Missouri Consolidated Health Care Plan
Responses to Vendor Questions
2025 Group Medicare Advantage PPO RFP
March 19, 2024

These responses are provided by MCHCP to questions received from potential bidders for the 2025 Group Medicare Advantage PPO RFP.

	Question	Response
1	For the MA Only and MA-PD Price Proposal Worksheet, how will the fully insured premiums be scored? For example, will a lower guaranteed one-year rate for 2025 with no or limited caveats receive a greater score than a multi-year rate guarantee that contains caveats due to the potential uncertainty with regards to Medicare Advantage funding changes in future years? Or how will a lower one year rate be scored against an offer that has a higher year one rate but offers not to exceed rates for a future year(s)?	As stated on Page 12 of the Introduction/Instructions document, *In determining pricing points, MCHCP will consider the potential five-year cost of the contract including the full not-to-exceed premiums for Years 2-5 of the contract. The contractor shall understand that annual renewal premiums for subsequent years of the contract will be negotiated, but must be within the not-to-exceed premiums submitted within this bid. All renewal options are at the sole option of the MCHCP Board of Trustees. Renewal prices are due by May 15 of each year and are subject to negotiation.*
2	Under fully insured arrangements, offerors are considered the covered entity, rather than a Business Associate. Please confirm your intent to include the BAA into the contract.	As we are also a health plan under HIPAA, we prefer to maintain a BAA in order to cover any information we may be giving our contractor. Any changes you would like to include in the BAA to reflect this unique arrangement should be highlighted in your bid.
3	Exhibit B, Section B2.2.2 states "The contractor shall not regard a member as terminated until the contractor receives an official termination notice directly from MCHCP". MA carriers must accept and process termination requests directly from CMS for compliance reasons. Please advise if accepting termination directly from CMS is permissible.	There are two sources of eligibility under this contract - MCHCP eligibility and Medicare eligibility. For those instances that are governed by MCHCP eligibility, then MCHCP has sole authority regarding eligibility. Medicare eligibility is governed by CMS. Should the contractor receive notice of Medicare eligibility termination from CMS, then the contractor must notify MCHCP immediately of the notice and act in accordance with CMS regulations in regard to termination requests from CMS.
4	Please provide detail around the potential site visits that would take place in early May. What type of facilities or activities would MCHCP like to see?	MCHCP has not made a determination that a site visit is needed at this time. However, should one be necessary we would more than likely want to see member services or clinical management activities.
5	Do the 2023 monthly risk scores on the MCHCP Financial Summary file include a final settlement assumption?	No. 2023 risk scores do not include final settlement.
6	Do the monthly claims on the MCHCP Financial Summary include sequestration?	Yes, monthly claims include sequestration.
7	On the MCHCP Financial Summary file it states that claims exclude additional rider costs. What services are included under additional rider costs?	Claims provided are inclusive of ancillary benefits.
8	Are the Rx risk scores available for 2023 and 2024?	The January 2024 Rx risk score was 0.81 and the February 2024 Rx risk score was 0.80.
9	Are there any Part B only members on the census? If so, how many members?	No.
10	Regarding Exhibit B, Section B9.1.4, please confirm it is acceptable for the carrier to provide electronic enrollment reporting via secure email or through other secure channels on a recurring basis.	MCHCP will work with the carreir to ensure that enrollment reporting is transmitted to MCHCP and/or to the contractor securely.

