

**QUESTIONS
SHBP-RFA-2013**

| # | SERVICE | QUESTION | SECTION | ANSWER |
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| Medical Management | | | | |
| 1 | Medical Management | We have not historically provided Behavioral Health services under our internal Medical Management services. We are able to include these services as part of our proposed solution by leveraging a contracting relationship. Will this be acceptable to the State, or will this make us ineligible to respond for the Medical Management section? | Section 4.1 | While an integrated (medical and behavioral) approach is preferable, a contracting relationship for behavioral health will not make a bidder ineligible to provide Medical Management services. |
| 2 | | Will the State provide summary information for participants and cost by primary condition? | Cost Proposal | No, but the Offeror can derive summary information using the claims data provided. |
| 3 | | Will the State be providing the Administrative Services Agreements for the active and retiree population specific from United Healthcare and Cigna? | | No. |
| 4 | | Will the State be providing the actual contracted fees for the past 5 years from United Healthcare and Cigna? This request would include a breakdown by each of the vendors and of the administrative fee and components for: TPA Administration, Medical Management (UM, CM, DM, Behavioral Health), PBM, and Wellness. | Cost Proposal. | No. |
| 5 | | Are the requested UM, CM and DM programs the same as the current offerings? Are any programs being requested that are not currently offered? | Section 1.1. | DCH is interested in receiving proposals from Offerors that provide recommendations for the best overall program design and structure. See 4.1 for minimum capabilities and expectations. See section 8. |
| 6 | | May we obtain a rolling 12-month enrollment and claims history for the active and retiree population, by vendor? Citation: Supporting Attachment Requested for Cost Proposal. | | No, but the Offeror can derive summary information using the enrollment data provided. |
| 7 | | We were sent different data sets for Medical Management and Wellness. Please confirm that the following data files for Medical Management and Wellness should be used for Medical Management | MM Attachments: 19,13,16,10,20,17, 14,11a,21,18 | The files are split by commercial (attachments 10- 12) and Medicare Advantage (attachments 13-22) |

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| | | <p>Analysis:</p> <ul style="list-style-type: none"> • Citation: Attachment 19 Member eligibility data (CY 2010) - CIGNA.txt • Citation: Attachment 16 Member eligibility data (CY 2011) - Humana.txt • Citation: Attachment 13 Member eligibility data (CY 2011 and CY 2010) - UHC .txt • Citation: Attachment 10 Member eligibility data (CY 2011).txt • Citation: Attachment 20 Medical claims detail (CY 2010 incurred) - CIGNA .txt • Citation: Attachment 17 Medical claims detail (CY 2011 incurred) - Humana.txt • Citation: Attachment 14 Medical claims detail (CY 2011 and CY 2010 incurred) - UHC .txt • Citation: Attachment 11A Medical facility claims detail (CY 2011 incurred and paid through August 2012) .txt • Citation: Attachment 21 Pharmacy claims detail (CY 2010 incurred) - CIGNA .txt • Citation: Attachment 18 Pharmacy claims detail (CY 2011 incurred) - Humana.txt | | |
| 8 | | <p>We typically look to have 24 months of eligibility data with the most recent 12 months used for study. According to eligibility file names, we have the following:</p> <ul style="list-style-type: none"> • CY 2010 - 2011 eligibility for UHC • CY 2010 eligibility for CIGNA • CY 2011 eligibility for Humana, and St of Ga <p>Is this the most recent eligibility data available? We have</p> | MM Attachments: 10, 13,16, 19 | No. The data previously provided in the RFA represents the complete data set that will be provided. 2010 was the final year for Cigna Medicare Advantage with SHBP. Humana began 2011 as a Medicare Advantage vendor with SHBP. Also, the RFA for Medical Management services is for the commercial, non-Medicare Advantage membership. |

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| | | 2 years eligibility for UHC, but only 1 year for CIGNA (2010), Humana (2011), and St of GA (2011). Are the Medical Management Attachments 10, 13, 16 and 19 missing the additional 1 year of eligibility data for CIGNA, Humana, and St of Ga? | | |
| 9 | | All eligibility files are void of birth date information but have a "member age" field which has been calculated. How were members ages calculated? Can member birth dates be supplied? | Medical Management Attachments 10, 13, 16 and 19. | No, date of birth will not be supplied. Age is calculated as of 2011. |
| 10 | | All eligibility files are void of enrollment information. Are all members represented in the files active throughout entire CY? Is enrollment information (enroll date dates, termination dates) available? | Medical Management Attachments 10, 13, 16, 19. | Assume active throughout the CY. No additional data will be provided. |
| 11 | | The "CIGNA CY 2010" eligibility file we received is void of Gender and Age/Date of Birth information. Is it possible to receive Gender and Birth Date information for this file? | Medical Management Attachment 19. | No. |
| 12 | | How do we properly split the populations (i.e., Commercial vs. Medicare)? | Medical Management Attachments 10, 13, 16 and 19. | The files are split by commercial (attachments 10- 12) and Medicare (attachments 13-22) |
| 13 | | For best results, we typically look to have 27 months of medical claims (2 years + 3 months paid date run-out). Specific to the attachments for this effort, we have received: <ul style="list-style-type: none"> • 2 years claims data for UHC (CY 2010-2011) – Medical Management Attachment 14. • 1 year claims data for Humana (CY 2011) – Medical Management Attachment 17. | Medical Management Attachments 11A, 14, 17 and 20. | No. The data previously provided in the RFA represents the complete data set that will be provided. This section is only applicable to the commercial plans (attachments 10-12). 2010 was the final year for Cigna Medicare Advantage with SHBP. Humana began 2011 as a Medicare Advantage vendor with SHBP. Also, the RFA for Medical Management services is for the commercial, non-Medicare Advantage membership. |

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| | | <ul style="list-style-type: none"> • 1 year claims data for CIGNA (CY 2010) – Medical Management - Attachment 20. • 18 months data for St of Ga (CY 2011 w/ paid through 8/2012) – Medical Management Attachment 11A. <p>Is it possible to receive a 27 month set of claims for all files? Do we have the most recent medical claims data available for all claims? We have 2 years claims data for UHC but only 1 year for Humana (CY 2011) and Cigna (2010). Are we missing the additional year of claims data for Humana and Cigna?</p> | | |
| 14 | | All medical claim files are void of any Paid amount information. Is this information available? | Medical Management Claims Data Attachments 11A, 14, 17 and 20. | No. The data previously provided in the RFA represents the complete data set that will be provided. This section is only applicable to the commercial plans (attachments 10-12). |
| 15 | | The “UHC CY 2010 - 2011” medical claims are void of Place of Service codes. Are these codes available for this data set? | Medical Management Attachment 14. | No. The data previously provided in the RFA represents the complete data set that will be provided. This section is only applicable to the commercial plans (attachments 10-12). |
| 16 | | The “CIGNA CY 2010” medical claims data file does not contain procedure codes. Are these codes available for this data set? | Medical Management Attachment 20. | No. The data previously provided in the RFA represents the complete data set that will be provided. This section is only applicable to the commercial plans (attachments 10-12). |
| 17 | | The File “Attachment 11A Medical facility claims detail (CY 2011 incurred and paid through August 2012)” does not have CPT codes. Are these available? | Medical Management Attachment 11A | No. The data previously provided in the RFA represents the complete data set that will be provided. This section is only applicable to the commercial plans (attachments 10-12). |
| 18 | | For best results, we typically look to have 27 months of pharmacy claims (2 years + 3 months paid date run-out). | Medical Management | No. The data previously provided in the RFA represents the complete data set that will be provided. This section is only |

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| | | Specific to the attachments for this effort, we have received: 1 year Rx claims for CIGNA (CY 2010); 1 year Rx claims for Humana (CY 2011). Is this the most recent set of Rx claims? Are we able to have the additional months of data? | Attachment 18 and 21 | applicable to the commercial plans (attachments 10-12). |
| 19 | | All pharmacy claims are void of Paid amount information. Is this information available? | Medical Management Attachment 18 and 21. | No. The data previously provided in the RFA represents the complete data set that will be provided. |
| 20 | | Will the State provide Word versions of required response appendices? | Appendix A, B, C and D. | Appendix D – Company Information and Financial Stability will be provided in MS Word on the DCH website: https://dch.georgia.gov/documents/shbp-rfa-2013 |
| 21 | | Please provide the definition for short and long-term case management. | Section 4.1 - Minimum Requirements. | We have previously provided the definition of case management. An example of short-term case management would be case management services provided for a limited time period to coordinate home health services such as skilled nursing visits. Long-term case management refers to the management of highly complex conditions requiring long-term follow-up, assessment, and monitoring. |
| 22 | | 8.6.1 Offeror shall provide an engagement model Disease Management (DM) program (opt-out) that includes, at a minimum, asthma, diabetes for adult and pediatrics, COPD, congestive heart failure, coronary artery disease, depression, oncology, and co-morbid conditions. Depression as a primary (standalone) condition to get invited to DM? Our current DM program only offers depression as a co-morbid. Medical Mgt RFA | 8.6.1 | Any inability to provide required services should be noted in your response to the question. |
| 23 | | Is there a distinct set of review items? How many networks does GA have? How often do they update the file? Do they expect an authorization file? If so, can they provide the standard layout? | Medical Mgt RFA 8.1 | The Successful Bidder will make recommendations to DCH on what the review items should include. During implementation, Vendor interface meetings will be established to share information such as network composition and file/data sharing. |
| 24 | | For prior approvals- out of network reviews, do you have | Medical Mgt RFA | No. The DCH does not make review determinations. |

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| | | certain criteria that you use to make these determinations? | 8.2 | |
| 25 | | There are 2 RFAs (medical management and wellness). If we are bidding on both RFAs are we able to combine some of the requirements. For example sections 5.4 Account Management. The medical management and wellness RFAs each state a dedicated account director is required. Can same dedicated resources be shared across programs? For example, can the account director for medical management and wellness be the same dedicated individual? Same for Operations Director, Implementation Manager and Quality Manager | 5.4 | The RFAs for Medical Management and Wellness were written as separate documents and will be separate contracts. Please refer to the definitions regarding “dedicated”. |
| 26 | | Minimal Requirements – how are the incentives funded? It is expected that the Medical Management Partner will measure such improvements through HEDIS-quality health metrics, or other measurable standards, as agreed upon with SHBP. As part of this initiative, the Medical Management Partner will provide incentives to the SHBP membership based on HEDIS score improvement and lowering risk scores. | Section 2 | The successful Bidder will fund the incentives to SHBP membership. |
| 27 | | Who is the DSS vendor? | Section 4 | Currently, Truven Health Analytics, Inc |
| 28 | | Can we describe the accounts without the account names, or are you looking for the specific account names (requires permission from accounts to name them) | Section 5.3.1 | Yes, describe without account names. |
| 29 | | We utilize informatics professionals with experience in the evaluation of medical management programs to calculate ROIs and consult on program recommendations to achieve objectives. These individuals are not Fellows of the Society of Actuaries - are we able to utilize these type of individuals for this function? | Section 5.4 Actuary: | No, you must use an actuary. |

