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Date: September 9, 2016  
To: All Proposers  
RE: **ADDENDUM No. 4**  
**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 information from Section 1.4 of the RFP:

Express delivery:

Michael D. McNally, Jr.  
**RFP ETG0003**  
Dept. of Employee Trust Funds  
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2. **ADD** the following information to Section 1.4 of the RFP:

Express delivery:

Jason Barrett  
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3. **REMOVE** the following bullet from Section 2.3 of the RFP under **Proposals submitted via fax or e-mail will not be accepted.**

- Proposal Date: September 9, 2016 2:00 PM CDT.

4. **ADD** the following bullet to Section 2.3 of the RFP under **Proposals submitted via fax or e-mail will not be accepted.**

- Proposal Date: September 19, 2016 2:00 PM CDT.

5. **ADD** the following bullet to Section 2.4 of TAB 1 of the RFP directly following “Provide the following in the following order:”

- ADDENDUM No. 4 Acknowledgement: Remove the back page (Page 20) from Addendum No. 4, complete, and sign.

6. **REMOVE** the following bullet from Section 2.4 of TAB 1 in the RFP:

- FORM G – DOA-3261 Request for Proposal

7. **ADD** the following bullet from Section 2.4 of TAB 1 in the RFP:

- FORM G - DOA-3261 Request for Proposal - Per Addendum No. 4

8. **REMOVE** the last paragraph from Section 8.3.1.

If Proposers are selected as finalists, a validation process of the submitted summary data will be initiated. At that time, the Proposer may be required to submit the entire repricing file along with any requested supporting documentation. Failure to comply will cause the Proposal to be rejected.

9. **ADD** the following paragraph to the end of Section 8.3.1.

If Proposers are selected as finalists, a validation process of the submitted summary data will be initiated. At that time, the Proposer may be required to submit the entire repricing file along with any requested supporting documentation. The validation process will likely occur 2-3 weeks after the Proposal Due Date. Failure to comply will cause the Proposal to be rejected.

10. **REMOVE** the following paragraph from Section 215A, 1) of Exhibit 1.

Written guidelines that providers must follow to comply with the CONTRACTOR’S UR program for Independent Physicians Association (IPA) model HMOs.

11. **ADD** the following paragraph to Section 215A, 1) of Exhibit 1.

Written guidelines that providers must follow to comply with the CONTRACTOR’S UR program.

12. **REMOVE** the following paragraph from Section 220C of Exhibit 1.

The CONTRACTOR must submit to the DEPARTMENT a QUARTERLY report of all claims paid to OUT-OF-NETWORK providers that includes the billed amount and amount paid to the provider in the format specified by the DEPARTMENT.

13. **ADD** the following paragraph to Section 220C of Exhibit 1.

The CONTRACTOR must submit to the DEPARTMENT a QUARTERLY report of all claims (including non-urgent and non-emergent) paid to OUT-OF-NETWORK providers that includes the billed amount and amount paid to the provider in the format specified by the DEPARTMENT.

14. **ADD** the following paragraph before the last paragraph in Section 230C of Exhibit 1.

The CONTRACTOR will assist the PARTICIPANT in selecting a new IN-NETWORK provider or facility and obtaining any necessary referrals and/or authorizations.

15. **REMOVE** the following paragraph from Section 245D of Exhibit 1.

Investigation and resolution of any grievance will be initiated by the CONTRACTOR within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within three (3) DAYS of the CONTRACTOR'S receipt of the grievance.

16. **ADD** the following paragraph to Section 245D of Exhibit 1.

Investigation of any grievance will be initiated by the CONTRACTOR within five (5) BUSINESS DAYS of the date the grievance is filed by the complainant for a timely resolution of the problem. Grievances related to an urgent health concern will be handled within three (3) DAYS of the CONTRACTOR'S receipt of the grievance.

17. **REMOVE** the following paragraph from Section 265D, 1), c) of Exhibit 1.

