STATE OF WISCONSIN
Department of Employee Trust Funds
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SECRETARY

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Date: August 19, 2016

To: All Proposers

RE: **ADDENDUM No. 3**
Request for Proposal (RFP) ETG0003
Administrative Services for the State of Wisconsin Health Benefit Program

Please note the following updates to the referenced RFP above:

1. **REMOVE** the following paragraph of Section 1.2.1 of the RFP.

   Employer Groups: There are 58 different State agencies in the GHIP program, which operate under eight (8) different payroll processing centers. There are currently 368 local government employers offering health benefits to employees through the WPE program. This participation varies slightly, each year, due to an annual opt-in and opt-out provision for any local government employer in Wisconsin. The UW System Administration manages payroll functions for the 13 four-year campuses and the 13 two-year campuses with locations throughout the State. See Appendix 2 GHIP/WPE Employer Group Detail for a complete list of employer groups. Also, see Appendix 3 Department of Corrections (DOC) Work Locations, and Appendix 4 State Work Locations (non-DOC) for physical locations of employer groups.

2. **ADD** the following paragraph to Section 1.2.1 of the RFP.

   Employer Groups: There are 58 different State agencies in the GHIP program, which operate under eight (8) different payroll processing centers. There are currently 368 local government employers offering health benefits to employees through the WPE program. This participation varies slightly, each year, due to an annual opt-in and opt-out provision for any local government employer in Wisconsin. The UW System Administration manages payroll functions for the 13 four-year campuses and the 13 two-year campuses with locations throughout the State. See Appendix 7 for the State employer group roster and Appendix 8 for the WPE employer group roster.

3. **REMOVE** the following events in Table 4 of Section 1.9 of the RFP.

Table 4 Calendar of Events*

Date	Event
Friday, August 26, 2016	Additional Proposer Questions Due Date
Friday, September 2, 2016	ETF Posts an Addendum (Additional Responses to Proposer Questions, if necessary)

Friday, September 9, 2016 2:00 PM CDT	**Proposals Due Date and Time**
Tuesday, November 15, 2016	Group Insurance Board meeting

All dates are estimated except the submission of Proposer Questions and Proposal Due Dates.

4. **ADD** the following events in Table 4 of Section 1.9 of the RFP.

Table 4 Calendar of Events*

Date	Event
Friday, September 2, 2016	Additional Proposer Questions Due Date
Friday, September 9, 2016	ETF Posts an Addendum (Additional Responses to Proposer Questions, if necessary)
Monday, September 19, 2016 2:00 PM CDT	**Proposals Due Date and Time**
Wednesday, November 30, 2016	Group Insurance Board meeting

All dates are estimated except the submission of Proposer Questions and Proposal Due Dates.

5. **ADD** the following bullet to Section 2.4 of the RFP to the right of TAB 1 directly following "Provide the following in the following order:"
    - ADDENDUM No. 3 Acknowledgement: Remove the back page (Page 27) from Addendum No. 3, complete, and sign.

6. **ADD** the following bullet to Section 2.4 of the RFP under TAB 2 directly following "Appendix 11 Health Care Performance Metrics (see 7.4.4)"
    - Medicare Benefit Summary and Rates (7.6.1)

7. **REMOVE** the following sentences from Section 6.3.1 of the RFP.

    Explain how your company plans to meet the customer service requirements as specified in Sections 265C and 315E of the Pro Forma State of Wisconsin Contract in Exhibit 1. Provide examples of reports or materials related to meeting these requirements.

8. **ADD** the following sentences to Section 6.3.1 of the RFP.

    Explain how your company plans to meet the customer service requirements as specified in Sections 265C and 315D of the Pro Forma State of Wisconsin Contract in Exhibit 1. Provide examples of reports or materials related to meeting these requirements.

9. **REMOVE** the following sentence from Section 6.5.4 3) d) of the RFP.

    Describe the technical solution and the authentication standards that will be implemented to integrate with other third party providers.

10. **ADD** the following Section directly following Section 7.5 of the RFP.

7.6 MEDICARE MEMBERS

This section is not scored.

7.6.1 Does your organization currently offer group Medicare Advantage coverage for Participants enrolled in Medicare? If yes, provide the following information:

1) Type of plan(s) offered (e.g., HMO, PPO, Private Fee-For-Service, etc.).

2) Clearly describe the benefits offered through each of the plan(s) and provide benefit summaries for 2015 and 2016 as described in Section 2.4. Describe your flexibility in making benefit modifications to the plan(s), including coverage for benefits that Medicare does not cover such as vision and hearing.

3) Describe the pharmacy benefits available through each plan and the name of the PBM, if you utilize one. Describe your capabilities with working with the Department's PBM.

4) Describe the service area and provider network for the plan(s) both within the state and nationwide.

5) Describe how the plan(s) is rated and whether it is age-rated. Provide the rates for each plan for 2015 and 2016 as described in Section 2.4.

6) Identify the total number of Wisconsin residents enrolled in each plan.

7.6.2 Describe any plans to expand, discontinue, or otherwise change your group Medicare Advantage plan(s) prior to January 1, 2018.

7.6.3 Describe your outreach strategy to potential members and provide examples of content.

7.6.4 Describe your member education strategy and provide examples of content.

7.6.5 Identify your Centers for Medicare & Medicaid Services (CMS) Star Rating for the most recent period.

7.6.6 Would you be interested in offering your Medicare Advantage product to the State of Wisconsin Group Health Insurance Program?

11. **ADD** the following to Section 150, 5) of Exhibit 1.

f) Benefit Accumulator Data - On each BUSINESS DAY, the CONTRACTOR must submit and retrieve data files with the vendor designated by the DEPARTMENT for the purpose of calculating the benefit accumulator for medical and pharmacy benefits. The CONTRACTOR must retrieve the pharmacy accumulator data and apply it to any combined deductibles and/or maximum out-of-pocket amounts for PARTICIPANTS. The CONTRACTOR must work with the DEPARTMENT to audit

the benefit accumulator against the DEPARTMENT'S PBM to ensure the accumulator amounts are in sync.