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| 30 | | Please clarify the hours of operation required: after hour services are described as 6:00 pm to 8:00 AM. Are services required Saturday and Sunday from 8 AM to 6 PM so that we are covering all precertification requests from Friday 6 PM to Monday 8 AM? | Section 5.5.1: | Yes |
| 31 | | Is there currently a provider web portal for online precertification and PA submission? If so, please describe vendor and functionality | Section 5.7.1 | We are asking for your capability in this area. |
| 32 | | Please describe "Connect". | Section 5.8.5 | "Connect" refers to the product Connect:Direct which provides secure, automated delivery of data files. |
| 33 | | Do current medical management services include on-site nurse review? If so, please describe vendor and functionality | Section 8.1.3: | We are asking for your capability in this area. |
| 34 | | Do you expect to have any DRG contracted facilities in the network? If yes, how are the DRG contracts structured and will DRG details be provided to support appropriate precertification and concurrent review processes? | Section 8.2 | Yes, however, that information is not known at this time; as the TPA and network services are under procurement in a different section of the RFA. |
| 35 | | Please describe or provide examples of "Automated decision tree logic" | Section 8.3.2 | Software for predictive modeling and forecasting using data mining logic |
| 36 | | Are you looking for retrospective bill negotiation or confirmation that negotiated services and rates are accurately reflected in the bill? If Retrospective Bill Negotiation, please describe your requirements including criteria for which bills are negotiated. Is this a current function and if so, which vendor is providing? | Section 8.3.1.8 | Both. We are asking for your capability in this area. |
| 37 | | Can scales, glucose monitors, blood pressure cuffs, etc. be provided based on criteria (those who will benefit) vs. offering to all with the appropriate diagnosis? | Section 8.6.4 | Yes. |
| 38 | | General Medical Management question: Can the disease | | Separate programs by conditions recognizing that there may be |

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| | | management program be delivered and reported on in an integrated fashion (taking a population management approach where all chronic conditions are addressed across the continuum of issues) OR are you looking for separate programs by condition? | | members with co-morbid conditions. |
| 39 | | Please describe “real time”. Are daily batch interfaces sufficient or are you looking for “real-time” web services? | Section 9.1.1 | Real-Time was a reference to web services; however, during implementation, Vendor interface meetings will be established to share information on how such file/data sharing may be accomplished most efficiently. |
| 40 | | Please provide clinical, utilization, wellness, and incentive program reporting data for 2011 and 2012 | Medical Management - General | No. The data previously provided in the RFA represents the complete data set that will be provided. |
| 41 | | Please provide current precertification list. | Medical Management - Attachments | We would like bidders to propose a list that they would recommend based on their experience in providing medical management services. |
| 42 | | In Section 8.3, separate medical and behavioral health responses have been requested. Is a separate document allowed or should both be answered (separately) in space allocated? | Medical Management - Section 8.3 | Both should be answered separately in the space allotted. If processes are identical then that may be noted. |
| 43 | | Please elaborate on what the DCH means by outcome/goal | Medical Management Overview 1.1 | No. DCH expects the vendors to have experience collaborating with clients and the expectation is that the successful bidder will be able to lead the discussion on their efforts measuring and reporting population health improvement. |
| 44 | | Please provide examples of the population health improvement measures that the DCH expects the vendors to report. | Medical Management Overview 1.1 | No. DCH expects the vendors to have experience collaborating with clients and the expectation is that the successful bidder will be able to lead the discussion on their efforts measuring and reporting population health improvement. |
| 45 | | Will the DCH collaborate with the vendors to select a set of HEDIS measures and the expected targeted goals? | Medical Management Minimum Capabilities and Expectations 2.1 | Yes, however, DCH expects the vendors to have experience collaborating with clients and the expectation is that the successful bidder will be able to lead the discussion with recommendations. |
| 46 | | Can the DCH provide the methodology for readmission rate, low birth rate, and emergency room visits? | Medical Management Minimum | No, but DCH will consider your proposed methodology. |

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| | | | Capabilities and Expectations 2.1 | |
| 47 | | Please confirm that the terms prior approval/predetermination reviews refer to voluntary request versus a medical necessity review indicating prior authorization. | Medical Management Minimum Business Capabilities 4.1 | No, cannot confirm. Offeror will respond to the minimum business capabilities as stated in section 4.1 |
| 51 | | Please clarify what type of “documentation substantiating responses” is being requested. | Medical Management Account Management | The call center reports |
| 52 | | Is the DCH requesting a description of the precertification process in addition to the description of the appeals process? | Medical Management Appeals and Grievances | Appeals process only |
| 53 | | Please elaborate on what the DCH means by a partial approval letter. | Medical Management Appeals and Grievances | An example would be a letter where one procedure may be approved and another procedure denied. |
| 54 | | Clinical Metrics and Value based purchasing initiatives, line 32- Please define targeted population and active participants | Medical Management Attachment 7 GA DCH-SHBP Medical management Performance Guarantees | The Successful Bidder will work with DCH to mutually agree upon these definitions. |
| 55 | | Please confirm that the term precertification is synonymous with the term prior authorization as defined in attachment 1 GA DCH | Medical Management Precertification/Medical Necessity Review- 8.1.1 | Not confirmed. |
| 56 | | What does the DCH mean by non-certification rates for top diagnostic tests and surgical procedures? | Medical Management Prior Approval/Predetermination Review - 8.2.3 | The rates/percentage of denials based on lack of medical necessity for those tests and surgeries. |
| 57 | | Can the State clarify if this would apply to libraries of | Attachment 7 Med | The specific fulfillment library will not require approval. |

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| | | clinical fulfillment material generated on demand by nurses to send to members as needed? Or is this directed at “mass” communications directed to large blocks of members? There are potentially thousands of these clinical fulfillment pieces involved in the total care management solution as requested. | Mgmt PGs, Row 12 | |
| 58 | | This question is in Citation to these PGs, related to readmission and non-emergent ER utilization. Both of these PGs ask for a 5% year-over-year reduction in related utilization. It is not feasible to continue to reduce this utilization at the requested 5% annual rate for an indefinite period of time. At some point rates they will reach a rate beyond which further reductions will be unreachable through commercially viable means. Would the state be willing to set a cap or maximum acceptable readmission and/or ER utilization rate below which there is no longer an expectation for improvement? | Attachment 7 Med Mgmt PGs, Rows 28 and 29, 33,34,35 and 36 | The engagement is for 4 years. The state is not willing to set a cap. |
| 59 | | Please clarify who we would need to provide the incentive items to and what level of engagement into the DM program. | 8.6.4 | The Successful Offeror will provide these items according to their criteria. |
| 60 | | The benefit enrollment overview states that members that did not meet the requirements for the Wellness Promise in 2012 are not eligible to participate in 2013. Is that a permanent “elimination” of eligibility, or will those members not eligible to participate in 2013 be given a second chance to sign up again in 2014 | RFA Attachment 4. | Members will be given additional opportunities. The requirement will be defined and given to the Successful Offeror. |
| 61 | | In Attachment 6, the diagram indicates that the Wellness vendor is expected to provide claims data to the TPA. Can you please clarify if the arrow is intended to go the other direction (claims data coming from the TPA to the Wellness vendor)? | Attachment 6. | Yes. |
| 62 | | In Attachment 7, Clinical Metrics – Compliance with EBM, Reduce BMI in adults, tobacco cessation: will the state provide any incentive for telephonic coaching for the following risk areas: 1. Obesity 2. Tobacco cessation? | Attachment 7. | No but the Offeror should propose an effective program and may offer incentives. |
| 63 | | In the RFA wellness questions, 2.1., the participation table highlights 1.3% telephonic and online coaching. | RFA Questions Section 2.1 | The data previously provided in the RFA represents the complete data set that will be provided. |

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| | | What is the total number of telephonic coaching participants in 2012? | | |
| 64 | | Please elaborate on what the DCH means by outcome/goal- based measurements. | Medical Management Overview -1.1 | See the answer to question 43. |
| 65 | | Please provide examples of the population health improvement measures that the DCH expects the vendors to report. | Medical Management Overview- 1.1- | See the answer to question 44. |
| 66 | | Will the DCH collaborate with the vendors to select a set of HEDIS measures and the expected targeted goals ? | 2.1 | See the answer to question 45. |
| 67 | | Can the DCH provide the methodology for readmission rate, low birth rate, and emergency room visits? | Medical Management Minimum Capabilities and Expectations-2.1 | See the answer to question 46. |
| 68 | | Please confirm that the terms prior approval/predetermination reviews refer to voluntary request versus a medical necessity review indicating prior authorization. Reference Medical Management Minimum Business Capabilities indicating prior authorization. | Medical Management Minimum Business Capabilities -4.1 | See the answer to question 47. |
| 69 | | Please clarify what type of “documentation substantiating responses” is being requested. | Medical Management Account Management - 5.4.6- | See the answer to question 51. |
| 70 | | Is the DCH requesting a description of the precertification process in addition to the description of the appeals process? | Medical Management Appeals and Grievances -5.6.1 | See the answer to question 52. |
| 71 | | Please elaborate on what the DCH means by a partial approval letter. | Medical Management Appeals and Grievances- 5.6.1 | See the answer to question 53. |
| 72 | | Clinical Metrics and Value-based purchasing initiatives, line 32- Please define targeted population and active | | See the answer to question 54. |

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| | | participants. Reference Medical Management Attachment 7 GA DCH-SHBP Medical management Performance Guarantees | | |
| 73 | | Please confirm that the term precertification is synonymous with the term prior authorization as defined in attachment 1 GA DCH-SHBP RFA Definition of terms Reference Medical Management Precertification/Medical Necessity Review- 8.1.1 | Precertification/Medical Necessity Review- 8.1.1 | See the answer to question 55. |
| 74 | | What does the DCH mean by non-certification rates for top diagnostic tests and surgical procedures? | Medical Management Prior Approval/Predetermination Review - 8.2.3 | See the answer to question 56. |
| 75 | | Can the State clarify if this would apply to libraries of clinical fulfillment material generated on demand by nurses to send to members as needed? Or is this directed at “mass” communications directed to large blocks of members? There are potentially thousands of these clinical fulfillment pieces involved in the total care management solution as requested. | Attachment 7 Med Mgmt PGs, Row 12 | See the answer to question 57. |
| 76 | | This question is in reference to these PGs, related to readmission and non-emergent ER utilization. Both of these PGs ask for a 5% year-over-year reduction in related utilization. It is not feasible to continue to reduce this utilization at the requested 5% annual rate for an indefinite period of time. At some point rates they will reach a rate beyond which further reductions will be unreachable through commercially viable means. Would the state be willing to set a cap or maximum acceptable readmission and/or ER utilization rate below which there is no longer an expectation for improvement? | Attachment 7 Med Mgmt PGs, Rows 28 and 29, 33,34,35 and 36 | See the answer to question 58. |
| 77 | | Please clarify who we would need to provide the incentive items to and what level of engagement into the DM program. | Reference 8.6.4 | See the answer to question 59. |