The web-portal must be available via the three (3) most recent versions of each of the popular browsers available in the market which include Internet Explorer, Mozilla Firefox, Chrome and Safari.

18. **ADD** the following paragraph to Section 265D, 1), c) of Exhibit 1.

The web-portal must be available via the three (3) most recent versions of each of the popular browsers available in the market which include the Microsoft's products Internet Explorer and Edge, Mozilla Firefox, Chrome and Safari. Ongoing adoption and support of future browser versions and other browsers that gain significant market share is required.

19. In response to Q39 below, **REMOVE** exclusions v) through x) from Section 400, IV., A., 11. of Exhibit 1.

v) On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the TPA.

w) EMERGENCIES in the SERVICE AREA when the PRIMARY CARE PROVIDER or another IN-NETWORK PROVIDER cannot be reached.

x) EMERGENCY or URGENT CARE services outside the SERVICE AREA. Non-urgent follow-up care requires PRIOR AUTHORIZATION from the TPA.

20. In response to Q39 below, **ADD** the following sub-bullets under exclusion u) in Section 400, IV., A., 11. of Exhibit 1 and renumber the subsequent bullets y) through ao) to v) through al).

- i. On written REFERRAL by an IN-NETWORK PROVIDER with the prior written authorization of the TPA.
- ii. EMERGENCIES in the SERVICE AREA when the PRIMARY CARE PROVIDER or another IN-NETWORK PROVIDER cannot be reached.
- iii. EMERGENCY or URGENT CARE services outside the SERVICE AREA. Non-urgent follow-up care requires PRIOR AUTHORIZATION from the TPA.

21. **GENERAL INFORMATION** about the RFP:

The FORM G – DOA-3261 Request for Proposal form has been removed and replaced with FORM G - DOA-3261 Request for Proposal - Per Addendum No. 4 form. A Microsoft Word document of FORM G - DOA-3261 Request for Proposal - Per Addendum No. 4 accompanies this addendum.

22. **REMOVE** the following answer from Addendum No. 3:

A57			Section 23.0 and its subsections, concerning indemnification, are part of the Department's standard contract terms and conditions that 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.
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23. **ADD** the following answer to Addendum No. 3:

A57			Section 23.0 and its subsections, concerning indemnification, are part of the Department's standard contract terms and conditions that 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. As concerns the State health benefit program, such claims first go through the health plan's grievance process. If the grievance is denied by the plan, the member has the option of filing an appeal with the Department using the process established by <a href="#">Wis. Admin. Code ETF 11</a> .
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24. **ADD** the following answers to questions submitted by Proposers:

No.	RFP Section	RFP Page	Question / Answer
Q1	2.3	13	The RFP gives instructions for shipping the proposal to a P.O. Box.  Is hand delivering the proposal binders an option? If so, where can they be delivered and when?
A1			Yes, proposals can be delivered to the address indicated in Section 1.4 of the RFP.
Q2	2.3	14	Can proposers deliver RFP to DETF?
A2			See A1 of Addendum No. 4.
Q3	2.3 and 2.4	13-18	Are electronic signatures allowed for the electronic and hard copy submissions? Rationale: To ensure that the submission meets all requirements.
A3			Yes, use of electronic signatures will be acceptable.
Q4	2.4	15	Can proposers separate RFP responses with additional "tabs" (in addition to the three required)? Ease of readability for reviewers.
A4			No, for consistency in reviewing the RFPs, the DEPARTMENT requires that PROPOSALS be submitted as specified in Section 2.1 of the RFP.
Q5	7.2.1	30	If the TPA is to take on fiduciary responsibility, then it will be subject to the standard prohibitions against fiduciary self-dealing. How does the State propose to effectuate pay for performance, capitation or shared-savings programs when those programs necessitate self-dealing on the part of the TPA?  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.
A5			It is common for a TPA to take on fiduciary responsibility for benefit determination, handling of appeals, determining appropriate use of cost management programs such as case management, utilization review, prior authorization, etc., while also operating pay-for-performance programs with