12. **REMOVE** the following paragraph from Section 230C of Exhibit 1.

> The CONTRACTOR must comply with the continuity of care provisions under Wis. Stat. § 609.24 for providers listed in the IT'S YOUR CHOICE OPEN ENROLLMENT materials and listed in the provider data submission. The CONTRACTOR certifies that providers listed in the IT'S YOUR CHOICE OPEN ENROLLMENT materials and the provider data submission are either under contract for all of the ensuing benefit period. In the event a provider or provider group terminates its contract with the CONTRACTOR during a benefit period, the CONTRACTOR will follow the continuity of care provisions and pay claims for covered services at the negotiated rate. In this case, the SUBSCRIBER shall be held harmless and indemnified. This does not apply in the loss of providers due to normal attrition (death, retirement, a move from the service area) or as a result of a formal disciplinary action relating to quality of care.

13. **ADD** the following paragraph to Section 230C of Exhibit 1.

> The CONTRACTOR must comply with the continuity of care provisions under Wis. Stat. § 609.24 for providers listed in the IT'S YOUR CHOICE OPEN ENROLLMENT materials and listed in the provider data submission. In the event a provider or provider group terminates its contract with the CONTRACTOR during a benefit period, the CONTRACTOR will follow the continuity of care provisions and pay claims for covered services at the negotiated rate. In this case, the SUBSCRIBER shall be held harmless and indemnified. This does not apply in the loss of providers due to normal attrition (death, retirement, a move from the service area) or as a result of a formal disciplinary action relating to quality of care.

14. **REMOVE** the following paragraph from Section 265C of Exhibit 1.

> The CONTRACTOR must have a customer service inquiry system for inquiries received by phone and email and/or website. The system must maintain a history of inquiries for performance management, quality management and audit purposes. Related correspondence and calls shall be indexed and properly recorded to allow for reporting and analysis based on a distinct transaction.

15. **ADD** the following paragraph to Section 265C of Exhibit 1.

> The CONTRACTOR must have a customer service inquiry system for inquiries received by phone and email and/or website. The system must maintain a history of inquiries for performance management, quality management and audit purposes. Related correspondence and calls shall be indexed and properly recorded to allow for reporting and analysis based on a distinct transaction. On a monthly basis, the CONTRACTOR must submit a report by month for a rolling twelve (12) month period showing the volume and type of inquiry with a break-down by topic. The report must include a comparison to the same month of the previous calendar year and illustrate trends.

16. **REMOVE** the following paragraph from Section 265C of Exhibit 1.

> The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At

least five (5%) percent each month of all PARTICIPANT inquiries made by each submission type (e.g. phone, email, website) must be audited by CONTRACTOR management staff (e.g. lead worker, supervisor, manager) to ensure accurate information was given to PARTICIPANTS and appropriate coaching and training is given to customer service representatives who failed to accurately respond to PARTICIPANTS. At the DEPARTMENT'S request, the CONTRACTOR must provide the audit results.

17. **ADD** the following paragraph to Section 265C of Exhibit 1.

    The CONTRACTOR must have and implement procedures for monitoring and ensuring the quality of services provided by its customer service representatives. At least five (5%) percent each month of all PARTICIPANT inquiries made by each submission type (e.g. phone, email, website) must be audited (e.g. by lead worker, supervisor, manager, auditor, etc.) to ensure accurate information was given to PARTICIPANTS and appropriate coaching and training is given to customer service representatives who failed to accurately respond to PARTICIPANTS. At the DEPARTMENT'S request, the CONTRACTOR must provide the audit results.

18. **REMOVE** the following paragraph from Section 265H of Exhibit 1.

    The period of access and examination described in the paragraph above, for records that relate to: (1) litigation or settlement of claims arising out of the performance of this AGREEMENT; or (2) costs or expenses of this AGREEMENT with which exception is taken by litigation, claims, or exceptions have been disposed.

19. **ADD** the following paragraph to Section 265H of Exhibit 1.

    Any records that relate to: (1) litigation or settlement of claims arising out of the performance of this AGREEMENT; or (2) costs or expenses of this AGREEMENT with which exception is taken by litigation, claims, or exceptions, must be retained for seven (7) years after the conclusion of the litigation, regardless of the termination date of the contract.

20. **REMOVE** the following paragraph from Section 315E, 4) of Exhibit 1.

    Notification of Data Breach: The CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the PHI and/or PII of one (1) or more PARTICIPANTS may have been breached, or has been breached. The CONTRACTOR is required to report using the form provided by the DEPARTMENT. *(See Section 155F.)*

21. **ADD** the following paragraph to Section 315E, 4) of Exhibit 1.

    Notification of Data Breach: The CONTRACTOR shall notify the DEPARTMENT Program Manager and Privacy Officer within one (1) BUSINESS DAY of discovering that the PHI and/or PII of one (1) or more PARTICIPANTS may have been breached, or has been breached. The CONTRACTOR is required to report using the form provided by the DEPARTMENT. *(See Section 155G.)*

22. **REMOVE** the following section from Exhibit 4.

    7.0 CRIMINAL BACKGROUND VERIFICATION: The Department follows the provisions in the Wisconsin Human Resources Handbook Chapter 246, Securing Applicant Background Checks (see http://oser.state.wi.us/docview.asp?docid=6658). The Contractor is expected to perform background

checks that, at a minimum, adhere to those standards. This includes the criminal history record from the Wisconsin Department of Justice (DOJ), Wisconsin Circuit Court Automation Programs (CCAP), and other State justice departments for persons who have lived in a state(s) other than Wisconsin. More stringent background checks are permitted. Details regarding the Contractor's background check procedures should be provided to the Department regarding the measures used by the Contractor to protect the security and privacy of program data and participant information. A copy of the result of the criminal background check the Contractor conducted must be made available to the Department upon request. The Department reserves the right to conduct its own criminal background checks on any or all employees or subcontractors of and referred by the Contractor for the delivery or provision of Services.