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| Medical Claims Third Party Administration and Network Services | | | | |
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| 78 | TPA | <p>In order to both Disrupt (8.1.2) and Reprice the data (Instructions tab of “GA SHBP TPA_MA Cost Proposal FINAL 20130131.xlsx”), and provide the best possible cost proposal for the State of Georgia, can you please confirm that:</p> <ul style="list-style-type: none"> ○ The files to be repriced are 18A, 18B first half, 18B second half, 21, 24 and 27? ○ If so, can you please provide the TIN, Name, Address, City, State, Zip code of the Providers, along with a POS/Place of Service indicator, defining Inpatient/Outpatient/Professional? (Some or all of this data is missing from the different files- for example Attachment 24 is missing all the data, and the Attachments 21, 24, 27 have no POS indicators) | Question 8.1.2 | The data in Attachment 11 is the medical claims data for the commercial/pre-Medicare membership and is the only data required to be repriced for the TPA cost proposal. Attachments 13-22 contain data for the Medicare membership and are provided as reference in developing your proposed Medicare Advantage premiums. |
| 79 | | In light of the above missing data referenced for the repricing, disruption, etc. can you grant bidders a period of at least five weeks to complete the disruption and repricing, due to the scope of the data? | Attachments 21, 24, 27 | No. |
| 81 | | Can you please provide zip codes for the “23.25 Attachment 13 Member eligibility data (CY 2011 and CY 2010) - UHC .txt “ file? | Attachment 23.25 | This information is not currently available. |
| 82 | | Please provide Attachment 4: GA SHBP 2013 Plan Design and Rates. While there are several Attachment 4 files included, this one seems to be missing | 2.1 | All Attachments labeled “Attachment 4” are representative of GA SHBP 2013 Plan Designs and Rates, there is no one file that is all inclusive. |
| 83 | | Please provide monthly claims data, broken out by plan type, including corresponding enrollment in either an Excel, Word or PDF format for the past 24 months or | 23.20, 23.21, 23.22, 23.26, 23.29, 23.32 | The data included in Attachments 10-22 is provided to assist in the Offerors’ analysis and proposal development. Refer to the data dictionary for the fields and codes available to summarize |

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| | | more | | the data into subsets. |
| 84 | | Please provide a facility utilization file, including claims spend, for at least the top 10-20 facilities utilized by the State of Georgia members in an Excel, Word or PDF format. | 23.20 | The data included in Attachment 11 includes facility claims detail for claims incurred in 2011. |
| 85 | | Question 9.1.1 asks us to Provide three (3) electronic copies of our proposed network(s) of providers. The question also refers to a formatted spreadsheet to use. For purposes of the Proposal Tech submission, can the State confirm only one copy would be required? Can the State also confirm that the three CD copies would be included with the hard copy submission? Is the State just telling us to provide this on a spreadsheet, or are they providing a specific template or us to use? | 9.1.1 | Yes, you can include the 3 CDs of your proposed network providers with your one (1) hard copy submission. Please label and submit as part of your Medical TPA technical response to the DCH Issuing Officer identified in Section 2.2.6 of the RFA Main document. You are to provide this information on your own spreadsheet. We will not be providing a template. |
| 86 | | <p>The state asks for Hard copy and CD-Rom copies of the response being submitted on proposal tech. Can the state provide additional direction on a.) how to split up the cost and technical and b.) what to include in each.</p> <p>Would the cost be just the “cost proposal” referenced in 22.1, along with any supplemental cost documents the bidder provides?</p> <p>Would the technical be a hard copy of the downloaded Proposal tech response, with copies of all uploaded attachments on CD-ROM only?</p> <p>Would the performance guarantee worksheet be part of the cost or the technical?</p> | 2.2.6 | <p>Refer to the Main RFA document Sections - 4.4 Technical Submission (pg 14) and 2.2.6 “Hard Copy” and Electronic Copies Required (pg 12). Please organize and tab hard copy submission. The CD should be a replica of the hard copy.</p> <p>Yes, the cost proposal consists of the provided attachment, along with requested supplemental documents. The cost proposal should be labeled and packaged separately from the technical. Yes, the technical would be a hard copy of your downloaded Proposal tech responses including all of the attachments on CD-ROM.</p> <p>The performance guarantee worksheet is part of the technical submission.</p> |
| 87 | | Can the cost and technical be sent in the same box, as long as each one is in a separately sealed envelope within that box? | Cost Proposal | Yes |
| 88 | | You have Appendix C actually labeled as Appendix B. Just want to confirm this form should actually be Appendix C? | Appendix C | Yes, Minimum Requirements Form should be labeled Appendix C, while the Tax Compliance Form should be labeled Appendix |

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| | | | | B. |
| 89 | | Attachment 4 2013 Active and Retiree Rates- Please confirm that rates shown are the retiree's contribution only. Please provide the total rates by plan in addition to the average subsidy received by Medicare retirees. | Attachment 4 2013 Active and Retiree Rates (23.9) | Yes, the rates are the retiree's contribution only. Other rates will not be provided. |
| 90 | | Attachment 4 2013_SHBP_MA_PPO_Plans_Comparison- Gap coverage indicates "Yes"- please confirm that this means both generics and brands are covered in the gap. Please confirm that the coverage continues through the catastrophic coverage. | | Confirmed and coverage does continue through the catastrophic coverage. |
| 91 | | Attachment 4 2013_SHBP_MA_PPO_Plans_Comparison- Please provide more detail regarding Part D plan design. Please provide a copy of the current formularies. Also, do the plans include or exclude step therapy and mandatory generics? Do the plans cover non-Part D drugs? | Attachment 4 Plan Design (23.12) | Current formularies will not be provided. Plans do contain step therapy and other cost containment provisions. Part B drugs are under the medical portion of Medicare Advantage. However, Offeror is encouraged to propose offerings similar to the plan with their own formularies. |
| 92 | | Other than the elimination to the HUMANA premier plan have any plan design changes been made to current MAPD plans within the past 12 months? | General Question Plan Design | Yes. |
| 93 | | Please confirm what programs and services are included in current Medicare Advantage rates, i.e. wellness, disease management, vendor interfaces, allowances, etc. | General Question | Confirmed. |
| 94 | | GA SHBP TPA_MA Cost Proposal FINAL 20130131 - EX 16 MAPD (row 46) - Please provide more detail regarding requested "customized medical mgt program". | Ex. 16 MAPD (row 46) | DCH is looking for the Offeror to propose the customized program. |
| 95 | | Attachment 22 - Medicare Advantage Monthly Summary – UHC and Humana claims are only through 2011 while | Attachment 22 (23.34) | Additional claim and enrollment data will not be provided. The data provided should be used. |

**QUESTIONS
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| | | Cigna is through 2010. Please provide more recent claim and enrollment information, through 2012 if available. | Claims & Enrollment | |
| 96 | | Attachment 22 - Medicare Advantage Monthly Summary – Please confirm whether enrollment counts are subscribers or members. If subscribers, please provide monthly member counts. | Attachment 22 (23.34) Claims & Enrollment | The enrollments are members. |
| 97 | | Attachment 22 - Medicare Advantage Monthly Summary – Please clarify which plan(s) are included on Cigna tab. Is it possible to break out by plan? | Attachment 22 (23.34) Claims & Enrollment | It is not possible to split the CIGNA data by plan. |
| 98 | | Will 2010 or 2011 CMS risk score or CMS revenue information be made available so that it can be evaluated in connection with the experience provided? This data is key to providing our most competitive financial offer. | General Question Claims & Enrollment | Providing 2012 overall risk scores only: Premium plan: .90 Standard plan: .77 |
| 99 | | 16 Member Eligibility Humana- Please provide an updated file including date of birth | 16 Member Eligibility Humana Claims & Enrollment | The file includes member age achieved during 2011. |
| 100 | | 19 Member Eligibility Cigna- Please provide an updated file including DOB and Gender | 19 Member Eligibility Cigna Claims & Enrollment | The file includes all the information available. |
| 101 | | Attachment 15 Pharmacy claims detail (CY 2011 and CY 2010 incurred) - UHC - We are unable to open this Rx claim file- is it possible to re-send in another format, or split into two files? | Attachment 15 (23.27) Claims & Enrollment | This file is formatted to be opened using SQL or data tool that will accommodate large data files. Excel will not accommodate the size of these files and we cannot provide them in another format. |
| 102 | | Please confirm you will provide plans the opportunity to ask additional questions pertaining to the CMS filing limitations (45-day notice) that was just released, so bidders have enough time to analyze this new guidance. | Medical TPA RFA 17.1.2 | No, additional time will not be provided for additional questions. |

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| 103 | | Please confirm if MA carriers will be expected to offer a compatible HRA as indicated in “Attachments – 2013 Retiree Decision Guide” (pg. 28 – Changing MA PPO Option from HRA). | Attachments – 2013 Retiree Decision Guide – pg. 28 | Confirmed. |
| 104 | | Please provide an updated key to the Plan Code column of Attachment 10 Member Eligibility Data as the codes provided in this file do not match the plan code tab of Attachment 23 Data Dictionary, TPA Reference Documents Attachment 10. | Attachment 10 (23.19) | Please refer to the attached Plan Code listing. |
| 105 | | Please confirm that the 9,344 Active and Early Retiree subscribers that have a Medicare plan code in Attachment 10 should be quoted in a Medicare Advantage product, TPA Reference Documents Attachment 10. | Attachment 10 (23.19) | Confirmed. |
| 106 | | “GA SHBP TPA_MA Cost Proposal FINAL 20130131.xlsx” refers to an Exhibit 19, that is to be used to provide proposed premiums and supporting information for the MA-PDP program. However, we can’t find this tab in the workbook. Can you please provide or direct us to where it is? | Medical TPA RFA 22.1 | The correct reference should be to Exhibit 16 within the same Excel file. |
| 107 | | Can the State let us know which PBMs have qualified to bid on the Pharmacy Benefits Management RFP? | General | No. |
| 108 | | Regarding TPA questionnaire, page 75, Question #11.1.19 – Can you please provide clarification for this question? Is this question in reference to the claims system? Please clarify the terms “test region” and “production region”. | Medical TPA RFA 11.1.19 | Yes, we are referencing the claims system. Test region is an area in your claims system where testing is done to ensure the current benefit designs have been loaded and properly working before claims are actually processed and payments made in your claims processing system/“production region.” |
| 109 | | Regarding TPA questionnaire, page 112, Section 20.4 Medical Management – Please clarify if this section should be answered specifically for Medicare Advantage plans only, or if we should respond for both our commercial plans and Medicare Advantage plans. | Medical TPA RFA 20.4 | Medicare Advantage only. |
| 110 | | The Tax Compliance form in Appendix B, asks that it be | Appendix B- Tax | You are to complete the form and submit it with your Technical |

