments for stop-loss premium, premiums at current rates, and the indicated rate adjustment.

Revised Text:

The deliverables listed in this section are the minimum required from the Contractor.

Within fifteen (15) business days after the first of each month, Contractor shall submit reports which demonstrate Plan Participant demographics and utilization, financial experience, and other aspects of the Contractor’s performance identified by OGB to include, but not limited to, the following:

- **Financial Experience:** Premium Income and Claims Utilization Experience.
- **Average Speed to Answer:** Average lag time to answer by live voice percentage of plan participants who wait over 60 seconds to speak with a live customer service representative.
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