23. **ADD** the following section to Exhibit 4.

7.0 CRIMINAL BACKGROUND VERIFICATION: The Department follows the provisions in the Wisconsin Human Resources Handbook Chapter 246, Securing Applicant Background Checks (see http://doa.wi.gov/Documents/DPM/Document%20Library/Chap246VerifyingApplicantInfoSecuringBackgroundChecks.pdf). The Contractor is expected to perform background checks that, at a minimum, adhere to those standards. This includes the criminal history record from the Wisconsin Department of Justice (DOJ), Wisconsin Circuit Court Automation Programs (CCAP), and other State justice departments for persons who have lived in a state(s) other than Wisconsin. More stringent background checks are permitted. Details regarding the Contractor's background check procedures should be provided to the Department regarding the measures used by the Contractor to protect the security and privacy of program data and participant information. A copy of the result of the criminal background check the Contractor conducted must be made available to the Department upon request. The Department reserves the right to conduct its own criminal background checks on any or all employees or subcontractors of and referred by the Contractor for the delivery or provision of Services.

24. **REMOVE** the following section from Exhibit 4.

13.0 CONTRACT DISPUTE RESOLUTION: In the event of any dispute or disagreement between the parties under this Contract, whether with respect to the interpretation of any provision of this Contract, or with respect to the performance of either party hereto, except for breach of Contractor's intellectual property rights, each party shall appoint a representative to meet for the purpose of endeavoring to resolve such dispute or negotiate for and adjustment to such provision.

No legal action of any kind, except for the seeking of equitable relief in the case of the public's health, safety or welfare, may begin in regard to the dispute until this dispute resolution procedure has been elevated to the Contractor's highest executive authority and the equivalent executive authority within the Department, and either of the representatives in good faith concludes, after a good faith attempt to resolve the dispute, that amicable resolution through continued negotiation of the matter at issue does not appear likely.

The party believing itself aggrieved (the "Invoking Party") shall call for progressive management involvement in the dispute negotiation by delivering written notice to the other party. Such notice shall be without prejudice to the Invoking Party's right to any other remedy permitted by this Contract. After such notice, the parties shall use all reasonable efforts to arrange personal meetings and/or telephone conferences as needed, at mutually convenient times and places, between authorized negotiators for the parties at the following successive management levels, each of which shall have a period of allotted time as specified below which to attempt to resolve the dispute:

Level	Contractor	The Department	Allotted Time
First	Level 1 entity	Deputy Office Director	10 Business Days
Second	Level 2 entity	Office Director	20 Business Days
Third	Level 3 entity	Secretary	30 Business Days

The allotted time for the First Level negotiations shall begin on the date the Invoking Party's notice is received by the other party. Subsequent allotted time is days from the date that the Invoking Party's notice was originally received by the other party. If the Third Level parties cannot resolve the issue within thirty (30) business days of the Invoking Party's original notice, then the issue shall be designated as a dispute at the discretion of the Invoking Party and, if so, shall be resolved in accordance with the section below. The time periods herein are in addition to those periods for a party to cure provided elsewhere in this Contract, and do not apply to claims for equitable relief (e.g., injunction to prevent disclosure of Confidential Information). The Department may withhold payments on disputed items pending resolution of the dispute.

25. **ADD** the following section to Exhibit 4.

13.0 CONTRACT DISPUTE RESOLUTION: In the event of any dispute or disagreement between the parties under this Contract, whether with respect to the interpretation of any provision of this Contract, or with

respect to the performance of either party hereto, except for breach of Contractor's intellectual property rights, each party shall appoint a representative to meet for the purpose of endeavoring to resolve such dispute or negotiate for and adjustment to such provision.

Contractor shall continue without delay to carry out all its responsibilities under this Contract which are not affected by the dispute. Should Contractor fail to perform its responsibilities under this Contract that are not affected by the dispute without delay, any and all additional costs incurred by Contractor and ETF as a result of such failure to proceed shall be borne by Contractor and Contractor shall not make any claim against ETF for such costs. ETF's non-payment of fees in breach of this Contract that are overdue by sixty (60) days is a dispute that will always be considered to affect Contractor's responsibilities.

No legal action of any kind, except for the seeking of equitable relief in the case of the public's health, safety or welfare, may begin in regard to the dispute until this dispute resolution procedure has been elevated to the Contractor's highest executive authority and the equivalent executive authority within the Department, and either of the representatives in good faith concludes, after a good faith attempt to resolve the dispute, that amicable resolution through continued negotiation of the matter at issue does not appear likely.

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26. **ADD** the following answers to questions submitted by Proposers:

No.	RFP Section	RFP Page	Question / Answer
Q1	1.2.1	6	We understand that ETF has selected StayWell as their wellness AND disease/case management vendor. For disease and case management, what is the intent? Will all DM/CM services be carved out to Staywell? Or is it the intent that DM/CM services by StayWell will be limited to only certain services or diagnoses? If so, what would those be? What information can be provided to us regarding expectations around coordination of services and information sharing around DM/CM? If a TPA is not willing to allow a carve-out of DM/CM services, are they automatically disqualified from bid consideration? Clarification around what services are being requested.