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| | | emailed to tsd-state-contractors@dor.ga.gov . Can you confirm this is something we would need to do on award of the RFP, or if we would need to send it prior to submitting the RFP? | Compliance Form (23.2) | Response (see Section 2.2.6 of the RFA main document.) DCH as the "State Entity" will email the successful Offeror's completed Tax Compliance Form to DOR. |
| 111 | | Can you confirm that Microsoft PowerPoint would also be considered a commonly accepted program to submit certain files (such as organization charts) in? | Introduction Document 2.2.2 | Yes. |
| 112 | | Can you please specify the three digit zip code you would like us to use run "EX 10 - Prof-CPT "tab of "GA SHBP TPA_MA Cost Proposal FINAL 20130131.xlsx" | | Use all 3 digit zip codes within the State of Georgia. |
| 113 | | Can you please specify the three digit zip code you would like us to use run "EX 10 - Prof-CPT "tab of "GA SHBP TPA_MA Cost Proposal FINAL 20130131.xlsx" | Medical TPA RFA 22.1 | Duplicate to 112 |
| 114 | | Please clarify how transplants would be handled for SHBP's members. Would the TPA be responsible for the transplant network, as well as coordinating care? What, if any, transplant related services would the Medical Management coordinator be responsible for providing? | 8.7.1: | The TPA will be responsible for the Transplant network. During implementation, Vendor interface meetings will be established to coordinate and share information. |
| 115 | | The following tabs in the "GA SHBP TPA_MA Cost Proposal FINAL 20130131.xlsx" worksheet seem to be intended for the incumbent providers to have submitted data prior to the RFP release, and they are blank. Can you let us know if this should have been prefilled with data, and if so provide that data and instructions. If this is not the case, can you provide us with direction on how to complete these exhibits? <ul style="list-style-type: none"> ○ EX 3 – Inpatient DRG ○ EX 4 – Inpatient Provider ○ EX 5 – Outpatient Encounters: ○ EX 6 – Outpatient Providers: B ○ EX 7 – Urgent Care Centers: ○ EX 8 – Dialysis Centers: ○ EX 9 – Skilled Nursing Facility ○ EX 11- Prof Provider | Medical TPA RFA 22.1 | These tabs are provided as a template for the book of business information each Offeror is required to submit as part of the cost proposal. For example, on Ex 3, provide the information requested (number of instances, total number of days, submitted charges, etc) for every DRG in each 3 digit zip code in Georgia in 2011. Please refer to Ex 2 for complete instructions. |
| 116 | | Please confirm that we are only being asked to complete tabs EX1, EX12, EX13 and EX16 of GA SHBP TPA_MA Cost Proposal FINAL 20130131.xlsx. Medical | Medical TPA RFA 22.1 | Offerors responding to the Medical TPA/MA RFA are required to provide the information requested in tabs EX 1, Ex 3- Ex 14 (inclusive), and Ex 16. |

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| | | TPA RFA 22.1 | | |
| 117 | | Do you want us to run the Geo access based on the eligibility data in Attachment 10 Member eligibility data (CY 2011).xlsx? | Medical TPA RFA 23.19 | Yes, that is correct. |
| 118 | | Can you please provide zip codes for the "23.25 Attachment 13 Member eligibility data (CY 2011 and CY 2010) - UHC .txt " file? | Medical TPA RFA 23.25 | The file includes all the information available. To the extent that some zip code information is not included, utilize the state and county information included as a basis for the analysis. |
| 119 | | <p>In order to both Disrupt (8.1.2) and Reprice the data (Instructions tab of "GA SHBP TPA_MA Cost Proposal FINAL 20130131.xlsx"), and provide the best possible cost proposal for the State of Georgia, can you please confirm that:</p> <ul style="list-style-type: none"> ○ The files to be repriced are 18A, 18B first half, 18B second half, 21, 24 and 27? ○ If so, can you please provide the TIN, Name, Address, City, State, Zip code of the Providers, along with a POS/Place of Service indicator, defining Inpatient/Outpatient/Professional? (Some or all of this data is missing from the different files- for example Attachment 24 is missing all the data, and the Attachments 21, 24, 27 have no POS indicators) | Medical TPA RFA 22.1; 8.1.2 | The files to be used for the disruption and repricing required in your response to the Medical TPA/MA RFA are the files included in Attachment 10 and Attachment 11 only. It is believed the information in this files is complete enough to provide the requested analysis. Summarize the requested information by employee 3 digit zip code. |
| 120 | | In light of the missing data referenced for the repricing, disruption, etc. can you grant bidders a period of at least five weeks to complete the disruption and repricing, due to the scope of the data. | General | No. |
| 121 | | Given that the members may switch vendors during open | General | Employee contributions vary by additional costs to SHBP of one |

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| | | <p>enrollment:</p> <ul style="list-style-type: none"> ○ How do the employee contributions vary by vendor? ○ How do the plan designs vary by vendor? ○ Historically, what % of members change vendors every year? | (Medicare Advantage) | vendor over another vendor. Historically, plan designs have not varied by vendor. 80-90% of members tend to remain with the same vendor each year. |
| 122 | | Why was Humana's premium plan discontinued for 2013? | General (Medicare Advantage) | Humana withdrew the premium plan. |
| 123 | | Is all Medicare eligible retiree coverage on a fully insured basis? | General (Medicare Advantage) | Medicare Advantage option is fully insured. |
| 124 | | Please confirm if the schedule of events is also inclusive of Medicare Advantage | Introduction document 1.3 | Confirmed. |
| 125 | | Will the Medicare Advantage options available to members vary by geography? | General (Medicare Advantage) | No. |
| 126 | | Please describe the employer contribution strategy towards Medicare Advantage supplemental premiums. | General (Medicare Advantage) | No. |
| 127 | | Will there be material changes in the employer contribution strategy relative to the experience periods provided? | General (Medicare Advantage) | Material changes are not anticipated. However, DCH reserves the right to change strategies in the negotiation phase. |
| 128 | | Please provide a listing of Medicare Advantage 2010 and 2011 benefit plan options and supplemental premium levels that correspond with the experience provided in attachment 22. | Medical TPA RFA 23.34 | Retiree decision guides for 2010 and 2011 and each year's corresponding MA rates have been posted to the DCH web site: www.dch.georgia.gov/document/shbp-rfa-2013 |
| 129 | | Please provide a listing of existing 2013 Medicare Advantage benefit plan options available and corresponding supplemental premium levels. | General (Medicare Advantage) | Reference attachment 17 for this information. |
| 130 | | Should carriers assume particular risk score(s) in developing bids? | General (Medicare Advantage) | Providing 2012 overall risk scores only: Premium plan: .90 Standard plan: .77 |
| 131 | | What is the expected growth rate in the Medicare | General | The expected growth for 2014 is 5%. There are no projections |

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| | | Advantage population per year for 2013 – 2016? | (Medicare Advantage) | yet for 2015-2016. |
| 132 | | What portion of total eligible members have selected Medicare Advantage? | General (Medicare Advantage) | 99.9% |
| 133 | | While the request is asking to match the existing plans, are there any Medicare Advantage benefit changes the State is contemplating for 2014? | General (Medicare Advantage) | At this time, none. However, DCH is open to new plans that benefit the membership and SHBP. |
| 134 | | Please confirm carriers may utilize a CMS compliant enhanced EGWP strategy to leverage the full manufacturer brand discounts without the need for a separate wrap. | General (Medicare Advantage) | Confirmed. |
| 135 | | Please confirm if we may receive the MAPD EOC's to closely match the requested prescription drug benefits. | General (Medicare Advantage) | The EOCs will not be provided. |
| 136 | | Please confirm whether you would like the EGWP on a fully insured and/or self-funded basis. | General (Medicare Advantage) | Fully insured |
| 137 | | Related to formulary, we observe in the Part D Individual and Group marketplace the practice of “co-mingling”; for example, brand and generic drugs may both appear in a tier labeled ‘preferred brands’. This is a common practice in the Part D industry and allowable per CMS. It allows for plans to reduce premiums by shifting liability to the member through a higher tier copay, or may promote certain drug utilization by moving the drug to a tier with a lower copay, for instance, in an attempt to promote medication adherence and improve STAR ratings. What formulary approach would the State like MAPD respondents to take? Is the co-mingled tier approach allowed or even preferred by the State? Or would the State prefer a formulary that does NOT allow co-mingling by tier? | General (Medicare Advantage) | DCH will consider all proposed approaches. |
| 138 | | While we can match the existing plans closely, please confirm if you wish the carriers to match the existing plans as well as provide CMS compliant plan design suggestions. For example, | General (Medicare Advantage) | DCH will consider all proposed approaches The SHBP has opted out from Mental Health Parity Act for 2013. |

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| | | <ul style="list-style-type: none"> In addition to the MOOP, CMS has limitations on benefit coinsurance levels (see chart below) In addition, please confirm if carriers should include the new non-Medicare covered chiropractic benefit The current plans implement the 190 day limit on inpatient mental health. Please confirm the State of GA is exempt from the Mental Health Parity Act. <table border="1" data-bbox="367 553 997 998"> <thead> <tr> <th>Service Category</th> <th>PBP Section B data entry field</th> <th>Voluntary MOOP</th> <th>Mandatory MOOP</th> </tr> </thead> <tbody> <tr> <td>Inpatient - 60 days</td> <td>1a</td> <td>N/A</td> <td>\$3,935</td> </tr> <tr> <td>Inpatient - 10 days</td> <td>1a</td> <td>\$2,231</td> <td>\$1,785</td> </tr> <tr> <td>Inpatient - 6 days</td> <td>1a</td> <td>\$2,016</td> <td>\$1,613</td> </tr> <tr> <td>Mental Health Inpatient - 60 days</td> <td>1b</td> <td>\$2,471</td> <td>\$1,977</td> </tr> <tr> <td>Mental Health Inpatient - 15 days</td> <td>1b</td> <td>\$1,796</td> <td>\$1,437</td> </tr> <tr> <td>Skilled Nursing Facility - First 20 Days¹</td> <td>2a</td> <td>\$100/day</td> <td>\$50/day</td> </tr> </tbody> </table> | Service Category | PBP Section B data entry field | Voluntary MOOP | Mandatory MOOP | Inpatient - 60 days | 1a | N/A | \$3,935 | Inpatient - 10 days | 1a | \$2,231 | \$1,785 | Inpatient - 6 days | 1a | \$2,016 | \$1,613 | Mental Health Inpatient - 60 days | 1b | \$2,471 | \$1,977 | Mental Health Inpatient - 15 days | 1b | \$1,796 | \$1,437 | Skilled Nursing Facility - First 20 Days ¹ | 2a | \$100/day | \$50/day | | |
|---|--------------------------------------|---|------------------------------|---|----------------|----------------|---------------------|----|-----|---------|---------------------|----|---------|---------|--------------------|----|---------|---------|-----------------------------------|----|---------|---------|-----------------------------------|----|---------|---------|---|----|-----------|----------|--|--|
| Service Category | PBP Section B data entry field | Voluntary MOOP | Mandatory MOOP | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Inpatient - 60 days | 1a | N/A | \$3,935 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Inpatient - 10 days | 1a | \$2,231 | \$1,785 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Inpatient - 6 days | 1a | \$2,016 | \$1,613 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mental Health Inpatient - 60 days | 1b | \$2,471 | \$1,977 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mental Health Inpatient - 15 days | 1b | \$1,796 | \$1,437 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Skilled Nursing Facility - First 20 Days ¹ | 2a | \$100/day | \$50/day | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 139 | | Please confirm that the SHBP abides by the Medicare secondary payer rule where the commercial plan pays primary to Medicare. If yes, please confirm members the SHBP's current practice allows for members to be enrolled on both the active and standard MA Humana plan. Lastly, if yes, please confirm if bidders should include separate pricing for those members enrolled in the ESRD plan. | General (Medicare Advantage) | Confirmed. Members may not be enrolled in active and retiree plan except split eligibility. No separate pricing for ESRD. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 140 | | Please provide clinical, utilization and wellness program reporting data for 2011 and 2012 | Medical Claims TPA - General | All data that is available to the Offerors is attached to the RFA. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 141 | | Do both carriers offer an Employer Group Waiver Plan (EGWP) + Wrap benefit? | Medical Claims TPA - General | Yes for Medicare Advantage plans. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| 142 | | Does SHBP currently allow for non-retirees that are Medicare eligible and disabled to enroll in the Medicare Advantage plan, or must a member under 65 and disabled also be eligible for retiree benefits? | Medical Claims TPA - General | No, only retirees eligible and enrolled in Medicare can enroll in the Medicare Advantage plan. |
| 143 | | Please include summary plan descriptions for all 2012 plan options for UHC and Cigna? | Medical Claims TPA - General | 2012 Summary Plan Description will not be provided. |
| 144 | | Please provide the current risk scores for the 3 Medicare Advantage populations for Medical and Part D. If risk scores are not available can you supply the current CMS revenue amounts? | Medical TPA Services – Claims data file Attachments | Providing 2012 overall risk scores only: Premium plan: .90 Standard plan: .77 |
| 145 | | The eligibility files are noted as 2011 and claim data includes enrollment only through 2011. Please supply information on enrollment changes that took place in 2012 and 2013 for the Medicare Advantage plans. | Medical TPA Services - Eligibility file attachments | The 2011 data provided should be used. Additional data will not be supplied. |
| 146 | | Please confirm if account team members under E, G, H should be designated or dedicated? | Medical TPA Services - 5.2.6. E | If the requirement does not specify dedicated, the Offeror should propose whether the position is dedicated or designated. |
| 147 | | Deviations were requested on the forms provided, however there were no specific forms for deviations included. Please specify where deviations should be noted. | Medical TPA Services - 17.1.1 and 17.2.3 | The Offeror can use the input field provided to cite any deviations in a narrative form or the Offeror may attach a file or exhibit that CLEARLY indicates any deviations in plan design. DCH is interested in reviewing proposals that are based on a replication of the current benefits and Offerors are encouraged to respond accordingly. |
| 148 | | Deviations were requested on the forms provided, however there were no specific forms for deviations included. Please specify where deviations should be noted. | Medical TPA Services - 17.2.5 | See question #147. |
| 149 | | The RFA mentions census files; however, there are no actual files labeled "census." Is the SHBP referring to the eligibility files or are there actually separate "census" files? If it is referring to the eligibility files, please provide zip data for UHC membership for 2010 and 2011. | Medical TPA Services - 18.1.1 and 19.2.1 | The census files refer to member eligibility files in Attachments 13, 16 and 19. These files include all of the information currently available. To the extent that some zip code information is not included, utilize the state and county information included as a basis for the analysis. |
| 150 | | When do you anticipate the site visit will take place? | Medical TPA Services - General | Site visits conducted will likely occur late May/early June. |
| 151 | | The data does not contain an employee ZIP code or a provider ZIP code. We are not able to reprice claims data | TPA – Repricing file | Attachment 10 includes employee/member zip codes. Attachment 11 includes Provider Tax ID. These are the only two |

