Missouri Consolidated Health Care Plan
832 Weathered Rock Court
PO Box 104355
Jefferson City, MO 65110
Phone: 800-701-8881
www.mchcp.org

Judith Muck, *Executive Director*

my health. my choice. myMCHCP

March 28, 2018

TO: **Invited Vendors**

FROM: **Judith Muck, Executive Director**

RE: **Request for Proposal for Group Medicare Advantage Plan**

Missouri Consolidated Health Care Plan (MCHCP) will be working with DirectPath, an online request for proposal (RFP) system, in the marketing of the 2019 MCHCP Group Medicare Advantage Plan RFP for a January 1, 2019 effective date. You are invited to submit a proposal for these services. We believe that you will find this RFP a great potential opportunity for your organization.

MCHCP is the employee health benefit program for most State of Missouri employees, retirees and their families. This contract provides for a fully-insured Group Medicare Advantage Plan on a national basis to Medicare primary eligible members of MCHCP.

Current Medicare primary eligible plan enrollment is over 15,000 lives. These members are currently enrolled in one of the self-insured PPO plans offered by MCHCP. Prescription drugs are provided through an Employer Group Waiver Plan (EGWP) Prescription Drug Plan (PDP) and are not included as part of this RFP.

The term of the contract will be one year with an additional five (5) one-year renewal options available at the sole option of the MCHCP Board of Trustees. Bidders are required to provide guaranteed pricing for the plan year beginning January 1, 2019, with not-to-exceed pricing for plan years beginning January 1 of 2020 and 2021. Pricing for plan years beginning January 1 of 2022, 2023 and 2024 will be negotiated.

Minimum Bidder Requirements

To be considered for contract award, bidders must meet the following minimum requirements:

- The contractor must be licensed as necessary to do business in the State of Missouri in order to perform the duties described in this RFP, and be in good standing with the office of the Missouri Secretary of State and the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP). The contractor must be approved by the Centers for Medicare and Medicaid Services (CMS) to offer a Group Medicare Advantage plan in the State of Missouri and nationwide. MCHCP requires the contractor to comply with all state and federal laws, rules and regulations affecting their conduct of business.

- Contractors must be flexible and demonstrate the ability to administer benefits determined by MCHCP. This includes the ability to offer multiple plan designs at MCHCP's option.

- Bidders shall agree to provide claim-level data and capitation information electronically to MCHCP or designated data vendor on a monthly basis, including twelve (12) run-out months (i.e.

months following contract expiration). Bidders may be required to demonstrate the ability to provide such data before a contract award is made.

- Bidders shall not link nor attempt to link (unless permitted by this RFP), the award of this contract to any other bids, products or contracts. Any bid proposal containing any contingency based upon MCHCP's actual or potential awards of contracts, whether or not related specifically to this RFP, or containing pricing contingencies, shall result in such bid proposal being rejected for non-responsiveness and non-compliance with this RFP.

- Bidders shall not be permitted to alter their rate or any other aspect of the proposal submission after submission except with negotiation and agreement by MCHCP.

- Timely Submission – All deadlines outlined are necessary to meet the timeline for this contract award. Submissions after respective deadlines have passed may be rejected. All bidder documents and complete proposals must be received by the proposal deadline of April 26, 2018, as outlined in the timeline of events for this RFP. Late proposals will not be accepted. MCHCP reserves the right to modify a deadline or extend a deadline for all bidders at its discretion.

- Performance Bond - The contractor must furnish an original performance security deposit in the form of check, cash, bank draft, or irrevocable letter of credit, issued by a bank or financial institution authorized to do business in Missouri, to MCHCP within ten (10) days after award of the contract and prior to performance of service under the contract. The performance security deposit must be made payable to MCHCP in the amount of $2,000,000. The contract number and contract period must be specified on the performance security deposit. In the event MCHCP exercises an option to renew the contract for an additional period, the contractor shall maintain the validity and enforcement of the security deposit for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal, not to exceed $2,000,000.

Intent to Bid

Once the RFP is released, bidders who are interested in submitting a proposal should complete the Intent to Bid (available as a response document within the DirectPath system). The Intent to Bid is due at 4 p.m. CT, Friday, April 13, 2018.

Use of DirectPath

During this RFP process you will find DirectPath's internet-based application offers an opportunity to streamline information exchange. We are confident your organization will find the process straight forward and user-friendly. DirectPath will be contacting you within the next two to three days to establish a contact person from your organization and to set up a training session, if necessary. To assist you in preparing for the online proposal process, we have outlined below some important information about this event.