No.	RFP Section	RFP Page	Question / Answer
A1			Sections 220L and 265B of Exhibit 1 details the requirements of integration and ongoing coordination planning with the wellness/disease management (DM) vendor. Section 215 of Exhibit 1 details the requirements for medical management. The current intention is that complex case management will remain a responsibility of the Contractor, not the wellness/DM vendor. The DM programs offered by the wellness/DM vendor will evolve over time in coordination with Contractor programs to avoid duplication in outreach and/or services but increase the likelihood of improved health. Coordinating DM with the wellness/DM vendor is a Contract requirement. If a Proposer is not willing to agree to that requirement, see Section 2.4 of the RFP regarding submitting assumptions and exceptions in the Proposal.
Q2	1.3	7	Please provide the name(s) of the other contractor(s) and/or third party vendor(s), and outline the necessary data sharing requirements for each. i.e. PBM, Wellness & DM, Data Warehouse, etc.
A2			The current PBM is Navitus Health Solutions. The wellness and disease management vendor is StayWell Company LLC. A procurement is in process to select the data warehouse vendor. The Board's consulting actuary is Segal Consulting. Data sharing requirements are specified in Exhibit 1, Pro Forma Contract, Section 150 Data Integration and Technical Requirements.
Q3	1.9 & Exhibit 1, Section 265A	11, 60	What is the expected contract execution date that is noted in section 6.4? The State has clearly defined the following dates in section 1.9: • November 15, 2016 - Group Insurance Board Meeting • July 1, 2017 - Contract Start Date For the implementation plan, we are required to meet specific deliverables after the contract execution date in the Pro Forma 265A and we

No.	RFP Section	RFP Page	Question / Answer
			would like this date clarified since it is not included in Section 1.9.
A3			The contract execution date is expected to be July 1, 2017.
Q4	2.3	13	Will it be acceptable to provide a CD instead of a USB flash drive?
A4			No.
Q5	2.4	16	Would the State like the original RFP questions/statements for each section included along with the proposer's response? We want to ensure we are thorough in our response but want to ensure we do not include any unnecessary language that may add clutter for the reviewers.
A5			Yes.
Q6	6.3.1	25	The RFP references sections 265C and 315E of the Pro Forma in responding to this question. Did you intend to direct Proposers to section 315D of the ProForma? Clarification is needed.
A6			Yes. The customer service requirements are specified in Exhibit 1, Sections 265C and 315D.
Q7	6.5.4	27 & 28	6.5.4.4 appears to be a duplicate to 6.5.4.3.d? Clarification is needed.
A7			Disregard question 6.5.4 - 3) d) of the RFP, which is a duplicate of question 6.5.4 - 4).
Q8	6.5.4	28	The statement -"Describe the technical solution and the authentication standards that will be implemented to integrate with other third party providers."- is listed twice in this section. Once under 6.5.4.-3d and second time as 6.5.4-4. Is the state looking for two separate answers? If so, could the State please clarify the difference between the questions? RFP clarification between question 6.5.4.-3d and 6.5.4-4.
A8			See A7 of Addendum No. 3.

No.	RFP Section	RFP Page	Question / Answer
Q9	7.3	32	Provide one specific de-identified actual example for complex case management and one for disease management. Are we required to provide a member example or a reporting example?
A9			Provide a member example that is de-identified.
Q10	7.3.2	32	Please describe the level of integration required with the disease management and wellness vendor(s)
A10			See A1 of Addendum No. 3.
Q11	8.1	36	If offering a narrow network, do providers need to be available in all counties in the eastern region? A narrow network is a smaller selection of providers that are more focused and cost effective. Do we need to have access in all locations at the level requested?
A11			If bidding in a region, a Proposer's narrow network, although more focused/selective, should be reasonably accessible throughout the region -- preferably having a reasonable presence in each county within the region.
Q12	8.1	36	If we are required to offer insurance in each of the counties in a given region what would be acceptable to meet this requirement other than a letter of intent? We are concerned that 30 days may not be enough time to adequately reach an agreement with a new set of providers for three counties.
A12			Proposers are asked to demonstrate their network breadth - both broad and narrow networks. A "Letter of Intent" is necessary for the Proposer to show expansion efforts. If holes still exist, Proposers should outline their plans to close the gaps, including the anticipated timeframe.
Q13	8.1	36	Please clarify the relationship of a potential statewide bid and the four potential regional bids. The statewide bid (which is required to contain a national network), for instance, could be viewed as a replacement for the IYC Access Health Plan (formerly the Standard Plan), or the aggregation

No.	RFP Section	RFP Page	Question / Answer
			of all four regions and all ETF populations into a single proposal. Trying to determine if the statewide/nationwide plan is in place of or in addition to regional bids.
A13			A combination of networks and administrators is possible. It is anticipated that the statewide contractor would replace the IYC Access Health Plan. It is possible there could be multiple contractors in each region, if advantageous both in terms of provider access and cost.
Q14	8.2	36-40	Will the State entertain a proposal that offers an open access plan alongside a tiered plan at a regional level? Clarification around network design.
A14			Yes, but the network options must be submitted separately. Financial proposals for each network must be provided -- i.e., separate Section 8 Attachments must be submitted for each scenario proposed.
Q15	8.2	36-40	Will the State entertain a proposal that offers a narrow network option alongside an open access plan at a regional level? Clarification around network design.
A15			See A14 of Addendum No. 3.
Q16	8.2	36-40	If we provide a tiered network design option, will the State require a Tier 1 provider be available in each county within the region? Clarification around network design.
A16			State statute requires the availability of a Tier 1 offering.
Q17	8.2.1	37-38	Please provide clarification regarding what should be included in the access reports. Should professionals for the specialties listed be physicians only or also include nurse practitioners, physician assistants or other mid-level practitioners? Clarification around what should be include in access reports.