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| | | without a ZIP code. | | files needed to reprice the Medical TPA claims. |
| 152 | | We need to confirm that we are correctly identifying the billed amount in the data for the analysis. For our analysis, we need the charge amount on the claim less any non-covered, denied, or ineligible amounts (i.e., the billed amount) and before any negotiated discount, member cost-sharing, or COB. The data contains only the "Total_Billed_Amount" field, which we believe represents the billed amount. Please have the current data administrator or incumbent carrier confirm for us that non-covered, denied, or ineligible amounts are not included in the "Total_Billed_Amount" amount. | TPA – Repricing file | Confirmed. |
| 153 | | The data does not contain a Revenue Code, which helps us determine the various outpatient hospital service categories. Without these fields, we will have to use overall outpatient hospital discounts to reprice outpatient hospital claims. | TPA – Repricing file | Utilize the Provider Type Claim Code field. |
| 154 | | We did not receive a data dictionary. We will need one in order for us to understand what the codes represent in the incumbent carrier's data for the Provider_Specialty_Code and Provider_Type_Code | TPA – Repricing file | The Data Dictionary is provided as Attachment 23 |
| 155 | | The claims data set provided for disruption analysis purposes does not contain the provider name or provider zip code. This information is necessary in order to perform a disruption analysis. Please provide a revised file which also includes this information (provider name and provider zip code). | TPA – Repricing file | Utilize the Provider Tax ID. |
| 156 | | The data does not contain a Reason Adjustment Code, which helps us identify claims that might need to be excluded from the analysis. Without this field, we will not be able to exclude claims that we would otherwise exclude from our analysis, which may skew the results. | TPA – Repricing file | The file(s) include all of the information available. |
| 157 | | The data does not contain a Revenue Code, which helps us determine the various outpatient hospital service categories. Without these fields, we will have to use | | See Question #153. |

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| | | overall outpatient hospital discounts to reprice outpatient hospital claims. | | |
| 158 | | We did not receive a data dictionary. We will need one in order for us to understand what the codes represent in the incumbent carrier's data for the Provider_Specialty_Code and Provider_Type_Code | | See Question #154 |
| Pharmacy Benefits Management and Claims Administration | | | | |
| 159 | PBM | Appendix C Questions 5 and 6 are identical. Is this intended, or has a condition been omitted? Should we respond to both? | Appendix C. | No condition has been omitted. Respond to both questions. |
| 160 | | Question 3.1 says to "provide true transparent pricing for all drugs." Please define "True Transparent Pricing." DCH's definition of "Pass Through and Transparent Pricing" states "the arrangement whereby SHBP receives the full value (100%) of Contractor's negotiated Discounts with Network Pharmacies at the point-of-service, and Contractor's only profit is the Administrative Fee." Does DCH allow that the PBM's mail order and specialty pharmacies may also achieve a profit, if beyond the guaranteed discounts? | Questionnaire, Question 3.1. | All adjudicated claims will be at 100% pass-through of negotiated dispensing fees, discounts and rebates. That includes retail point-of-sale, mail order, and specialty pharmacy. PBM profitability should be limited to the administrative fee. For mail order and specialty pharmacy contracted out from the offer pricing must be 100% pass-through. For mail order and specialty pharmacy provided directly by offeror, proposed AWP discount guarantees should reflect the actual acquisition cost of drugs based on the SHBP mix of historical drug claims provided. |
| 161 | | Question 4.2.4 says to "Describe in some detail these current engagements, including customers jointly served in the same manner proposed to SHBP." What does "these current engagements" refer to? | Questionnaire 4.2.4 | Current engagements refer to whomever you disclosed in response to Question 4.2.3. |
| 162 | | Question 10.1 asks for a geo-access report. Can you provide a sample demonstrating the completion of the table in this question? | Questionnaire 10.1 | Utilize the standard GeoAccess report output. Alternative output that clearly indicates the information required is also acceptable. Please provide the report in Excel and pdf. |
| 163 | | In the Contract Term section, the initial term of the contract is said to be from the date of award until the close of the then current calendar year. Assuming the date of award is during 2013, is the initial term ending on 12/31/13, therefore before the effective date of the program? | Page 7, Contract Term. 1.6. | Yes. |

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| 164 | | Please provide an approximate value of the Letter of Credit for the PBM contractor. | Page 13, Letter of Credit, Section 3.2. | Refer to the Appendix 32 for the PBM Shell Contract. The contract includes the provisions for the required Letter of Credit. |
| 165 | | Due to the length of the Shell Contract (133 pages), it is not possible for our legal staff to submit questions for this document prior to today's deadline. Would DCH grant an extension for questions regarding the Shell Contract? Attachment GA SHBP Shell Contract.pdf. | Attachment GA SHBP Shell Contract.pdf. | No extension for questions will be permitted. However, as part of your response to the RFA you are to include identification of any areas of the contract with which you take exception as per instructions at the beginning of the contract template. Those will be reviewed with the apparent winning bidder during the contract execution period of the procurement. In Section 4.4 of the Main Section, Offerors are instructed to submit contract exceptions, if any, provided in the format prescribed in RFA Section 7.1 Contract Terms and Conditions as part of their complete technical submission. |
| 166 | | Please confirm that the intent to bid for this opportunity was accepting the invitation which granted access to answer the RFA sections and that there is no separate Intent to Bid form or requirements. | 2.2.1 RFA Released-Intent to Bid: | Confirmed. |
| 167 | | Please confirm 100,000 lives requirement. Is that in the state of Georgia? Further define "some Membership located in each of the 21 3-digit zip codes". Does that mean at least 1 member in each zip code. | 1.2 Overview of Procurement Process/ Minimum Requirements (B) Pharmacy Benefit Management – 3rd Bullet point | The Offeror is required to provide PBM services to at least 100,000 members that reside within the State of Georgia. The Offeror is also required to provide PBM services to at least one member in each of the 21 3-digit zip codes in Georgia. This would indicate at least one pharmacy that can service the member. |
| 168 | | Is it the intent of the SHBP to "carve out" the pharmacy and contract directly with a PBM for the upcoming contract? | | Yes. |
| 169 | | Please clarify if this RFA is for pre-Medicare members only, no post-65 Medicare retirees. | PBM RFA 1 Background 1.1 | The RFA is for non-Medicare Advantage enrolled SHBP members. |
| 170 | | Can the DCH SHBP provide examples of the outcome/goal based measurements | PBM RFA 1 Background 1.1 | SHBP intends to work with each of the selected vendors to identify appropriate outcomes and goal based measurements for each of their service areas. We look forward to reading the responses to the RFA where opportunity is provided for Offerors to suggest some unique and individual quality measurements within your organization which we might be |

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| | | | | able to consider for our program. |
| 171 | | What type of member and provider incentives and/or disincentives are in place with the current pharmacy benefit administration? | PBM RFA 1 Background 1.1 | Within the pharmacy program, Member incentives currently include the copay waiver program for those enrolled in specific disease management programs. There are no other incentive or disincentive programs currently in place other than the traditional step therapy, prior authorization, and tiered copay structures. |
| 172 | | What type of incentives are being considered for the future | PBM RFA 1 Background 1.1 | SHBP does not currently have planned any other specific incentives beyond what is already in place with the disease management copay waiver, but we look forward to seeing the responses from Offerors to the RFA where recommendations regarding innovative programs within your organizations can be considered for our plan. |