General Instructions

Your proposal will be submitted over the Internet, through an anonymous online bidding process. DirectPath will assign a unique user name, which will allow you to view the information pertinent to the bidding process, submit response documents, communicate directly with MCHCP through the application's messaging component, and respond to our online questionnaires. In addition, DirectPath will provide a user guide with instructions for setting up your account.

You may wish to have other people in your organization access this online event to assist in the completion of the RFP. Each member of your response team must secure a unique username and password from DirectPath by way of a provider contact spreadsheet, e-mailed directly to you by DirectPath. There is no cost to use the DirectPath system.

System Training

DirectPath offers all participants of a DirectPath-hosted event access to their downloadable *User Guides* and *Pre-Recorded Training Sessions*. These guides are located on the homepage of the *vendor-user* view and provide an overview of the application's functionality. We recommend that you and your response team take advantage of this unique opportunity in order to realize the full benefit of the application. In addition to this self-help option, DirectPath's experienced support personnel will offer an application overview via a web-cast session.

DirectPath support is also available Monday through Friday from 8 a.m. to 6 p.m. ET to help with any technical or navigation issues that may arise. The toll-free number for DirectPath is 800-979-9351. Support can also be reached by e-mail at support@directpathhealth.com.

Key Event Information

Online RFP Released	Monday, April 9, 2018 8 a.m. CT (9 a.m. ET)
Intent to Bid Due	Friday, April 13, 2018 4 p.m. CT (5 p.m. ET)
Bidder Question Submission Deadline	Friday, April 13, 2018 4 p.m. CT (5 p.m. ET)
MCHCP Responses to Submitted Questions	Wednesday, April 18, 2018 4 p.m. CT (5 p.m. ET)
All Questionnaires and Pricing due	Thursday, April 26, 2018 4 p.m. CT (5 p.m. ET)

If this notice should have been sent to a different individual within your organization, please contact Tammy Flaugher at 573-526-4922 or by email at tammy.flaugher@mchcp.org.

We look forward to working with you throughout this process.

Exhibit A-1

Intent to Bid – 2019 MCHCP Group Medicare Advantage RFP

(Signing this form does not mandate that a vendor must bid)

Please complete this form following the steps listed below:

1) Fill this form out electronically and sign it with your electronic signature.

2) Upload the completed document to the Response Documents area of the RFP no later than Friday, April 13, 2018 at 4 p.m. CT (5 p.m. ET).

Minimum Bidder Requirements

To be considered for contract award, bidders must meet the following minimum requirements:

- The bidder must be licensed as necessary to do business in the State of Missouri in order to perform the duties described in this RFP, and be in good standing with the office of the Missouri Secretary of State and the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP).
- The bidder must be approved by the Centers for Medicare and Medicaid Services (CMS) to offer a Group Medicare Advantage plan in the State of Missouri and nationwide and have earned a minimum of three stars for plan quality and performance for a minimum of three years.
- The bidder must demonstrate the ability to operate a fully insured group Medicare Advantage plan for at least three organizations with 10,000 or more retirees.
- Bidders must be flexible and demonstrate the ability to administer benefits determined by MCHCP. This includes the ability to offer multiple plan designs at MCHCP's option.
- Bidders shall agree to provide claim-level data and capitation information electronically to MCHCP or designated data vendor on a monthly basis, including twelve (12) run-out months (i.e. months following contract expiration). Bidders may be required to demonstrate the ability to provide such data before a contract award is made.
- Bidders shall not link nor attempt to link (unless permitted by this RFP), the award of this contract to any other bids, products or contracts. The bidder may not impose participation requirement. Any bid proposal containing any participation requirements or contingency based upon MCHCP's actual or potential awards of contracts, whether or not related specifically to this RFP, or containing pricing contingencies, shall result in such bid proposal being rejected for non-responsiveness and non-compliance with this RFP.
- Bidders shall not be permitted to alter their rate or any other aspect of the proposal submission after submission except with negotiation and agreement by MCHCP.

- Timely Submission – All deadlines outlined are necessary to meet the timeline for this contract award. Submissions after respective deadlines have passed may be rejected. All bidder documents and complete proposals must be received by the proposal deadline of April 26, 2018, as outlined in the timeline of events for this RFP. Late proposals will not be accepted. MCHCP reserves the right to modify a deadline or extend a deadline for all bidders at its discretion.