No.	RFP Section	RFP Page	Question / Answer
A17			Include only those professionals who have a license to prescribe prescription drugs.
Q18	8.2.1	37-38	For all categories listed in the table within 8.2.1, are we to complete our access reports using the full census file in Attachment B? This census file does not include member gender and age information, which would be needed to specifically address “OB/GYN (female members, age 12 and older) and “Pediatrician (birth through age 18).” Please clarify what census information we should use to run our reports. Clarification around what census data should be used to run access reports.
A18			Separate census data, including member dates of birth and gender, will be provided and should be utilized.
Q19	8	39	We urge the State to reconsider extending the deadline beyond September 9th to ensure the highest quality data submission from RFP respondents. Given the amount of claims data expected, repricing the data file will take significant effort. Without having the data files and final versions of attachments D, E, F, G & K, ready till the week of August 8, this reduces an already tight timeline for this critical component.
A19			Data was released 8/19/2016. Proposals are due September 19, 2016.
Q20	8.2.3	39	Please provide more direction on the last column on the Provider Listing worksheet in Attachment B. This column is labelled “Network Status (Y/L).” What are we required to provide here? Clarification around required fields in Attachment B.
A20			Proposers should indicate whether the provider is a participating provider in their network ("Y"), or has a letter of intent ("L"). If provider is not a participating provider, and there is no signed letter of intent to become a participating provider, field should be left blank.

No.	RFP Section	RFP Page	Question / Answer
Q21	8.3 & Attachments C to G	40	A repricing file containing participant claims experience for the most recent twelve (12)-month period will be made available through a secure file transfer protocol. Will we receive four separate claim files and a total file for the repricing work? In other words, are we asked to submit 5 separate repricing analyses in addition to the other RFP attachments (D and E)?
A21			One aggregated data file will be provided, for repricing. The data will include a "region code", based on the provider's zip code, for those Proposers who wish to submit proposals on a regional basis.
Q22	8.3.1	40	Are claims that are being sent county specific, or are all counties being sent? What is the volume of claims that are being sent per county? We need to understand if all health plans are expected to only provide a response for selected counties they choose to participate in.
A22			Proposals should be submitted for statewide and/or regional coverage only, no county-specific bids. One aggregated data file will be provided, for repricing. The data will include a "region code", based on the provider's zip code, for those Proposers who wish to submit proposals on a regional basis.
Q23	8.3.1 & 8.3.2	40 & 41	How should proposers handle claims for the border counties we will include in addition to our regional bid? We are unclear how to handle border county claims to ensure we meet Section 8 requirements and the Department's expectations.
A23			Proposers should provide pricing for border counties if those providers are in their network. There is a section in the proposal allowing Proposers to add/remove border counties from their proposed service area.
Q24	8.4	41	Please clarify the basis for a requirement that the proposed administrative fee "assume claims fiduciary liability". There is no explicit requirement in the RFP or elsewhere that establishes that the Proposer is or would become a fiduciary.

No.	RFP Section	RFP Page	Question / Answer
			It is not standard in the industry for a TPA to assume fiduciary liability in instances, such as those proposed by ETF, where the employer retains final authority over benefit determinations.
A24			Private employers, having benefit plans governed by ERISA, regularly have the TPA take on fiduciary responsibility. Although the State plans are not governed by ERISA, the administrator is being asked to provide the same level of fiduciary responsibility as would be expected for an ERISA plan -- e.g., responsibility and liability for proper adjudication of claims, benefit determination, benefit payment, accurate and timely reporting, etc.
Q25	8.4	41	Please clarify the basis for a requirement that the proposed administrative fee include “various required filings (including New York and Massachusetts surcharge filing, and Michigan Public Act 142 filing). Please provide any legal analysis that establishes such fees are required or appropriate. Proposer has been successful in challenging the appropriate application of these fees on its operations in the past.
A25			Proposers will be required to provide supporting reports and assist with filing requirements of various states’ legislatures, such as . . . New York Health Care Reform Act: https://www.health.ny.gov/regulations/hcra/ Massachusetts Health Safety Net: https://www.sec.state.ma.us/reg_pub/pdf/100/1146014.pdf Michigan Public Act 142 (repealed, effective 1/1/18): http://www.legislature.mi.gov/(S(4yiypq45c0rgbeneo0rprtqc))/mileg.aspx?page=GetObject&objectname=mcl-Act-142-of-2011
Q26	8.4	42	Are contractors to provide administrative fees on a per employee (subscribers) per month basis or on a per participant (members) per month basis?
A26			Administration fees should be provided on a per-participant, per-month basis (PPPM). "Participant"

No.	RFP Section	RFP Page	Question / Answer
			is defined as "member" -- not "subscriber" or "contract".
Q27	8.4	42	Please provide clarification on Administrative Component “Assume Claims Fiduciary Liability” Clarification is needed to appropriately respond to this component.
A27			See A24 of Addendum No. 3.
Q28	Attachment I		Will it be acceptable to offer three year admin fees or is it a requirement to offer five years of admin fees?
A28			Five years are required.
Q29	Attachment K		The membership numbers in the “Baseline Data” table – are the counts members or subscribers? If members, how many subscribers are eligible per region?
A29			"Membership" figures represent number of members. Subscriber information may be pulled from the census data that will be provided.
Q30	Exhibit 1 - Section 000	9	The definition of an in-network provider states the provider’s written participation agreement must be in force at the time such services, supplies or other items covered under the policy are provided to a PARTICIPANT. It is our practice to review our plan participant’s use of non-network providers. When utilization volume warrants we extend an offer for the provider to join our network. Often times these contracts are back dated providing employers and plan participants with a discounted rate for services previously provided. Would this definition restrict us for applying this practice to state Health Benefit Program?
A30			No.
Q31	Exhibit 1 & Appendix 8	10	On page 10 of the Pro Forma Contract, a definition is provided for local employer (and in Appendix 8 there are 10 pages of local employers listed) – are we expected to establish eligibility feeds with each local employer group?