No.	RFP Section	RFP Page	Question / Answer
			<p>contracted providers. The DEPARTMENT recommends that PROPOSERS consult their internal Counsel for clarity regarding self-dealing.</p> <p>The DEPARTMENT considers it best practice to follow ERISA fiduciary standards and Internal Revenue Code (IRC) §4975 requirements. In addition, please be aware that the DEPARTMENT is bound by IRC §503 (b), as reflected in <a href="#">Wis. Admin. Code ETF 10.85</a>.</p>
Q6	7.2.3, 2), b)	31	<p>What percentage are we meant to provide here? Is the question asking what percentage of out-of-network claims we attempted to negotiate compared to only out-of-network claims? Compared to total claims?</p> <p>Clarification around what percentage we are supposed to provide – we need to know what the denominator is to provide a more specific response.</p>
A6			<p>The denominator for this percentage should be out-of-network claims.</p>
Q7	7.6.1 (Addendum 3)		<p>Can the items below be provided to [Proposer] for the MA quote?</p> <ol style="list-style-type: none"> <li>1- A member level census including age, gender, and dob.</li> <li>2- Medical claims for the previous 2 years. It will help if they can be broken by month and include monthly enrollment. The data should be only for the Medicare eligible and dependents.</li> <li>3- A statement clearly specifying what percentage of the premium is paid by the employer.</li> <li>4- If the current plans are COB then we will need to know how claims are coordinated with Medicare. In other words, is it a carve-out or COB.</li> <li>5- For the Part D quote we would like to get Rx detail to include the data items listed below: <ul style="list-style-type: none"> <li>- Subscriber ID/Unique Identifier</li> <li>- Rx Filled Date</li> <li>- NDC</li> <li>- Supply Days (i.e. 15,30,90)</li> <li>- Rx Classification (Generic, Brand, Non-Formulary, Specialty)</li> <li>- Place of Fill (Retail or Mail Order)</li> <li>- Allowed Cost or Gross Drug Cost</li> <li>- Member Pay</li> <li>- Plan Pay</li> <li>- Quantity (actual pill count)</li> <li>- Submitted U&amp;C Cost</li> <li>- NAPB</li> <li>- Compound Indicator or Code</li> </ul> </li> </ol>

No.	RFP Section	RFP Page	Question / Answer
			The RFP asks how the plan is rated. [The Proposer] requires those elements in order to produce a rate. This will be specially relevant to the 2018 rates.
A7			The DEPARTMENT is not asking for a quote for the State's Medicare population. Rather, the DEPARTMENT is asking for a narrative describing how the PROPOSER rates its group Medicare Advantage plans and provide rates from 2015 and 2016.
Q8	8.1 Attachment A	36-37	For a regional bid, should the proposer include repriced claims for counties outside the regions they will designate as "YES" in the Regional designation form?  Clarification
A8			Yes, PROPOSERS should include their entire network.
Q9	8.2 Attachment B		Total eligibility listed in Attachment B for a specific county does not match the eligibility provided in the census file. For example, Attachment B indicates there are 81,950 eligible members in Dane County, but the census has 81,523 eligible. Please confirm you will be using the number of eligible members from the census, not Attachment B? We want to make sure if we show all 81,523 with access (100% access) you don't compare to the 81,950 from Attachment B which will then show only 99% with access.
A9			The correct number of members in Dane county is 81,523. The Attachments posted to the Segal secure workspace represent the most current version of those Attachments. PROPOSERS have been advised of ALL revisions along the way, beginning with the initial notice, 8/17/16. PROPOSERS should ensure they are accessing and completing the most current version downloaded from the Segal secure workspace.
Q10	8.2 Attachment B		For OBGYN and Pediatricians it has us reduce down the number of eligible members based on criteria; such as females 12 and older for OB/GYN and birth through 18 for Pediatrician. The number of eligible for these were not provided in Attachment B. Can you please provide so we can verify we have identified all?