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11	We noted the Intent to Bid states "The bidder must demonstrate the ability to operate a fully insured group MA/MAPD plan for at least three organizations with 10,000 or more retirees", while the Introduction/Instructions document lists the above with 15,000 retirees. Please clarify.	The minimum bidder threshhold is three organizations with at least 15,000 retirees.
12	We noted the Intent to Bid states the proposal due date is April 2, but the Introduction/Instructions document states the due date is April 8. Please clarify.	MCHCP has granted more time for bidders to prepare their proposals. Proposals are due at 5 p.m. CT, Monday, April 8, 2024.
13	Please confirm if bidders may furnish a Surety Bond to satisfy the Performance Bond requirement.	Confirmed.
14	Per the Introduction/Instructions doument, no stipulations regarding participation are permitted in tandem with the provided quote. Is this same restriction in place for the current carrier? If not, is there a material difference in membership expected to come as a result of this new stipulation?	This provision was stipulated in the RFP issued in 2018.
15	Please confirm the MBE/WBE recommended targets should be calculated based on the admin portion of the premium.	Confirmed.
16	Please confirm if Exhibit A-2 should be used to list all redlines to the BAA, Exhibit C, and Scope of Work. Are you requesting redlined drafts of all contract documents?	You may provide redlined drafts of the exhibits noted but be sure to include that you have redlined those exhibits on Exhibit A-2 along with an explanation of why the redlines are necessary.
17	Generally under a fully-insured arrangement, the Carrier is considered the covered entity, rather than a Business Associate and therefore the BAA is not applicable to the fully insured offering. Please confirm whether a BAA is required.	As we are also a health plan under HIPAA, we prefer to maintain a BAA in order to cover any information we may be giving our contractor. Any changes you would like to include in the BAA to reflect this unique arrangement should be highlighted in your bid.
18	Regarding Exhibit B, Section B8.3, please describe what MCHCP has in place today concerning this. What is MCHCP's vision for this service and the carrier staff that would be required?	This will be provided by the contractor. MCHCP expects the contractor to provide the enrolled member advocates to help them navigate through their health care needs. We expect that the contractor may have unique and differing methods of achieving these goals and, therefore, choose not to prescribe how they propose to address this requirement.
19	Regarding Question 9.3 and 23.1 of the questionnaire, may carriers use the same references for both of these sections (allow overlap) rather than providing eight unique references?	Yes, the same references can be used in responding to both questions.
20	Regarding Question 15.21, please confirm if MCHCP is requesting a custom formulary. If so, can a full current formulary (in excel format) be provided for the purposes of creating and matching?	MCHCP is not requesting a custom formulary at this time, but if, during the contract period, we determine we would need to have customization, we are asking if there will be a charge to doing so,

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21	Regarding Question 15.21, is MCHCP open to carriers offering a standard open formulary (utilized for large group MA) as an alternative to the current formulary?	MCHCP is open to a carrier's standard formulary but we will have to understand the impact to our members and to ensure that drugs that MCHCP includes as part of a non-standard list can still be maintiained.
22	Regarding Question 24.6 relating to approval of written communications and marketing materials, please confirm communications required by CMS will be excluded due to CMS required timeframes and content.	CMS required content will not be subject to MCHCP approval.
23	Regarding Question 24.18 relating to standard reporting, will MCHCP accept quarterly Performance Guarantee reporting within 45 days following the reporting quarter's end, to allow time for audits to be performed and verified?	Yes.
24	Please provide the most current Summary Plan Document containing the Medicare benefits available to retirees. If the Summary Plan Document is not available, please provide a summary of these benefits with as much detail as possible.	Please see attached.
25	Regarding the MCHCP EGWP Rx text file, should items with “Formulary_Flag: N” or “PRC_TIER_CD: 0” be considered currently covered? If yes, can a current cost share be confirmed for those with “PRC_TIER_CD: 0”.	The formulary flag on the MCHCP EGWP Rx text file should be ignored. Use PRC_TIER_CD for cost share determination. Cost sharing determination of PRC_TIER_CD value of 0 (zero) is provided on the MCHCP EGWP Rx File Layout under “Tier Structure” tab starting at row 8.
26	If included, please list any Non-Part D drugs or lifestyle drugs covered on the current Part D plan?	Please refer to the formulary that was provided in the data files provided by Segal.
27	Please provide the monthly Medical and Pharmacy rates for 2022, 2023 and 2024.	2022 Medical: $0 Rx: $212 2023 Medical: $0 Rx: $214 2024 Medical: $0 Rx: $235
28	Please indicate whether retirees are allowed to come back on the plan if they have previously opted out of the employer sponsored plan.	Once a retiree terminates coverage, s/he may not re-enroll.
29	Please provide current Part D risk score. Please note the month or time period of the risk and if it includes mid-year or final payments. Also, please provide the most recent available MMR (monthly membership report).	The January 2024 Rx risk score was 0.81 and the February 2024 Rx risk score was 0.80.