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| 173 | | Is DCH SHBP seeking a stand-alone PBM partner ? | PBM RFA 1 Background 1.1 | Yes. |
| 174 | | What is DCH SHBP 's definition of "true transparent pricing | PBM RFAQuestion3.1 | See response to question 160 above. |
| 175 | | Can there be one team to handle customer service calls and one team to handle prior authorization calls? | PBM RFA Question 4.7.1 | Yes, it is SHBP's intent to have two separate teams – one which handles technical calls and one which handles prior authorization/clinical calls. |
| 176 | | Does this include the pharmacy provider line? If so, is the intent to have a total of three (3) toll-free numbers? Please confirm "Provider" calls include pharmacy. | PBM RFA Question 3.1 | See RFA question 4.7.2. The term "provider" can mean either a pharmacy or physician. Depending on the type of question they may use the technical call number |
| 177 | | Will DCH SHBP allow a single 1-800 number with IVR prompts off that number for technical assistance and clinical assistance?, | PBM RFA Question 4.7.2 | No. SHBP expects two separate dedicated toll free lines. |
| 178 | | Is it DCH SHBP 's intent to monitor live customer service calls from the Offeror call center, or is DCH SHBP requesting access to monitor calls from the State offices? Also, please clarify the number of DCH SHBP participants requesting access | PBM RFA Question 4.7.4 | SHBP is asking Offerors to identify all methods (and locations) available to us for live and recorded monitoring. Please be specific in any limitations your organization may have in this ability. SHBP does not currently have a set number of participants in mind. If there is a limitation associated with this that should be identified in your response. |
| 179 | | Can DCH SHBP please elaborate on what it means by COB Services? We are assuming this is not only related to coordination of benefit for online claims. | PBM RFA Question 6.1.19 | COB is any service available by the Offeror to assist with claims from Members that may have other coverage. Your response should indicate all COB efforts your organization may have available both online and otherwise. |
| 180 | | Please confirm, can Offeror reject repackaged NDCs? | PBM RFA Question 7.12 | If that is the standard practice of the Offeror that should be the response provided along with a brief explanation of why that process is used. |
| 181 | | Please clarify; Is DCH SHBP asking if Offeror will bill members for prescriptions filled if they have not provided payment up front with their order?, | PBM RFA Question 7.29 | Yes. |
| 182 | | Please clarify, is the mail service pharmacy prohibited from pursuing collection of uncollected mail service balances? | PBM RFA Question 7.30 | No. The PBM vendor is not prohibited from attempting to collect unpaid balances. It is the PBM's responsibility to obtain any unpaid balances and not pass that cost along to SHBP. |
| 183 | | In the RFA, it states: Note: A pharmacist is required for the administration of first level appeals, and second level appeals require a physician as technical requirements of | PBM RFA Question 9.3.5 | All 1 st and 2 nd level appeals must be reviewed by a Georgia licensed pharmacist with access to a physician for consultation. DCH will correct the PBM shell contract to reflect this response. |

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| | | this RFA. However, in the Contract Agreement, Section 5.15, it states all second level appeals must be handled by a pharmacist, licensed to practice pharmacy in the state of GA. Please clarify which is correct. | | |
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| 184 | | Is DCH SHBP asking what our source is for normative comparison data, and if we include industry benchmark? Does DCH SHBP want to customize the data source (e.g., fully insured, public sector, national accounts), the data parameters (PMPM, PEPM, PUPM, frequency) or something else? | Please clarify., PBM RFA Question 12.1.3 | Yes, DCH is asking the Offeror to describe the source. Specific client name does not need to be provided. DCH wants to know if customization is available for the data source and data parameters. If the Offeror has multiple data sets, please describe in the response. |
| 185 | | In the PBM PGs, the requirement to review all communication materials to members and providers was not listed as a specific PG, but it is listed as a requirement in the RFA (4.7.7). Is there a PG for this, perhaps, in another place, or does this not carry a specific financial penalty?, | PBM RFA Attachment 7, GA DCH SHBP PBM PGs | There is no PG associated with this, however it is a contract term and therefore subject to all termination penalties under the contract if not met. |
| 186 | | Please clarify, what e-prescribing initiatives does DCH SHBP currently have in place? | SHBP PBM Shell Contract, Question 5.16 | None currently. |
| 187 | | The Cost Proposal Final 20130130 Excel spreadsheet indicates data is provided for calendar year 2011. However, data for the Cigna plan in Attachments 19, 20 and 21 appear to be from 2010. Should Offeror be expecting revised 2011 data, or is this the data DCH SHBP would like repriced?, | PBM RFA Cost Proposal Final 20130130 | Attachment 12 includes pharmacy data for non-Medicare membership, which will be serviced by the successful Offeror. This data is for 2011 and is the data referenced in the cost proposal. Attachment 10 includes a full member eligibility file for the 2011 membership. |
| 188 | | Is this question referring to practitioners other than physicians (dentists, nurse practitioners, physician assistants, etc.) with limited prescribing authority? | PBM RFA Question 9.2.7 | SHBP is interested in determining if you have the ability to verify any physician's specialty (and through what process you may do that) and then utilize that information for application with any of your programs. For example, if a drug can be allowed to pass through at POS if the prescriber is of a certain specialty type and require a hard stop for all others. Also for any applications in utilization review programs and RetroDUR mailings. |
| 189 | | Please define the level of customization required on the member portal? | PBM RFA, Question 3.1 | Section 4.8 of the RFA allows the Offerors to describe the amount of customization possible for the website utilized by the SHBP members. SHBP desires a web portal that is specific to our plan with only our plan detail shown and easily utilized by our membership. |
| 190 | | Attachment H simply states "Replace with new Ethics in Procurement Policy." Should we be expecting to receive this document? | PBM RFA Shell Contract | The new Ethics in Procurement Policy will be posted to the DCH Website. |
| 191 | | Has the State in the past requested their PBMs to modify | Section 6.1.3 | SHBP has in the past decided not to implement a proposed tier |

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| | | tier levels for member disruption? If so, for which drugs has this request been made? | | change due to member disruption however, this has been minimal in nature. The exact list of drugs is not currently compiled. The current PDL list for both the UHC and the Cigna plans can be found at: www.dch.georgia.gov >programs>state health benefit plans>health plans & programs> health plan preferred drug lists. |
| 192 | | Would the State consider a formulary that excludes certain medications from coverage rather than placing them on the 3rd tier? Does the State currently exclude any medications that are 3rd tier drugs? If so, how many? | Section 9.1 | SHBP is open to hearing all recommendations regarding plan design. The final benefit plan design will be determined by SHBP during the implementation phase of this procurement. SHBP does currently exclude a limited number of drugs which are listed in the Summary Plan Description (SPD) at www.dch.georgia.gov >programs>state health benefit plans>health plans & programs |
| 193 | | Would the State be willing to consider a benefit design that more actively steers members to purchase 90 day supplies through Mail Order for 2014? | Section 11.8 | SHBP is open to hearing all recommendations regarding plan design. The final benefit plan design will be determined by SHBP during the implementation phase of this procurement. |
| 194 | | Does the State require that all PBMs provide transparent/pass through pricing at Mail Order/Specialty also or is it possible that a PBM owns its own Mail Order pharmacy rather than sub-contracting for those services is not required to provide pass through pricing at Mail Order? The definition of pass/through in the Attachment 1 Definition of Terms appears to apply only to Retail pricing. | Section 12.1 | See response to #160 above. |
| 195 | | Are the Post-65 Retirees of the State included in the PBM RFA? If not, is that handled via a separate RFA? | | Medicare Advantage enrolled SHBP members will have their pharmacy benefits handled by the TPA/MA vendor. |
| 196 | | Is the State interested in Worker's Compensation solutions that could be paired with PBM services? | | No. |
| 197 | | Please provide clinical, utilization and wellness program reporting data for 2011 and 2012. | PBM - General | All data that is available to the Offerors is attached to the RFA. |
| 198 | | In Section 12.1.7, please elaborate on the type of information and data that is requested to be accessed in real time? Please give examples. | PBM - 12.1.7 | This question is regarding access to real-time claims adjudication data. |
| 199 | | Can 2012 Claims data (for Medical and Pharmacy be provided)? | PBM - Pharmacy Claims Data Files | All data that is available to the Offerors is attached to the RFA. |

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| 200 | | <p>Please provide additional information regarding Pharmacy clinical edits and programs, in addition to what was included in the SPDs, to include the following (Prior Auth – Details on which edits will help. Not sure if they implemented at the program or drug level (i.e. PA on Growth Hormones)</p> <ul style="list-style-type: none"> • Step Therapy • Generic Mandate programs • Dose Opt • Half Tab • Benefit Level coverage – For example – OTC items like Smoking Cessation products? Age edits on Acne Medication? | PBM- General | DCH is interested in receiving proposals from Offerors that provide recommendations for the best overall program design and structure. If the listed programs are part of your program design, include it in your response along with any other initiatives. See question #192 for SPD access instructions. |
| Wellness Programs | | | | |
| 201 | Wellness | What are the 2012 goals and actual participation levels for the Wellness program in 2012? | | Outlined in the RFA under Minimum Capabilities and Expectations. |
| 202 | | Who is the Voluntary Wellness program vendor? | | Cigna and United Healthcare offer all services on an integrated basis, including Wellness. |
| 203 | | What kind of support is required for the Health fairs? eg. Account Manager or Health Coach | | Health Coaches and other applicable health team members. |
| 204 | | How many members do you estimate being eligible for Wellness in the years 2014-2016? | | All members are expected to be eligible. |
| 205 | | What level of telephonic support is required in the incentive design? | | We have asked bidders to propose what they would recommend based on their experience in providing wellness services. |
| 206 | | The incentive amounts expected to be similar for 2014-2016? | | DCH is looking to the Offeror to propose innovative programs and incentives. |
| 207 | | You report your inpatient readmission rate as 9%. Can you share your methodology? Is this an all cause readmission rate? Are there exclusions for planned readmissions, trauma, etc.? What is the time frame? 30 days? | | No, DCH is not sharing the methodology but it is based on 30 days. |

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| 208 | | How do you define emergency room visits as non-emergent? | | According to the DCH's Decision Support Systems the Non-emergent Emergency Room visit rate is 38%. DCH will consider your proposed methodology. |
| 209 | | Are you asking if we have an incentive-related UI that allows them to track member progress on the fly? Or is this simply a file output? Also, with what frequency are they looking to access this 'view-only' resource? | Wellness RFA, Question 5.6.5 | Yes, DCH expects it on the fly. View only as needed. |
| 210 | | Are you asking that members be able to print 'certificates of completion' for activities? They kind of hint towards that when they ask 'can a member print confirmation of completion?' then follow with 'can it have their name and date of completion on it?' – sounds like a certificate. So, what types of activities would require 'certification'? Programs completions? Tracker completions? Attestations? | Wellness RFA, Question 7.1.1.b | Yes. Activities will be based on the Offeror's recommendations for the innovative programs. |
| 211 | | Offeror will receive monthly eligibility feeds and daily eligibility updates. Offeror will provide routine reporting and systems access. What is meant by systems access? | Question 9.1.1 SHBP | DCH access to Offeror's system to view eligibility. |
| 212 | | General Wellness question: Can the wellness program be delivered and reported on in an integrated fashion (taking a population management approach where all wellness topics are addressed across the continuum of issues) OR are you looking for separate programs by wellness topic? | | Both. |
| 213 | | Wellness proposal – Please describe "real-time"? | Section 4.1 | As SHBP requests; should be automated and current as of that moment without lag. |
| 214 | | Can dedicated phone line be shared across medical management and wellness programs? | Section 5.7.1 | No. |
| 215 | | Who is funding the incentives | Section 6.1.2 | The successful bidder. |
| 216 | | Clarify question around programs to incent provider practices | Section 6.1.3 | DCH has asked bidders to propose innovative programs and recommend incentives based on their experience in providing wellness services. |
| 217 | | Please define expectations for access to "real-time" data. Is SHBP looking for remote access to a real-time reporting | Section 8.3.4: | See question #213...and, yes, a real-time reporting tool. |