No.	RFP Section	RFP Page	Question / Answer
A10			Wisconsin Non-Medicare Membership: Females > 12 years of age: 90,788 All members, birth through age 18: 52,124
Q11	8.2.1 8.6	38-39 43	Will ETF/Segal be providing a census with the Medicare membership in order to prepare accessibility reports and a claim projection for all members, not just the non-medicare?  In order to report on access for all members a census with the zip codes is required. Also, to account for all members in the claim projection.
A11			No Medicare membership will be provided. Access requirements and claim projection should reflect only the non-Medicare membership.
Q12	8.3.1	39-40	For pricing the claims file, we assume that if a member receives services from one of our network providers within the covered region, the price will be based on in-network pricing. If the member chooses to seek care outside that region, the claim will be priced as out-of-network. The price allowed for a service will, therefore, depend on where the member is located, and that information will not be provided in the claims file to responders. Is this assumption correct? Since the data available to determine pricing will not include the location where the member resides, how should this be handled in the pricing of the claims?
A12			Network pricing should be based on the network status of the provider. If the member received care from a network provider, regardless of the region being proposed, then the member would receive in-network pricing and should be reported that way. The DEPARTMENT anticipates providers that are on the borders of regions to have in-network pricing if those providers are part of the network being proposed.
Q13	8.3.1	39-40	[Our company] utilizes narrow provider networks in certain regions. The price allowed will depend on which narrow network a member chooses within a given region. If a member selecting one network sees an in-network provider from the other network, the claim will be priced as out of network. How should this be handled in the pricing of the claims? Assume all members selected the network affiliated with the provider where they received care, use an estimate for the impact of out of network service utilization, or some other method?

No.	RFP Section	RFP Page	Question / Answer
A13			If the PROPOSER offers more than one network within a region, it should either choose the most appropriate one to offer to HEALTH BENEFIT PROGRAM members, or the multiple networks should be offered in tandem with the member receiving in-network benefits for any provider who has a network contract in place with the PROPOSER – no matter which network that provider is typically associated with. Out-of-network benefits would apply only if utilizing a provider with no applicable network contract in place with the PROPOSER.
Q14	8.3.1	39-40	Can a complete description be provided of how the “Service Units” value in the claims record is derived?
A14			Service Units were reported by each of the State's current plans, according to each plan's method of derivation. It would be based on standard reporting practices and the cost per unit should be determined based on standard actuarial principles. Attachment K lists the value utilized for each service category by line item – either “service units” reported or “claims” count derived.
Q15	8.3.1	39-40	“ProcTypeFlag” in the claims file indicates what type of “ProcCode” is being provided. For situations where the original claim included two or more types of procedures (Revenue Code and HCPCS or CPT, for example), how is it decided which type of code will be reported within the data provided?
A15			Each professional procedure performed should have its own line item in the file. Facility claims may be reported differently and would depend on the information provided by the incumbent plans.
Q16	8.3.1	40	How should plans handle claims in the repricing file that contain invalid procedure codes? Example of invalid procedure codes in claim file: 300000, *deleted, NULL, blank are invalid procedure codes. Offering instructions for all respondents will allow consistency in their data submissions and ensure the data can be more accurately compared.
A16			Such invalid or blank procedure codes comprise an insignificant percentage of billed charges. If there is no valid procedure code or revenue code, indicate the network status of the associated provider/facility