No.	RFP Section	RFP Page	Question / Answer
A31			No. As described in Exhibit 1, Section 150, the Department will transfer to the Contractor the enrollment files for all participants.
Q32	Exhibit 1 - Section 105		Please clarify the statement: “Eligible PARTICIPANTS have the opportunity to choose a benefit plan design. A minimum of two (2) competing benefit plans is required per Wis. Stat. § 40.51 (6).” Does this mean two benefit designs or two carriers/TPAs?
A32			The statute does not further define competing benefit plans.
Q33	Exhibit 1 - Section 110		Wellness and Disease Management services; are we asked to offer wellness and disease management services within our proposal?
A33			The Contractor will be required to coordinate offerings with the wellness/disease management vendor to avoid duplication. See Appendix 6 and Sections 215, 220L, and 265B of Exhibit 1 for requirements. In addition, Proposers responses to Section 7.3 will be scored based on the programs offered. Also see A1 of Addendum No. 3.
Q34	Exhibit 1 - Section 115, 15)	15	We can assign a unique system assigned ID number or use a customer assigned ID number for each employee that will be used on the ID card and other member output. If a customer assigned ID number is used, we assign a unique three digit prefix to the customer number (which can be up to nine digits) for a total of a 12 digit ID. Please confirm this is acceptable.
A34			Yes. Contractors may assign their own identifiers for ID cards but must maintain the Department's unique 8-digit participant identification number in their systems, and utilize a crosswalk between the two numbers.
Q35	Exhibit 1 - Section 120	15	Board Authority. Item 1 states the Board may contract directly with providers of Hospital, Medical or ancillary services to provide eligible and enrolled Employees with the BENEFITS. Please clarify the Board’s intent to negotiate

No.	RFP Section	RFP Page	Question / Answer
			direct contracts with providers. Would the BOARD engage the CONTRACTOR prior to negotiating with specific providers?
A35			While the Board has statutory authority to contract with providers, the Board's intent is to partner with and work through its Contractors to meet strategic goals.
Q36	Exhibit 1 - Section 120, 5)	16	Has the Board ever termed a contract due to provisions outlined in this section? If yes, please advise how significant was the loss that prompted the termination.
A36			No.
Q37	Exhibit 1 - Section 120, 9)	17	Clarify intent. Please define "any changes" to the CONTRACTOR's administrative and/or operative systems. Providing notification of minor programming changes related to normal maintenance will be administratively burdensome for all parties.
A37			Changes to administrative and/or operative systems includes substantive changes to any system used to deliver services for the HEALTH BENEFIT PROGRAM. This does not include routine maintenance.
Q38	Exhibit 1 - Section 150, 2)	31	Is the (8)-digit unique member identification number assigned by the DEPARTMENT the same for the employee and all dependents in the family? If it is different for each person within the family is it a completely different number. Please provide some samples of the (8)-digit unique member identification number.
A38			The 8-digit identification number is unique to each participant and may be a completely different number. For example, a newborn added to an existing family contract may have a significantly different identification number.
Q39	Exhibit 1 - Section 150, 5), c)	32	We are a current fully-insured health plan providing uniform benefits and get an Rx claims file from Navitus. Will this file continue? Our assumption is that we will continue to receive this file to meet the requirement for shared accumulators.

No.	RFP Section	RFP Page	Question / Answer
A39			Currently, health plans provide and receive a daily data feed to/from the Department's PBM for determining the benefit deductible and out-of-pocket accumulators. The Contractor will continue to exchange these files, although the process may change after the Department's data warehouse is operational. Details on these data exchanges will be determined during the implementation of any contract(s). Also see item number 11 of Addendum No. 3.
Q40	Exhibit 1 - Section 150, 9)	33	Item 9 states the contractor must not place restrictions on the use of the data provided to the state and local programs. While our organization supports transparency, what protections are put in place by the Department and/or BOARD to ensure information the CONTRACTOR views as proprietary is not shared beyond the intended recipients allowing the CONTRACTOR to protect its interests while accommodating the needs of the Department/BOARD?
A40			Form F of the attachments to the RFP is the Non-Disclosure Agreement (NDA). Both the Department and the Segal Consulting will sign the NDA (as well as the company), which identifies the limits on the use of confidential information both the Department and Segal expect to receive from a Proposer. The NDA also references Wisconsin's Public Records law and the Department's responsibilities if the Department receives a public records request and/or a challenge to the designation of confidential information.
Q41	Exhibit 1 - Section 155A, 2), e)	34	Please clarify statement 2e – "Be accompanied by a brief narrative that describes the content of the report and highlights significant findings of the report." Is this applicable to every report? If not, please specify.
A41			Yes, however, the Department may waive this requirement on certain reports.
Q42	Exhibit 1 - Section 155A, 3)	34	Item 3 states The Department requirements regarding frequency of report submissions may change during the term of the Contract and that the CONTRACTOR has 45 days to comply.