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| | | tool | | |
| 218 | | Clarify site being referenced: "Confirm your ability to utilize this site as a landing page.....". Clarify "ability to replicate the functionality for 2014". What functionality is being referenced? | Section 7.3.4 and 7.3.5: | The site referenced is your site. The functionality would be based on www.AHealthierSHBP.com |
| 219 | | This section of the RFA states that all Offerors must submit questions by the deadline identified in the Schedule of Events for submitting questions. Will the DCH consider allowing Offerors to submit additional questions at a later date but, prior to the RFA due date, as the RFA and attachments continue to be reviewed and/or if amendments to the RFA are issued by the DCH? | Section 2.1.3 Submitting Questions | No. |
| 220 | | Please clarify as to whether the 640,000 number includes employees and dependents, or just employees?, RFA Section 1.1 Current Environment | Section 1.1 Current Environment | Employees and dependents. |
| | | In addition to what was provided in the attachment documents, can you please provide the follow information: Count of eligible employees Count of eligible dependents (spouses and children broken out separately if available, combined if break out is not available) Count of retirees How many retirees are Medicare eligible? | RFA number 9. List of RFA attachments | Attachment 10 includes a full member eligibility file. Medicare retirees and dependents will receive pharmacy coverage in the MA-PD plans. |
| 221 | | Please share the current cost per participant for biometric screenings?, Wellness Program Cost Proposal | Wellness Program Cost Proposal | No, the information will not be provided. |
| 222 | | Does GA SHBP have a current budget for Wellness services? If so, can you please share the amount for 2014? | Wellness Program Cost Proposal. | No. |
| 223 | | Medical management and Medical TPA will provide daily data feeds to the wellness Offeror. Please confirm that the medical management vendor and medical TPA have the ability to feed data daily. | 8.1 Vendor Interfaces. | Confirmed as it a requirement of the successful medical management and TPA bidders. |
| 224 | | How does SHBP envision the wellness vendor to use daily data from Medical management and Medical TPA? | 8.1 Vendor Interfaces | DCH expects the Wellness vendor, with innovative programs, to determine how to use such data. |
| 225 | | In addition to the Account Management staff requested, | 5.4 Account | Yes. |

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| | | can the Offeror also make include additional recommendations for staff positions | Management | |
| 226 | | Does the SBHP currently have current communication strategy for wellness? How does SBHP currently communicate to members? | 6.1.1 General | Yes, current services vary by vendor. We are asking for your capability in this area. |
| 227 | | The benefit enrollment overview states that members that did not meet the requirements for the Wellness Promise in 2012 are not eligible to participate in 2013. Is that a permanent “elimination” of eligibility, or will those members not eligible to participate in 2013 be given a second chance to sign up again in 2014? | RFA Attachment 4. | Members will be given additional opportunities. The requirements will be defined and communicated to the successful Offeror. |
| 228 | | In Attachment 6, the diagram indicates that the Wellness vendor is expected to provide claims data to the TPA. Can you please clarify if the arrow is intended to go the other direction (claims data coming from the TPA to the Wellness vendor)? | Attachment 6. | Claims are to flow from the TPA to the Wellness vendor. |
| 229 | | In Attachment 7, Clinical Metrics – Compliance with EBM, Reduce BMI in adults, tobacco cessation: will the state provide any incentive for telephonic coaching for the following risk areas: 1. Obesity 2. Tobacco cessation? | Attachment 7. | No. |
| 230 | | In the RFA wellness questions, 2.1., the participation table highlights 1.3% telephonic and online coaching. What is the total number of telephonic coaching participants in 2012? | RFA Questions Section 2.1 | See question #63. |
| 231 | | In the wellness RFA it references a requirement for an Actuary to “be a Fellow of the Society of Actuaries and have experience in the evaluation of wellness programs for groups similar to SHBP.” Does this need to be a third party actuary or can it be the vendor’s employee? | Question Section 5.4.1 | Either one as long as both the third party and the vendor’s employee is a Fellow of the Society of Actuaries. |
| 232 | | The wellness RFA references clinical staff (exercise physiologists, registered dietitians, or other clinical staff) as part of the vendors dedicated staff. Is there an expectation for clinical staff to be a part of the program delivery for health coaching and related? If you do require clinicians, do they need to be licensed in Georgia? | RFA section 5.4.4. | Yes. All clinical staff and other applicable team members must be appropriately licensed or certified. The DCH expects the Offeror to provide the licensing requirements for your staff according to State and federal laws. |

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| 233 | | Does the State expect wellness vendors to have IVR capability? Section 5.7.2 references a member services requirement to allow members to opt out of IVR. | Section 5.7.2. | Yes. |
| 234 | | Can you provide more details regarding the current marketing and communications efforts that are in place for wellness? Specifically we are referencing the requirement in 6.1.1 for a \$1M allowance for marketing and promotion. It would be helpful to have an understanding if this amount of marketing is currently in place with the program vendors and what is currently being delivered to the population. Does this include printing and mailing? | Citation: 6.1.1. | No, DCH has asked Offerors to propose what they would recommend based on their experience in providing wellness services. Printing and mailing are currently included. |
| 235 | | Can you provide more specific details about the existing wellness web portal and modules that are available? Specifically we are referencing section 7.3 and the questions regarding a vendor's ability to meet and expand on the current delivery. Is it possible to provide a detailed overview of the existing modules? | 7.3. | No. DCH has asked Offerors to propose what they would recommend based on their experience in providing wellness services. Current module information can be found at www.AHealthierSHBP.com . |
| 236 | | Can you expand upon the goal of the wellness modules? Is the focus on getting a member to participate and complete a time-based event or on driving behavior change and outcomes? | 7.3 | No. The focus is to achieve the DCH's goals outlined in the RFA. DCH has asked Offerors to propose what they would recommend based on their experience in providing wellness services. |
| 237 | | The Wellness Contract Shell states the following: All Bidder exceptions must be set forth in detail in the table below and in the format below. Bidders shall provide the table below in PDF format and in Word 97 format." Is the requirement for Word 97 format a mistake and can we provide our exceptions in a more recent version of Word? | Contract Shell. | No, the exceptions must be submitted in the format as defined in the contract. |
| 238 | | The Wellness Contract Shell references page numbers, sections and paragraphs for Specific Contractor Responsibilities and Deliverables. Can you please direct us to the right document to cross reference these requirements? | Contract Shell | The Shell Contract references paragraph numbers that are associated with the RFA. The "paragraph numbers" referenced are question numbers within the RFA. Please see the crosswalk of associated paragraph numbers to Wellness RFA questions posted on the DCH Web site: https://dch.georgia.gov/documents/shbp-rfa-2013 |
| 239 | | Regarding the Wellness Contract Shell, what methodology will be used to determine the dollar value associated with efforts and/or materials pertaining to member outreach | Contract Shell section 5.4.1. | The dollar amount based of the actual expenses associated with the efforts and materials pertaining to each of the initiatives mentioned in 5.4.1 that is mutually agreed upon in advance with |

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| | | and communications, health challenges, targeted interventions, promotions, incentives, and other Wellness Initiatives? | | GA DCH. |
| 240 | | Regarding the Wellness Contract Shell, is SHBP willing to make telephonic coaching participation a requirement as part of its incentive program? | Contract Shell section 5.4.2 | DCH will consider your proposed recommendations. |
| 241 | | Regarding the Wellness Contract Shell, should pricing and scope regarding childhood obesity programs be included with our proposal, or will that be developed at a later time in collaboration with the State? | Contract Shell section 5.5.4 | Should be listed as an additional program in the cost proposal and include the fees for the program. The scope should be described in the technical portion of the RFA for childhood obesity. |
| 242 | | In the Wellness Contract Shell, with regards to modules, is the State open to new or innovative approaches that are focused on behavior change? | Contract Shell section 5.8 | Yes, DCH has asked Offerors to propose what they would recommend based on their experience in providing wellness services. |
| 243 | | Regarding Wellness Contract Shell, can SHBP please provide an estimate for the number of vendors with whom the contractor will be expected to establish data interfaces? | Contract Shell section 5.13.6 | At a minimum the TPA, PBM and Medical Management vendors and the DCH DSS vendor. |
| 244 | | With regards to member communication materials, is printing cost the responsibility of the vendor? | Contract Shell section 5.1 | Yes. |
| 245 | | What is the timeline for reporting health effectiveness Data and Information Set (HEDIS) Wellness and Health Promotion measures as required by NCQA? | Appendix C – Minimum Requirements, Item 4 | The DCH will consider the successful Offeror’s proposed timeline. |
| 246 | | Can DCH-SHBP provide more detail on what would constitute a “real-time fashion,” such as the exact frequency required to meet that reporting standard? | Reference 4.1 Minimum Business Capabilities, “Monitor, track, and report member participation data for each Plan Option in a real-time fashion to DCH-SHBP .” | On request; should be automated and current as of that moment without lag. |
| 247 | | Can you expand on what is meant by “duplicating services | RFA Document, Part 2 – Minimum Capabilities and | Two vendors unnecessarily performing the same services that leads to increased cost and inefficiencies. |

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| 248 | | What is the definition of “eligible DCH-SHBP members” as it relates to telephonic wellness coaching? | Attachment 7 GA DCH-SHBP Wellness PGs, Rows 28 and 29 | Those DCH-SHBP members that meet the coaching initiative requirements as determined by those outside the target range and agreed upon by DCH and the Offeror. |
| 249 | | What is the definition of “eligible DCH-SHBP members” as it relates to the preventive care screenings PG? | Attachment 7 GA DCH-SHBP Wellness PGs, Row 30 | Those DCH-SHBP members who meet the specific age/gender guidelines for the preventive screening. |
| 250 | | The “Basic Fee” contains an asterisk that refers to a note/statement on row 36 of the cost proposal document. That note/statement appears to include wellness coaching on a per subscriber basis, but then row 9 also identifies wellness coaching and it is based on a per participant basis. Please clarify if your intent is to have wellness coaching provided as a cost in row 7 or row 9 | Reference GA DCH-SHBP Wellness Cost Proposal, Row 7 | Wellness coaching is to be addressed in Row 9, and not to be included in the Basic Fee. |
| 251 | | These rows refer to biometric screenings with participants of greater than 50 and less than 50, respectively. How many sites would have more than 50 participants and how many sites would have less than 50, and how many total sites do you expect to conduct biometric screening events? | GA DCH-SHBP Wellness Cost Proposal, Rows 17 and 18 | There are over 600 employers covered under SHBP with multiple worksites at each employer. The total number of sites will be determined at a later date. |
| 252 | | Please provide further detail about methods vendors could use to satisfy this requirement. For example, is web-based access required? Are there particular individuals within DCH-SHBP who would require this access? | RFA Document, Part 5 –Appeals and Grievances, Item 5.6.5 | DCH has asked Offerors to describe capabilities. Yes, there are particular DCH-SHBP individuals who would require access. |
| 253 | | Please provide expectations and what is included in the Wellness Quality Management Program? | RFA Document – Section 8 – Question 8.5.1 Quality Management Program | DCH has asked Offerors to propose what they would recommend based on their experience in providing wellness services. It should include any current accreditations and program certifications including expiration dates. |
| 254 | | Please provide clinical, utilization, wellness, and incentive | Wellness - General | No. The data previously provided in the RFA represents the |