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30	Please indicate if claims are on a “paid through” or incurred basis. If claims are reflective of incurred dates, indicate the “paid through” dates.	Claims are on an incurred basis.
31	Please provide the estimated CMS revenue corresponding to the provided claims period.	Monthly summary RAF was provided in lieu of CMS revenue.
32	Were the actual paid final CMS adjustments/payments included in the Risk Scores provided?	Confirmed.
33	Have any additional adjustments been made to the risk score data provided such that they would not reflect the paid risk scores as of the date the data was provided? If so, please describe and quantify those adjustments in detail.	No additional adjustments have been made.
34	Regarding all termination clauses, please confirm that MCHCP will provide carrier with notice at least 30 days in advance of a termination effective date to ensure Carrier can fulfill CMS required member notice of at least 21 days in advance if the member’s plan is terminating. (§50.7, Chapter 2, Medicare Managed Care Manual).	MCHCP will comply with all federal laws and if a change in the language of our termination clauses is needed in order to reflect this, please submit the changes on Exhibit A-2.
35	Regarding Exhibit B, Section B14.2, please provide more information regarding the use and functionality of the Optavise Vendor Manager product to be used to report Performance Guarantees.	The functionality of the Optavise vendor manager product is very similar to the procurement module being used for this RFP.
36	Regarding Exhibit B, Section B14.2, please confirm delays and/or errors in reporting, mutually agreed to be caused by the Optavise Vendor Manager product, will not be subject to penalties.	Contractors self-report most performance guarantees through the Optavise vendor manager product. Any delays and/or errors caused by the Optavise solution is extremely rare.
37	Please confirm carriers are able to ask additional follow-up questions based on answers to these questions.	Additional questions are allowed and will be answered as time permits.

Summary of Benefits 2024

UnitedHealthcare® Group Medicare Advantage (PPO)
Group Name (Plan Sponsor): Missouri Consolidated Health Care Plan
Group Number: 13768
H2001-817-000

Look inside to learn more about the plan and the health services it covers.
Call Customer Service or go online for more information about the plan.

Toll-free **1-844-884-1848**, TTY **711**
8 a.m.-8 p.m. local time, Monday-Friday

retiree.uhc.com/mchcp

United Healthcare®
Group Medicare Advantage

Y0066_SB_H2001_817_000_2024_M

Summary of Benefits

January 1, 2024 - December 31, 2024

This is a summary of what we cover and what you pay. Review the Evidence of Coverage (EOC) for a complete list of covered services, limitations and exclusions. You can call Customer Service if you want a copy of the EOC or need help. When you enroll in the plan, you will get more information on how to view your plan details online.

UnitedHealthcare® Group Medicare Advantage (PPO)

Medical premium, deductible and limits	
	In-network and out-of-network
Monthly plan premium	Contact Missouri Consolidated Health Care Plan to determine your actual premium amount.
Annual medical deductible	Your plan has an annual combined in-network and out-of-network medical deductible of $300 each plan year.
Maximum out-of-pocket amount	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $1,500 for this plan year. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the plan year. Please note that you will still need to pay your monthly premiums.

Medical benefits		
		In-network and out-of-network
Inpatient hospital care[1]		$150 copay per stay
		Our plan covers an unlimited number of days for an inpatient hospital stay.
Outpatient hospital[1] Cost sharing for additional plan covered services will apply.	Ambulatory surgical center (ASC)	$100 copay
	Outpatient surgery	$100 copay
	Outpatient hospital services, including observation	$100 copay
Doctor visits	Primary care provider	$15 copay
	Virtual doctor visits	$0 copay
	Specialists[1]	$30 copay
Preventive services	Routine physical	$0 copay; 1 per plan year*
	Medicare-covered	$0 copay

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Annual wellness visit
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screening
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- Diabetes screenings and monitoring
- Diabetes – Self-Management training
- Dialysis training
- Glaucoma screening
- Hepatitis C screening
- HIV screening
- Kidney disease education
- Lung cancer with low dose computed tomography (LDCT) screening
- Medical nutrition therapy services

Medical benefits		
		In-network and out-of-network
		▯ Medicare Diabetes Prevention Program (MDPP) ▯ Obesity screenings and counseling ▯ Prostate cancer screenings (PSA) ▯ Sexually transmitted infections screenings and counseling ▯ Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) ▯ Vaccines, including those for the flu, Hepatitis B, pneumonia, or COVID-19 ▯ "Welcome to Medicare" preventive visit (one-time) Any additional preventive services approved by Medicare during the contract year will be covered. This plan covers preventive care screenings and annual physical exams at 100%.
Emergency care		$100 copay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the emergency care copay. See the "Inpatient Hospital Care" section of this booklet for other costs.
Urgently needed services		$50 copay (worldwide) If you are admitted to the hospital within 24 hours, you pay the inpatient hospital cost sharing instead of the urgently needed services copay. See the "Inpatient Hospital Care" section of this booklet for other costs.
Diagnostic tests, lab and radiology services, and X-rays	Diagnostic radiology services (e.g. MRI, CT scan)[1]	$30 copay
	Lab services[1]	$0 copay
	Diagnostic tests and procedures[1]	$25 copay
	Therapeutic radiology[1]	$30 copay
	Outpatient X-rays[1]	$25 copay