No.	RFP Section	RFP Page	Question / Answer
			and apply the overall discount received by that provider.
Q17	8.3.1	40	If we can verify a provider is under contract, but have invalid procedure code, how should we price? Y for contracted, \$0 for reprice because the procedure is invalid? Offering instructions for all respondents will allow consistency in their data submissions and ensure the data can be more accurately compared.
A17			See A16 of Addendum No. 4.
Q18	8	40	Will a revised claim file be provided which includes the TIN information or will respondents be expected to complete significant data transformation to map NPI to TIN to complete the repricing exercise?  Many carrier's claims processing systems require both NPI and TIN or exclusively TIN to process claims. Typically a claim would be rejected back to the provider if it did not contain this information. A majority of the repricing data file is missing TIN. If a carrier follows claims process logic and therefore does not reprice the claims, it would produce an invalid submission.
A18			There will be no claim file revisions. TIN and NPI data reflect information submitted by incumbent plans. If a PROPOSER'S system requires both TIN and NPI to reprice claims, then yes, it will have additional data work to accommodate the repricing. Most vendors reported having NPI information as sufficient.
Q19	8.4 Attachment I	42-43	Are proposers allowed to indicate a value of "included in total" for categories in Attachment I?  There are categories in Attachment I that are included for all clients and considered part of the base fee as opposed to a la carte pricing.
A19			PROPOSERS should provide as much detail as possible as the BOARD may decide not to include certain services in the final CONTRACT(S). With that being said, yes, PROPOSERS may respond with "included in total" or \$0.00 as the fee, if necessary.
Q20	8.6 Attachment K	43	Can the State verify that the claims data in Attachment K been summarized based on provider county/region which is the basis for the claims

No.	RFP Section	RFP Page	Question / Answer
			<p>repricing file and that the member data in Attachment K has been summarized based on the member county/region member census?</p> <p>Typically, a carrier would not mix claims based on provider location with member information based on member location. Since members often seek care outside of the current region, particularly for certain types of specialty care, the data based on provider location will overstate claims in certain regions and understate claims in other regions.</p>
A20			<p>Yes, in Attachment K, claims data has been summarized based on provider county/region, and membership data has been summarized based on member county/region. Utilization of some providers listed as out-of-state were also re-categorized into a region based on known vendor submission.</p> <p>The DEPARMTENT is aware of potential anomalies but current vendors would not provide crosswalks to the eligibility database. Attachment K provides a reasonable comparison of the group experience in each region. PROPOSERS should do their best to represent anticipated pricing and utilization within their network.</p>
Q21	Attachment C - Column AH		<p>Can you provide us with the total dollar billed amount from the re-pricing file?</p> <p>The file was so large we had to convert it. We want to ensure we didn't miss any data in that conversion.</p>
A21			<p>The control file was loaded to the secure workspace, Monday, 8/22. See file: Attachment C Data Totals_20160822.xlsx.</p>
Q22	Attachment H - Data Specifications		<p>Data Exclusions indicate to exclude "All capitation paid as well as any claim lines and/or encounter data associated with or paid through capitated arrangements." Please verify this means we should be excluding all provider and facility claims currently paid under a capitated arrangement?</p> <p>Need to clarify because a significant number of our provider facility claims are paid under capitation.</p>
A22			<p>Include capitation data by pricing the encounter data equivalent to how the pricing will be under the contracts/networks being proposed. Also see A27 of Addendum No. 4.</p>

No.	RFP Section	RFP Page	Question / Answer
Q23	Attachment H - Data Specifications		Data Exclusions indicate to exclude “Claims paid through custom network arrangements established for specific customers that are not part of the network being offered.” Does this mean we are to exclude claims for providers and facilities that will not be part of the network (region) being offered; such as PPO providers that would not be part the region being offered? Please clarify.  Verify provider and facility claims to exclude.
A23			PROPOSERS should include only those claims associated with the network and contract arrangements that would be offered to the HEALTH BENEFIT PROGRAM membership. PROPOSERS should then summarize by county – this may include providers outside the region(s) being proposed, but within the network being offered. Exclude claims associated with any client-specific customized contract arrangements that do not represent the network that PROPOSERS would be offering to the membership.
Q24	Attachment H - Inpatient		Data is requested for all CMS DRGs. If SNF data does not contain a DRG do we exclude even though the Inpatient instructions specifically say to include it?  Verify claims to include or exclude.
A24			Assuming this references the market pricing, Attachment H, all inpatient data should be included. For those claims without a DRG assignment, provide an all other category with either a blank or "000" as the DRG code.
Q25	Attachment H - Inpatient		Data is requested for all CMS DRG’s. If we don’t have claims experience for all DRGs in 2015 or in all counties in the region, what do we do?  Verify claims to include or exclude.
A25			Assuming this references the market pricing, Attachment H, responses should be based on each PROPOSER’S book-of-business experience. The DEPARTMENT anticipates gaps in some counties, as well as some CPT codes. Segal has analytics to allow appropriate comparisons between networks.
Q26	Attachment H - Inpatient		Data is requested for all CMS DRG’s. We don’t have County of Service information just Facility/Provider IDs and names, what do we do?