- Performance Bond - The contractor must furnish an original performance security deposit in the form of check, cash, bank draft, or irrevocable letter of credit, issued by a bank or financial institution authorized to do business in Missouri, to MCHCP within ten (10) days after award of the contract and prior to performance of service under the contract. The performance security deposit must be made payable to MCHCP in the amount of $2,000,000. The contract number and contract period must be specified on the performance security deposit. In the event MCHCP exercises an option to renew the contract for an additional period, the contractor shall maintain the validity and enforcement of the security deposit for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal, not to exceed $2,000,000.

This form will serve as confirmation that our organization has received the 2019 MCHCP Group Medicare Advantage RFP.

☐ We intend to submit a complete proposal.

☐ We decline to submit a proposal for the following reason(s):

Name of Organization

Signature of Plan Representative

Title of Plan Representative

Date

EXHIBIT A-2
LIMITED DATA USE AGREEMENT

In order to secure data that resides with Missouri Consolidated Health Care Plan (MCHCP) and in order to ensure the integrity, security, and confidentiality of information maintained by MCHCP, and to permit appropriate disclosure and use of such data as permitted by law, MCHCP and _____enter into this Agreement to comply with the following specific paragraphs.

1. This Agreement is by and between MCHCP, a covered entity under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and_____, hereinafter referred to as "User".

2. This Agreement addresses the conditions under which MCHCP will disclose and the User will obtain and use MCHCP's file(s) specified in this agreement. This Agreement supersedes any and all agreements between the parties with respect to the use of MCHCP's file(s), and preempts and overrides any instructions, directions, agreements, or other understanding in or pertaining to any prior communication from MCHCP with respect to the data specified herein. Further, the terms of this Agreement can be changed only by a written modification to this Agreement, or by the parties adopting a new agreement. The parties agree further that instructions or interpretations issued to the User concerning this Agreement or the data specified herein, shall not be valid unless issued in writing by MCHCP's Executive Director.

3. Unless otherwise expressly stated in this Agreement, all words, terms, specifications, and requirements used or referenced in this Agreement which are defined in the HIPAA Rules shall have the same meanings as described in the HIPAA Rules. Any reference in this Agreement to a section in the HIPAA Rules means the section as in effect or amended. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

4. The parties mutually agree that MCHCP retains all ownership rights to the demographic file referred to in this Agreement, and that the User does not obtain any right, title, or interest in any of the data furnished by MCHCP.

5. The parties mutually agree that the following named individual is designated as "Custodian" of the file on behalf of the User, and will be personally responsible for the observance of all conditions of use and for establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use. The User agrees to notify MCHCP within five (5) days of any change of custodianship. The parties mutually agree that MCHCP may disapprove the appointment of a custodian, or may require the appointment of a new custodian at any time.

   Name of Custodian:
   Name of Company:
   Street Address:
   City, State and Zip Code:
   Phone Number w/ Area Code:
   E-mail Address:

6. The User represents and warrants, and in furnishing the claims file(s), MCHCP relies upon such representation and warranty, that these files will be used solely for the purposes outlined below. The User agrees not to use or further disclose the data covered by this Agreement other than as provided for by this Agreement. The parties agree that no provision of this Agreement permits the User to use or disclose protected health information (PHI) in a manner that would violate

HIPAA if used or disclosed in like manner by MCHCP. MCHCP's claims files are used solely for the following:

- Modeling of potential claim volume for purposes of bidding on a fully insured contract with MCHCP for a group Medicare Advantage plan; and/or
- Network analysis and evaluation of proposed network's geographic accessibility to MCHCP for Medicare Advantage benefits; and/or
- Underwriting and premium rating for purposes of bidding on an insured contract with MCHCP for a group Medicare Advantage plan.

The User represents and warrants further that the User shall not disclose, release, reveal, show, sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement to any person(s) other than as allowed by this Agreement. The User agrees that, within the User organization, access to the data covered by this Agreement shall be limited to the minimum number of individuals necessary to achieve the purpose stated in this section and to those individuals on a need-to-know basis only. The User agrees to ensure that any individual(s) or agent(s) the User discloses or allows to access the data covered by this Agreement will be bound to the same restrictions and conditions that apply to the User. Disclosure of this data is made pursuant to 45 CFR §§ 164.514(e)(1) and (g).

7. MCHCP will provide the User with the files, which is a subset of MCHCP's master records. MCHCP warrants that the file is accurate to the extent possible.