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| | | program reporting data for 2011 and 2012. | | complete data set that will be provided. |
| 255 | | Please provide a breakdown of ee's, adult dependents and child dependents under 18 years of age. | Wellness - General | Attachment 10 includes a full member eligibility file. |
| 256 | | Please provide responses to health risk assessment member response data (in aggregate) for 2012. | Wellness - Attachments | No. The data previously provided in the RFA represents the complete data set that will be provided. |
| 257 | | In Section 8.3.4, please elaborate on the type of information and data that is requested to be accessed in real time? Please give examples. | Wellness - Section 8.3.4 | As SHBP requests; should be automated and current as of that moment without lag. Examples will not be provided. |
| General | | | | |
| 258 | General | Will the State be consolidating all vendor questions and answers into one response and posted or will you be replying only to each vendor's questions? | | All vendor questions will be consolidated, with the State's responses, into one document and posted for all vendors to view. |
| 259 | | Please provide a census file which includes Date of Birth, Gender, Enrollment Tier, Home Zip Code and Plan code in Excel format | | Attachment 10 includes a full member eligibility file. |
| 260 | | Please provide the current ACS fees for the Medical plans. | | DCH is not providing any current fees to bidders. |
| 261 | | Please provide Large Claims data, which is broken out by plan type and includes diagnosis and or prognosis information for the most recent past 24 months or more. Please provide in an Excel, Word or PDF format | | Attachments 11-12 include all medical and pharmacy claims incurred during 2011. Attachment 10 includes member eligibility and demographic data. |
| 262 | | Please provide any plan design changes that have been implemented in the past 24 months | | Only current plan designs are provided for purposes of this RFA. |
| 263 | | Please confirm that the State of Georgia will accept the Hard Copies and CDs by 5:00 pm on 03/28/2013 (the next business day, following the closing date of the RFA). | 2.2.6 | DCH will accept Hard Copies and CDS by 5:00 pm (EST) the next business day, following the closing date of the RFA. The closing date for each RFA service is provided in the schedule of events (section 1.3) of the Main RFA document. |
| 264 | | Who is the State's current EAP vendor? Can you verify this is not out to bid? | | EAP services are not part of the SHBP procurement and are not administered by SHBP. |
| 265 | | Who is the State's current Dental vendor? Can you verify this is not out to bid? | | Dental services are not part of the SHBP procurement and are not administered by SHBP. |

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| 266 | | Who is the State's current Vision vendor? Can you verify this is not out to bid? | | Vision services are not part of the SHBP procurement and are not administered by SHBP. |
| 267 | | How does the SHBP measure success with the current vendor relationships? Can the SHBP share the measurement tool and past results? | | SHBP will not share past results or a measurement tool. |
| 268 | | Is there a Life & Disability RFP that is being procured by the State Health Benefit Plan as well? | | Life & Disability services are not part of the SHBP procurement and are not administered by SHBP. |
| 269 | | Please clarify the expected number of individuals to be eligible for the Wellness Programs. Specifically, of the 640,000 lives mentioned on page 2 of the RFA, how many are employees, how many are spouses, how many are dependents ages 18+, and how many are children below the age of 18? If the 640,000 number only includes employees, please provide an estimate for the number of spouses, dependents ages 18+, and children below the age of 18. | General Questions regarding Main Section document | Attachment 10 includes a full member eligibility file. All are eligible for a wellness initiative. |
| 270 | | Can you provide more specific information regarding the plans for the 2014 Wellness Promise minimum requirements for eligibility? | General Questions regarding Main Section document | The information provided is what is available at this time as 2014 benefits have not been finalized. DCH is seeking a vendor with innovative solutions for SHBP to consider before determining 2014 wellness requirements. |
| | | Regarding the minimum requirements for Medical Management, please confirm that if a bidder does not provide all of the required services they are prohibited from bidding on the RFA (for example if a vendor provides disease management but not behavioral health |)General Questions regarding Main Section document | Confirmed. Vendor must respond 'yes' to the minimum requirements in order to bid. |
| 271 | | With respect to the Letter of Credit required to be furnished by successful Offerors, are there alternative methods by which Offerors can provide assurances of performance to DCH? For example, if the Offeror is a publicly traded company that meets certain financial requirements, would DCH consider waiving this requirement? | General Questions regarding Main Section document, section 3.2 | No. The Letter of Credit is required. |
| 272 | | What are the exact contents of the hard copy cost proposal? Should performance guarantees be included here? | General Questions regarding Main Section document. | The contents of the cost proposal are contained in a separate exhibit and the response should follow the format in the exhibit. The performance guarantees are also in a separate exhibit. |

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| 273 | | How should bidders prepare their hard copy technical proposal, specifically the completed RFA questionnaire from the Proposal Tech system? Should we use the Reports/Print feature and return the completed questionnaire without modifications? Is so, how should we insert requested attachments that are updated in Proposal Tech for specific questions? | General Questions regarding Main Section doc. | Submit your hard copy in standard question and answer format. Click reports on the left menu and choose the type of report that will meet your needs. The Reports/Print feature can provide you with a print out of the entire submission. The system also allows users to choose blank response documents or include answers to your questions. The system will provide a zip of all the attachments at the end of the project. Please note that hard copy submissions should be tabbed. |
| 274 | | Confirm the Medicare Advantage program should be provided on a fully insured program only. Reference Purpose for Request for Approach 1.1 | Reference Purpose for Request for Approach 1.1 | Confirmed. |
| 275 | | What is the current DCH-SHBP utilization and specific goal metric for the 14 strategic goals for the DCH-SHBP outlined on page 4? Reference Purpose for Request for Approach 1.1 | Reference Purpose for Request for Approach 1.1 | Data that is available is contained in the beginning sections of the RFA and as part of the performance guarantees. |
| 276 | | Please confirm if the Letter of Credit referenced in this section and the sample contract is requested upon award or during this RFA process. Letter of Credit 3.2 | Letter of Credit 3.2 | The Letter of Credit is requested upon award. For the contract, the exceptions (or statement of no exceptions) must be included with the RFA response as per instructions in the main section. |
| 277 | | Please confirm if DCH -SHBP will allow fees to be quoted using a tiered approach based on final membership enrolled. | Cost Proposal 5.1 | Fees for Medical TPA services are the only fees allowed to be quoted on a tiered approach – as indicated in Exhibit 1 of the Cost Proposal. |
| 278 | | Please confirm pricing for additional services that may be proposed as described and encouraged in Exhibit 1 – TPA Administration Fees may be offered in addition to the standard fees that include the minimum requirements required by DCH -SHBP as outlined in the RFA. | Reference Cost Proposal 5.1 | Confirmed. |
| 279 | | Please confirm DCH -SHBP's fee negotiation process for services requested after the RFA contract award yet are services not clearly specified or included in the RFA or contract with the Offeror. | Cost Proposal 5.1 | Vendor must specify services with fees in the cost proposal. If the vendor has additional fees for innovative programs newly introduced in the RFA, these fees must be clearly identified in the cost proposals. Additional services and related fees will be negotiated on a case by case basis and the process may vary on a case by case basis. DCH will not enter additional negotiations for 2014 services after contract award. |
| 280 | | Please share your scoring methodology. | Reference Review of Scored Technical Questions 6.2.2 | The scoring methodology is provided in the introductory portion of each of the four sections of the RFA under the heading 'Evaluation Criteria'. |

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| 281 | | Please confirm the process in which DCH -SHBP will evaluate services provided by a particular Offeror on an integrated versus non-integrated basis for that Offeror understanding that Offeror has qualified to provide services for each of the areas of the RFA to be integrated (for example, integration of TPA with Medical Management) | Reference Review of Scored Technical Questions 6.2.2 | Each section of the RFA will be evaluated separately. |
| 282 | | How should an Offeror respond to questions throughout the technical questionnaire where the Offeror is able to provide services on both an integrated and non-integrated basis? | Reference Review of Scored Technical Questions 6.2.2 | Each section of the RFA will be evaluated separately. |
| 283 | | When will cost scoring methodology be determined and shared with Offerors. Reference Cost Scoring 6.3.1 | Cost Scoring 6.3.1 | The scoring methodology is provided in the introductory portion of each of the four sections of the RFA under the heading 'Evaluation Criteria'. No additional methodologies will be provided. |
| 284 | | In addition to the information provided in 6.3 General Overview please provide the methodology to evaluate and negotiate non-integrated versus integrated cost proposals? | Cost Scoring 6.3.1 | The scoring methodology is provided in the introductory portion of each of the four sections of the RFA under the heading 'Evaluation Criteria'. No additional methodologies will be provided.. |
| 285 | | Please describe how many of the highest ranking Offerors DCH-SHBP will be able to enter into negotiations with DCH. | Overview of Negotiations 6.5.1 | The top three highest ranking Offerors will be identified. DCH will enter into negotiations in succession until an agreement is reached. |
| 286 | | Please clarify if mandatory and minimum requirements may be amended during negotiations with the highest ranking Offeror as described in the last sentence of the first paragraph of this | Overview of Negotiations 6.5.1 | Mandatory and minimum requirements are non-negotiable and may not be amended. |
| 287 | | Please confirm if DCH-SHBP is interested in both a single vendor or multiple vendor award for each of the four RFA proposals | Section 6.6 | DCH-SHBP is interested in 'best in practice' and best cost with a single vendor for each of the four RFA proposals. However, it is at DCH's discretion to consider a multiple vendor award if DCH determines it is in the best interest of SHBP. |
| 288 | | Can you provide more specific information regarding the plans for the 2014 Wellness Promise minimum requirements for eligibility? | General Questions regarding Main Section document. | See question 270. |
| 289 | | Regarding the minimum requirements for Medical Management, please confirm that if a bidder does not provide all of the required services they are prohibited from bidding on the RFA (for example if a vendor provides | General Questions regarding Main Section document. | Confirmed. Vendor must respond 'yes' to the minimum requirements in order to bid. |

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| | | disease management but not behavioral health). | | |
| 290 | | With respect to the Letter of Credit required to be furnished by successful Offerors, are there alternative methods by which Offerors can provide assurances of performance to DCH? For example, if the Offeror is a publicly traded company that meets certain financial requirements, would DCH consider waiving this requirement? | | See question #271 |
| 291 | | What are the exact contents of the hard copy cost proposal? Should performance guarantees be included here? Citation: General Questions regarding Main Section document. | General Questions regarding Main Section document, section 3.2. | Please refer to RFA Main Section 4.4 Technical Submission. Yes, please include performance guarantees with the Technical Submission. |
| 292 | | How should bidders prepare their hard copy technical proposal, specifically the completed RFA questionnaire from the Proposal Tech system? Should we use the Reports/Print feature and return the completed questionnaire without modifications? Is so, how should we insert requested attachments that are updated in Proposal Tech for specific questions? | General Questions regarding Main Section document | See question #273 |
| 293 | | With respect to the Letter of Credit required to be furnished by successful Offerors, are there alternative methods by which Offerors can provide assurances of performance to DCH? For example, if the Offeror is a publicly traded company that meets certain financial requirements, would DCH consider waiving this requirement? | | See question #271 |
| 294 | | Under main requirements, required documentation to confirm financial viability was requested. What information and/or format is required? | RFA Main Section - Minimum requirements Section A | The requirements are listed in the Minimum Requirements Acknowledgement form. |
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