Medical benefits		
		In-network and out-of-network
Hearing services	Exam to diagnose and treat hearing and balance issues[1]	$0 copay
	Routine hearing exam	$0 copay, 1 exam per plan year*
	Hearing Aids UnitedHealthcare Hearing	Through UnitedHealthcare Hearing, the plan pays a $5,000 allowance for hearing aids (combined for both ears) every 2 years. Hearing aid coverage under this plan is only available through UnitedHealthcare Hearing. Hearing aids purchased outside of UnitedHealthcare Hearing's nationwide network are not covered.
Vision services	Exam to diagnose and treat diseases and conditions of the eye[1]	$30 copay
	Eyewear after cataract surgery	$0 copay
	Routine eye exam	$0 copay, 1 exam every 12 months*
Mental Health	Inpatient visit[1]	$150 copay per stay, up to 190 days
		Our plan covers 190 days for an inpatient hospital stay.
	Outpatient group therapy visit[1]	$30 copay
	Outpatient individual therapy visit[1]	$30 copay
	Virtual behavioral visits	$30 copay
Skilled nursing facility (SNF)[1]		$0 copay per day: days 1-100
		Our plan covers up to 100 days in a SNF per benefit period.

Medical benefits		
		In-network and out-of-network
Outpatient Rehabilitation (physical, occupational, or speech/language therapy)[1]		$30 copay
Ambulance[2]		$100 copay
Medicare Part B Drugs Part B drugs may be subject to Step Therapy. See your Evidence of Coverage for details.	Chemotherapy drugs[1]	20% coinsurance
	Other Part B drugs[1]	20% coinsurance after you meet your deductible

Additional benefits		
		In-network and out-of-network
Acupuncture services	Medicare-covered acupuncture (for chronic low back pain)	$20 copay
Chiropractic services	Medicare-covered chiropractic care (manual manipulation of the spine to correct subluxation)[1]	$20 copay
	Routine chiropractic services	$0 copay, for each visit per plan year*
Diabetes management	Diabetes monitoring supplies[1]	$0 copay We only cover Accu-Chek® and OneTouch® brands. Covered glucose monitors include: OneTouch Verio Flex®, OneTouch Verio Reflect®, OneTouch® Verio, OneTouch® Ultra 2, Accu-Chek® Guide Me, and Accu-Chek® Guide. Test strips: OneTouch Verio®, OneTouch Ultra®, Accu-Chek® Guide, Accu-Chek® Aviva Plus, and Accu-Chek® SmartView. Other brands are not covered by your plan.
	Medicare covered Continuous Glucose Monitors (CGMs) and supplies[1]	$0 copay
	Diabetes self-management training	$0 copay
	Therapeutic shoes or inserts[1]	20% coinsurance

Additional benefits		
		In-network and out-of-network
Durable Medical Equipment (DME) and Related Supplies	Durable Medical Equipment (e.g., wheelchairs, oxygen)[1]	20% coinsurance
	Prosthetics (e.g., braces, artificial limbs)[1]	20% coinsurance
Fitness program Renew Active® by UnitedHealthcare		$0 copay for Renew Active® by UnitedHealthcare, the gold standard in Medicare fitness programs for body and mind. It includes a free gym membership at a fitness location you select from our nationwide network, online classes, content about brain health and fun social activities. Visit UHCRenewActive.com to learn more today. Once you become a member you will need a confirmation code. Log in to your plan website, go to Health & Wellness and select Renew Active or call the number on your UnitedHealthcare member ID card to obtain your code.
Foot care (podiatry services)	Foot exams and treatment[1]	$30 copay
	Routine foot care	$0 copay, 6 visits per plan year*