No.	RFP Section	RFP Page	Question / Answer
			Verify claims to include or exclude.
A26			Assuming this references the market pricing, Attachment H, the PROPOSER should have the provider specific information. PROPOSERS could also use the NPI mapping on the repricing data that is from the WHIO database. If this references the repricing files, most providers have a map to appropriate county. There are a small percentage (0.03%) of the claims with only provider names and IDs and are listed as out-of-state. These were included for completeness of the information submitted from incumbent vendors. This will have no impact on the evaluation and should be priced out-of-network.
Q27	Attachment H - Inpatient		Data is requested for all CMS DRG's. If Facility/Provider was capitated in 2015 and is now FFS in 2016, how do we handle since the data request specifically says to use 2015 data and to exclude capitated services?  Verify claims to include or exclude.
A27			PROPOSERS are encouraged to include these providers and services in the analysis. If possible, PROPOSERS should provide a level of reimbursement equivalent to that being proposed for 2016, particularly if the providers represent a significant component of the proposed network. Also see A22 of Addendum No. 4.
Q28	Exhibit 1 - Section 135A, 2), a) Section 305, 3)	24 74	"The CONTRACTOR must submit to the DEPARTMENT on the twentieth (20th) DAY of each calendar month"  The 20th of the month in which billing is based on or the month prior?
A28			Invoices are due on the 20th day in each calendar month based on enrollment for the first day of the same month.
Q29	Exhibit 1 - Section 155G	37-38	Is the intent for the CONTRACTOR to notify within one business day of confirmation of a breach?  Clarification of language intent.
A29			Section 155G requires notification within one business day of discovering that protected health information (PHI) or personal identifiable information

No.	RFP Section	RFP Page	Question / Answer
			(PII) may have been breached, or has been breached.
Q30	Exhibit 1 - Section 215A, 1)	44	<p>Please provide exactly which IPA standards are being referred to in this item:</p> <p>Examples of the minimum UR procedures that CONTRACTORS shall have in place include the following:</p> <p>1) Written guidelines that providers must follow to comply with the CONTRACTOR'S UR program for Independent Physicians Association (IPA) model HMOs.</p> <p>To determine exactly which IPA standards are being referred to so we can confirm this requirement.</p>
A30			Section 215A, 1) of Exhibit 1 has been modified to remove the IPA reference. See item numbers 10) and 11) of Addendum No. 4.
Q31	Exhibit 1 - Section 245D	56	<p>We request clarification of this provision. It indicates that "investigation and resolution of any grievance will be initiated by the CONTRACTOR within five (5) business days of the date the grievance is filed..." Does this mean we must begin the investigation within 5 business days of receipt or is the Department expecting us to resolve the grievance within the 5 business day timeframe? Grievances frequently require us to request medical records from providers, which a 5 business day timeframe will not allow for time to actually receive the records from the providers and obtain a medical opinion if we must complete the grievance process within 5 business days.</p> <p>Clarification of contract language</p>
A31			Section 245D of Exhibit 1 has been clarified to specify the investigation for non-urgent grievances must be initiated within five business days. See item numbers 15) and 16) of Addendum No. 4.
Q32	Exhibit 1 - Section 265C	67	<p>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.</p> <p>Would it be acceptable for us to maintain our current practice of auditing 2 percent of calls? We would like maintain consistency in our auditing practices.</p>