No.	RFP Section	RFP Page	Question / Answer
			Can this be stated as: The CONTRACTOR must comply with **any reasonable** changes within forty-five (45) days.(?)
A42			No, however, the Department may waive this requirement when the Department determines a longer period is necessary.
Q43	Exhibit 1 – Section 155D	35	Please provide clarification on Non-Discrimination Testing requirement. Is the intention the TPA would assist by providing data to support the audit of this requirement? Clarification is needed.
A43			Details of this process will be determined between the Contractors and the Board's consulting actuary during implementation.
Q44	Exhibit 1 - Section 210	43	References to PCP and referral requirements. As stated in Exhibit 1 Page 111 Section 400 Uniform Benefits Definitions for referrals, Referral Requirements are determined by each TPA. If the TPA determines there are no referral requirements (Open Access PPO Network) is section 210 considered mandatory?
A44			Yes, the requirements in Exhibit 1, Section 210, apply. A strong PCP model has been shown to be an effective way to coordinate care. If a Proposer is not willing to agree to those requirements, see Section 2.4 of the RFP regarding submitting assumptions and exceptions in the Proposal.
Q45	Exhibit 1 - Section 230C	52	230C Continuity of Care first paragraph, second sentence is incomplete. It reads The CONTRACTOR certifies that providers listed in the IT'S YOUR CHOICE OPEN ENROLLMENT materials and the provider data submission are either under contract for all of the ensuing benefit period. Is there an "or" statement that should be included in this sentence?
A45			No. However, see item numbers 12 and 13 of Addendum No. 3.
Q46	Exhibit 1 - Section 230C	53	230C Continuity of Care last paragraph indicates that if a provider is removed from the network during a benefit period, they cannot be added back in during the same benefit period unless

No.	RFP Section	RFP Page	Question / Answer
			approved by the Department. Please explain the rationale for this limitation
A46			This provision is to limit changes to the provider network that could result in enrollment changes. For example, removing a specialty facility that cares for high-risk patients might cause those participants to switch to another contractor and could influence the health care performance metrics for that contractor.
Q47	Exhibit 1	60	Approximately how many subscribers utilize the direct pay premium process?
A47			Of the 110,448 total subscribers, 2,199 are direct pay. These are typically retirees or COBRA continuants.
Q48	Exhibit 1 – Section 265A	61	When will the pharmacy vendor be selected? The vendor ultimately selected impacts our data transfer process.
A48			A Request for Proposal to procure a pharmacy benefits manager is in development and vendor selection is expected to occur in May 2017.
Q49	Exhibit 1 - Section 265C	64	We would like additional information on the requirement for how we track information, specifically "the reason for the inquiry (includes a reason code using a code scheme)." We have the ability to track the reason for our interactions as a text reason. Is the requirement that we be able to align to a reason code scheme provided by ETF or is it that we continue to use our current reason code tracking?
A49			At this time, the Department is not specifying the reason codes. Also see item numbers 14 and 15 of Addendum No. 3.
Q50	Exhibit 1 – Section 265C	65	Can the five percent of all participant inquiries being audited each month be audited by contractor auditing staff versus contractor management staff? “[We have]” designated staff to perform these types of audits.
A50			Yes. See item numbers 16 and 17 of Addendum 3.

No.	RFP Section	RFP Page	Question / Answer
Q51	Exhibit 1 – Section 265H	69-70	Paragraph on the top of page 70. Can DETF please explain the requirement? Need clarification.
A51			Yes. See item numbers 18 and 19 of Addendum No. 3.
Q52	Exhibit 1 – Section 315	81	Will it be acceptable to submit performance guarantees that deviate from what is listed in Exhibit – 1, Section 3.15?
A52			The Department will require uniform Performance Standards from all Contractors. If a Proposer is not willing to agree to the Performance Standards and Penalties outlined in Section 155B of Exhibit 1, it should be noted in Tab 3 Assumptions and Exceptions of the Proposal but the Proposal may be rejected. The Proposer may offer additional Performance Standards for the Department's consideration, however, do not include them in Tab 3 of the Proposal. Instead, include such Performance Standards in the most appropriate response to Sections 6 or 7 of the RFP.
Q53	Exhibit 1 – Section 315E, 4)	84	Should the Section reference indicate 155G instead of 155F? Appears to link to the wrong section.
A53			Yes. See item numbers 20 and 21 of Addendum No. 3.
Q54	Exhibit 1 – Section 400	N/A	The State previously indicated that they followed the Pennsylvania benchmark plan for Essential Health Benefits. Is that still accurate for 2018? If so, did the State of Wisconsin make any modifications to Pennsylvania's Essential Health Benefits that we need to be aware of? Having complete and accurate information on Essential Health Benefits for the State of Wisconsin's plans will be important to code our claims system accurately.
A54			The Pennsylvania benchmark plan continues to be the benchmark selected by the Board. Upon review of the 2017 benchmark benefits, no changes are necessary to the Uniform Benefits at this time. The Board will review this again and

No.	RFP Section	RFP Page	Question / Answer
			Uniform Benefits for 2018 will be approved prior to the IYC open enrollment.
Q55	Exhibit 1 – Section 400	130	The question is related to Autism benefits. To comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) that requires parity with financial requirements (dollar limits), as well as with Quantitative Treatment Limitations (such as visit limits) and Non-Quantitative Treatment Limitations (such as Prior Authorization requirements), we need clarification related to the State's Coverage of Treatment for Autism Spectrum Disorders. The wording on page 130 in Exhibit 1, says that "Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for non-intensive level services is not subject to policy exclusions and limitations". How does the State of Wisconsin intend this benefit to be administered? We are concerned that this wording implies that there is a benefit maximum for autism, and/or that the State would require Prior Authorization, for instance, before a participant could be considered for additional autism benefits after the limits listed on page 130 are reached. This seems to conflict with MHPAEA. "[We have]" been advised to remove all prior authorization requirements and benefit limitations related to outpatient autism benefits to comply with MHPAEA.
A55			The program offers autism treatment in accordance with Wis. Stat. §632.895. The Board will review this again and Uniform Benefits for 2018 will be approved prior to the IYC open enrollment.
Q56	Exhibit 4 – 7.0	2	Background check handbook link isn't active. Can DETF of DOA please update? Need active link to review requirements.
A56			The link has been updated. See item numbers 22 and 23 of Addendum No. 3.
Q57	Exhibit 4 – 23.1 & 23.5	8-9	Can DETF please provide clarification as to what's intended by "claim for benefits?" Need clarification.
A57			Section 23.0 and its subsections, concerning indemnification, are part of the Department's standard contract terms and conditions that