Additional benefits		
		In-network and out-of-network
UnitedHealthcare Healthy at Home		$0 copay for the following benefits for up to 30 days after each inpatient and SNF discharge: □ 28 home-delivered meals* □ 12 one-way trips to medically related appointments and the pharmacy* □ 6 hours of non-medical personal care services - a professional caregiver can help with preparing meals, companionship, medication reminders, and more. No referral required. Call the customer service number on your UnitedHealthcare member ID card for more information and to use your benefits. *Call Customer Service to request a referral for each discharge. Some restrictions and limitations may apply.
Home health care[1]		$0 copay
Hospice		You pay nothing for hospice care from any Medicare-approved hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered by Original Medicare, outside of our plan.
Personal emergency response system (PERS) Lifeline		$0 copay for a personal emergency response system. Help is only a button press away. A PERS wearable device can quickly connect you to the help you need, 24 hours a day in any situation. Call or go online to order your device. 1-855-595-8485, TTY 711 or lifeline.com/uhcgroup
24/7 Nurse Support		Receive access to nurse consultations and additional clinical resources at no additional cost.
Opioid treatment program services[1]		$0 copay
Outpatient substance abuse	Outpatient group therapy visit[1]	$30 copay
	Outpatient individual therapy visit[1]	$30 copay

Additional benefits	
	In-network and out-of-network
Rally Coach™ Programs	$0 copay for Rally Coach™ programs: Real Appeal® Weight Management, Real Appeal Diabetes Prevention, Wellness Coaching and a tobacco cessation program. Call or go online to get started today. rallyhealth.com/retiree • Real Appeal 1-844-924-7325, TTY 711 • Rally Wellness Coaching 1-800-478-1057, TTY 711 • Tobacco Cessation 1-866-784-8454, TTY 711 *Refer to your Evidence of Coverage for eligibility requirements
Renal Dialysis[1]	$0 copay

[1] Some of the network benefits listed may require your provider to obtain prior authorization. You never need approval in advance for plan covered services from out-of-network providers. Please refer to the Evidence of Coverage for a complete list of services that may require prior authorization.
[2] Authorization is required for non-emergency Medicare-covered ambulance ground and air transportation. Emergency ambulance does not require authorization.

*Benefits are combined in and out-of-network

About this plan

UnitedHealthcare® Group Medicare Advantage (PPO) is a Medicare Advantage PPO plan with a Medicare contract.

To join this plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area as listed below, be a United States citizen or lawfully present in the United States, and meet the eligibility requirements of Missouri Consolidated Health Care Plan.

Our service area includes the 50 United States, the District of Columbia and all US territories.

About providers

UnitedHealthcare® Group Medicare Advantage (PPO) has a network of doctors, hospitals, and other providers. You can see any provider (in or out-of-network) at the same cost share, as long as they accept the plan and have not opted out of or been excluded or precluded from the Medicare Program. Hearing aids are only covered when you get them through our network hearing provider, UnitedHealthcare Hearing.

You can go to **retiree.uhc.com/mchcp** to search for a network provider using the online directory.

Required Information

UnitedHealthcare® Group Medicare Advantage (PPO) is insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Plans may offer supplemental benefits in addition to Part C benefits.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

UnitedHealthcare does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

UnitedHealthcare provides free services to help you communicate with us such as documents in other languages, Braille, large print, audio, or you can ask for an interpreter. For more information, please call Customer Service at the number on your member ID card or the front of your plan booklet.

UnitedHealthcare ofrece servicios gratuitos para ayudarle a que se comunique con nosotros. Por ejemplo, documentos en otros idiomas, braille, en letra grande o en audio. O bien, usted puede pedir un intérprete. Para obtener más información, llame a Servicio al Cliente al número que se encuentra en su tarjeta de ID de miembro o en la portada de la guía de su plan.

This information is available for free in other languages. Please call our Customer Service number located on the first page of this book.

Benefits, features and/or devices vary by plan/area. Limitations and exclusions may apply.

The provider network may change at any time. You will receive notice when necessary.

You must continue to pay your Medicare Part B premium.

Out-of-network/non-contracted providers are under no obligation to treat UnitedHealthcare members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

24/7 Nurse Support should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for informational purposes only. The nurses cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. Access to this service is subject to terms of use.

Participation in the Renew Active® program is voluntary. Consult your doctor prior to beginning an exercise program or making changes to your lifestyle or health care routine. Renew Active includes standard fitness membership and other offerings. Fitness membership, equipment, classes, personalized fitness plans, caregiver access and events may vary by location. Certain services, classes, events and online fitness offerings are provided by affiliates of UnitedHealthcare Insurance Company or other third parties not affiliated with UnitedHealthcare. Participation in these third-party services are subject to your acceptance of their respective terms and policies. AARP® Staying Sharp is the registered trademark of AARP. UnitedHealthcare is not responsible for the services or information provided by third parties. The information provided through these services is for informational purposes only and is not a substitute for the advice of a doctor. The Renew Active program varies by plan/area. Access to gym and fitness location network may vary by location and plan.