No.	RFP Section	RFP Page	Question / Answer
A32			No. If a Proposer is not willing to agree to this requirement to audit at least 5% of inquiries, it should be noted in Tab 3 Assumptions and Exceptions of the Proposal.
Q33	Exhibit 1 - Section 265D, 6)	69-70	Please clarify what is meant by (perhaps with an example).  Secure upload functionality for submitting program required documentation;  We want to know what the upload functionality is before
A33			The DEPARTMENT does not currently require web-portals in its contract with health plans. In the AGREEMENT, web-portals are required. An example of program required documentation that may require secure upload functionality includes documentation for disabled dependent status.
Q34	Exhibit 1 - Section 265D, 6)	69-70	Please clarify what is meant by (perhaps with an example).  Incentive payment status, if applicable (e.g., pending, issued, etc.)  We need definition of what is an Incentive payment? Is this in relationship to some type of wellness program?
A34			An incentive payment may include any DEPARTMENT authorized financial payment to encourage certain participant behavior. Most wellness and disease management incentives will be handled by the DEPARTMENT'S wellness and disease management vendor.
Q35	Exhibit 1 - Section 315 Introduction	81	The CONTRACTOR must track performance using a template provided by the Department.  Can we see a copy of the template the State will use? Depending on the template, audit time could be longer.
A35			The template is not yet available. The DEPARTMENT will solicit feedback from the CONTRACTOR(S) in developing the template to be used.

No.	RFP Section	RFP Page	Question / Answer
Q36	Exhibit 1 - Section 315 Introduction	81	<p>Contractor must notify prior to deadline if not going to meet a standard.</p> <p>How far in advance? Do we need to report at the point of discovery?</p>
A36			<p>Notification to the DEPARTMENT shall occur upon realization that a standard will not be met.</p>
Q37	Exhibit 1 Section 400 II.	113	<p>We request clarification of the definition of Usual and Customary Charge. This section indicates that TPA approved referrals or prior authorizations to out of network providers are not subject to Usual and Customary Charges. Are these types of claims to be priced using billed charges? What provision in the Uniform Benefits describes how TPA should price these types of claims?</p> <p>We request clarification of the hold harmless requirement set forth in the definition of Usual and Customary Charge. This section indicates that TPA must hold PARTICIPANT harmless for balance billing by OUT-OF-NETWORK PROVIDERS who render EMERGENCY or urgent care services. How does Department want TPA to administer the hold harmless requirements set forth in this section? Can TPA negotiate a mutually acceptable rate with the provider? Can the TPA decide to process the claim at billed charges?</p> <p>Clarification of contract language</p>
A37			<p>The CONTRACTOR is expected to negotiate reimbursement with OUT-OF-NETWORK providers when approving referrals and prior authorizations.</p> <p>The RFP is seeking information in 7.2.3 about the PROPOSER'S reimbursement methodology for OUT-OF-NETWORK providers.</p> <p>Yes, the CONTRACTOR can negotiate a mutually acceptable rate. The CONTRACTOR can process the claim at billed charges following a meaningful attempt to negotiate an acceptable rate. The DEPARTMENT will monitor payments for all OUT-OF-NETWORK claims as specified in Section 220C of Exhibit 1. See item numbers 12) and 13) of Addendum No. 4.</p>
Q38	Exhibit 1 - Section 400 III., C., 6.	130	<p>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</p>