No.	RFP Section	RFP Page	Question / Answer
			appear in all Department RFPs. Those provisions were not created or tailored specifically for this RFP. The term “claim for benefits” as it concerns this RFP refers to a claim filed by a Wisconsin Retirement System member for benefits under one of the various programs administered by the Department.
Q58	Exhibit 4	9	Please describe the scope of indemnification required of the Department for claim for benefits. If the Contractor correctly administers an exclusion required by the Department and is sued for doing so, does the Department assume no legal responsibility? Open-ended Contractor liability for correctly administering the Department’s plan is inequitable.
A58			See A57 of Addendum No. 3.
Q59	Appendix 4A & 4B	N/A	Confirm the specific format in which data is to be supplied to data warehouse. 837 HIPAA format or flat file, delimited format?
A59			After the Department procures a data warehouse/business intelligence vendor, the specific format will be determined.
Q60	Appendix 5	2	For HD003, what national plan ID should the Responder use? Data value/ format clarification.
A60			These are proposed specifications. After the Department procures a data warehouse/business intelligence vendor, the details of the file format and data elements will be determined.
Q61	Appendix 5	2	For HD005, should we use 201801? Data value/ format clarification.
A61			See A60 of Addendum No. 3.
Q62	Appendix 5	2	For HD006, should we use 201812? Data value/ format clarification.
A62			See A60 of Addendum No. 3.

No.	RFP Section	RFP Page	Question / Answer
Q63	Appendix 5	2	For HD007, is this the total number of provider records? Data value/ format clarification.
A63			See A60 of Addendum No. 3.
Q64	Appendix 5	2	For PV001, should Submitter equal the Responder's company name? Data value/ format clarification.
A64			See A60 of Addendum No. 3.
Q65	Appendix 5	2	For PV002, what Plan Provider ID should be used? Data value/ format clarification.
A65			See A60 of Addendum No. 3.
Q66	Appendix 5	2	For PV003, is this the TIN for the pay to of the provider? Data value/ format clarification.
A66			See A60 of Addendum No. 3.
Q67	Appendix 5	2	For PV004, is this required since the UPIN is discontinued? Data value/ format clarification.
A67			See A60 of Addendum No. 3.
Q68	Appendix 5	2	For PV022, is this required? Data value/ format clarification.
A68			See A60 of Addendum No. 3.
Q69	Appendix 5	2	For PV026 and PV027, what state and county code source should be used? Data value/ format clarification.
A69			See A60 of Addendum No. 3.
Q70	Appendix 5	2	For PV031, will a separate table be required to match the ID to a description? Data value/ format clarification.

No.	RFP Section	RFP Page	Question / Answer
A70			See A60 of Addendum No. 3.
Q71	Appendix 5	2	For PV032, should this be the description of the provider organization id (PV031)? Data value/ format clarification.
A71			See A60 of Addendum No. 3.
Q72	Appendix 5	2	For the final output, what type of file is required, CSV, TXT - Delimited? Data value/ format clarification.
A72			See A60 of Addendum No. 3.
Q73	Appendix 5	2	For HD002, what Submitter value should the responder use? Data value/ format clarification.
A73			See A60 of Addendum No. 3.
Q74	Appendix 5	3	For PV044, is this required? Data value/ format clarification.
A74			See A60 of Addendum No. 3.
Q75	Appendix 5	3	For PV055, what is needed here and how is it different than provider org? Data value/ format clarification.
A75			See A60 of Addendum No. 3.
Q76	Appendix 5	3	For PV056, based on the description, this field would be filled with the Health Plan phone. Should the unique provider phone number be used instead? Data value/ format clarification.
A76			See A60 of Addendum No. 3.
Q77	Appendix 5	3	For PV057, is delegated in respect to the credentialing? Data value/ format clarification.
A77			See A60 of Addendum No. 3.

No.	RFP Section	RFP Page	Question / Answer
Q78	Appendix 10	N/A	Is the intent for the contractor to provide the appropriate data to the state for completion of premium rates/certification by state actuaries? OR is the intent to have the contractor calculate and certify rates?
A78			The intent is for the Contractor to provide the required information to the Board's consulting actuary as required in Section 130 of Exhibit 1 and assist in rate development.
Q79			Will the experience that is provided be broken out by region, by carrier or will the experience be combined for all carriers offered presently? How soon will the experience be released after the 8/5 date?
A79			Various attachments will have the information summarized by region. The file is a compilation of data from all of ETF's current vendors. Data was released 8/19/2016.
Q80			Concerning the delay in getting the data from Segal for the repricing exercise—mentioned in the General Information section of Addendum 1--we (Proposer) are concerned that that delay could jeopardize our ability to complete the repricing exercise to meet the Sept. 9, 2016 submission deadline. As you know, there are other parts of the RFP that cannot be done before the repricing exercise is complete. During an earlier draft RFP release, a timeline stated Sept. 20, 2016 would be a due date. Given this delay in getting the repricing data from Segal, we recommend a return to the Sept. 20, 2016 due date.
A80			See A19 of Addendum No. 3.
Q81			Do respondents and subcontractors have to fill out the intent to respond and all other related materials for the RFP?
A81			Subcontractors are not required to submit any paperwork during the solicitation process at this time.

This Addendum is available on ETF's Extranet at https://etfonline.wi.gov/etf/internet/RFP/HealthBeneAdminRFP1/index.html.

ADDENDUM No. 3
Request for Proposal (RFP) ETG0003
Administrative Services for the State of Wisconsin Health Benefit Program
Wisconsin Department of Employee Trust Funds

Proposer must acknowledge receipt of the Addendum referenced above by providing the required information below. This form must be signed by an official that is authorized to legally bind the Proposer.

_____

Proposer's Company Name

_____

Authorized Printed Name

_____ _____

Authorized Signature Date