No.	RFP Section	RFP Page	Question / Answer
			<p>level services is not subject to policy exclusions and limitations”</p> <p>Previous question (Q55 in addendum) was answered, “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.”</p> <p>Is the State subject to the federal MHPAEA? If so, changes to that autism benefit would be needed.</p>
A38			<p>Yes, Uniform Benefits is subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA).</p>
Q39	Exhibit 1 - Section 400 IV., A., 11., u)	141	<p>We request clarification of exclusions v) through y). These appear to be subcategories to u) rather than stand-alone exclusions. Is that correct?</p> <p>Clarification of contract language</p>
A39			<p>Items v) through x) should be subcategories to u). See item numbers 19) and 20) of Addendum No. 4.</p>
Q40	Exhibit 4 - Sections 23.1 and 23.5	8-9	<p>The Department confirmed that reference to “claim for benefits” within Sections 23.1 and 23.5 means a claim filed by a WRS member for benefits under a Department program. Proposer is not clear as to how this definition applies to Services required by the RFP. Terms, as written, require the Proposer to indemnify the Department for all benefit payments. It is unclear how this term works in a self-funded environment because such terms (i) transform services proposed by the RFP to a fully-insured model and (ii) do not consider that the Department, GIB or IRO retain authority to make final claims/benefit determinations. Does the Department intend that indemnification obligations in these Sections extend only to “claims for benefits” related to a negligent act or omission of Proposer? Does the Department intend to exclude indemnification responsibilities when the Department, GIB or IRO confirms the Proposer’s determination? Terms and Conditions language regarding indemnification appears to conflict with the self-funded model. Proposer shouldn’t indemnify the Department if the Department, GIB or IRO confirms the Proposer’s determination regarding a “claim for benefits.” Indemnification responsibilities should apply only in the event of Proposer’s negligent acts or omissions.</p>

No.	RFP Section	RFP Page	Question / Answer
A40			<p>The DEPARTMENT does not intend that the indemnification sections apply only to a negligent act or omission of the CONTRACTOR.</p> <p>If damages, losses and/or expenses arise from a claim for benefits under the HEALTH BENEFIT PROGRAM, the CONTRACTOR shall indemnify, defend and hold the DEPARTMENT and BOARD harmless. The DEPARTMENT envisions the appeals process established by <a href="#">Wis. Adm. Code ETF 11</a>, and explained in Section 245 of Exhibit 1, as operating in the same manner with the same responsibilities as exists currently with the State of Wisconsin Group Health Insurance Program.</p>
Q41	Form G (DOA-3261)		Form G that is dated with a due date of 9/9 (the original RFP due date) okay to sign even though new RFP due date is 9/19? If not, will we be receiving updated form with new due date?
A41			Form G has been updated with the revised proposal due date. A revised Form G labeled <i>FORM G - DOA-3261 Request for Proposal - Per Addendum No. 4</i> will be issued with Addendum No. 4.
Q42	Form H - Affirmative Action		<p>What type of Affirmative Action Information will the contractor need to submit to the State?</p> <p>Understand the Affirmative Action obligations.</p>
A42			<p>Visit <a href="http://doa.wi.gov/Default.aspx?Page=e7e4ac94-bfb6-4fb0-a07c-6b6cb0190657">http://doa.wi.gov/Default.aspx?Page=e7e4ac94-bfb6-4fb0-a07c-6b6cb0190657</a> for more information.</p>
Q43	Form H - Affirmative Action		<p>Does the State provide a form or specify a required format for the Affirmative Action Information?</p> <p>Understand the Affirmative Action obligations.</p>
A43			See A42 of Addendum No. 4.
Q44	General		<p>Are we able to add policy information as appendices to the Official Responses Document?</p> <p>For purposes of explaining our responses, we would like to include supplemental documents.</p>
A44			Supplemental substantive information will be considered if the information is clearly labeled to reference the section of the response. Also see

No.	RFP Section	RFP Page	Question / Answer
			Section 2.4 of the RFP, page 14, regarding promotional materials.

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

**ADDENDUM No. 4**  
**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.

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Proposer's Company Name

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Authorized Printed Name

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Authorized Signature

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Date