8. The parties mutually agree that the aforesaid file (and/or any derivative file(s) [includes any file that maintains or continues identification of individuals]) may be retained by the User only for the period of time required for any processing related to the purposes outlined in section 5 above. After the bidding process is complete, the User agrees to promptly destroy such data. The User agrees that no data from MCHCP records, or any parts thereof, shall be retained when the aforementioned file(s) are destroyed unless authorization in writing for the retention of such file(s) has been received from MCHCP's Executive Director. The User acknowledges that stringent adherence to the aforementioned information outlined in this paragraph is required. The User further acknowledges that MCHCP's demographic file received for any previous periods, and all copies thereof, must be destroyed upon receipt of an updated version. The User agrees that for any data covered by this Agreement, in any form, that the User maintains after the bidding process is complete, the User agrees to: (i) refrain from any further use or disclosure of the PHI; (ii) continue to safeguard the PHI thereafter in accordance with the terms of this Agreement; and (iii) not attempt to de-identify the PHI.

9. The User agrees to establish appropriate administrative, technical, and physical safeguards to protect the privacy and security of the data, and to prevent any unauthorized use or disclosure. The safeguards shall provide a level and scope of security that is not less than the level and scope of security established by HIPAA. The User acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable, including protected health information, or deducible information derived from the file(s) specified above in section 6 is strictly prohibited. Further, the User agrees that the data must not be physically moved or transmitted in any way from the site indicated above in section 4, without written approval from MCHCP.

10. The User agrees that the authorized representatives of MCHCP and the Department of Health and Human Services ("HHS") will be granted access to the premises where the aforesaid file(s) are kept for the purpose of inspecting security arrangements and confirming whether the User is in compliance with the privacy and security requirements specified in this Agreement.

11. The User agrees that no findings, listing, or information derived from the file(s) specified in section 6, with or without identifiers, may be released if such findings, listing, or information contain any combination of data elements that might allow the deduction of a MCHCP member's identification (Examples of such data elements include, but are not limited to, address, zip code, sex, age, , etc.) The User agrees further that MCHCP shall be the sole judge as to whether any finding, listing, or information, or any combination of data extracted or derived from MCHCP's files identifies or reasonably could identify an individual or to deduce the identity of an individual.

12. The User agrees that the User shall make no attempt to link records included in the file(s) specified in section 6 to any other identifiable source of information or attempt to identify the information or individual(s) contained in the data. This includes attempts to link to other MCHCP data files. In addition, the User agrees not to contact the individual(s) who are the subject of the data covered by this Agreement.

13. The User understands and agrees that it may not reuse original or derivative data file(s) without prior written approval from MCHCP's Executive Director.

14. The User agrees to immediately report to MCHCP any use or disclosure of PHI not authorized or provided for by this Agreement in accordance with the notice provisions prescribed in this Section 14.

    14.1 The notice shall be delivered to, and confirmed received by, MCHCP without unreasonable delay, but in any event no later than three (3) business days of the User's first discovery, meaning the first day on which such unauthorized use or disclosure is known to the User, or by exercising reasonable diligence, would have been known to the User, of the unauthorized use or disclosure.

    14.2 The notice shall be in writing and shall include a complete description of the unauthorized use or disclosure, and if applicable, a list of affected individuals and a copy of the template breach notification letter to be sent to affected individuals.

15. The User agrees that in the event MCHCP determines or has a reasonable belief that the User has made or may have used or disclosed the aforesaid file(s) that is not authorized by this Agreement, or other written authorization from MCHCP's Executive Director, MCHCP in its sole discretion may require the User to: (a) promptly investigate and report to MCHCP the User's determinations regarding any alleged or actual unauthorized use or disclosure, (b) promptly resolve any problems identified by the investigation; (c) if requested by MCHCP, submit a formal written response to an allegation of unauthorized use or disclosure; (d) if requested by MCHCP, submit a corrective action plan with steps designed to prevent any future unauthorized uses or disclosures; and (e) if requested by MCHCP, destroy or return data files to MCHCP immediately. The User understands that as a result of MCHCP's determination or reasonable belief that unauthorized uses or disclosures have taken place, MCHCP may refuse to release further MCHCP data to the User for a period of time to be determined by MCHCP. Further, the User agrees that MCHCP may report the problem to the Secretary of HHS.

16. The User agrees to assume all costs and responsibilities associated with any breach, as defined in the HIPAA breach notification provisions, of any protected health information obtained from MCHCP's demographic file caused by the User organization. Such costs and responsibilities include: determining if and when a breach has occurred, however, all final decisions involving questions of a breach shall be made by MCHCP; investigating the circumstances surrounding any possible incident of breach; providing on behalf of MCHCP all notifications legally

required of a covered entity in accordance with HIPAA breach notification laws and regulations; paying for the reasonable and actual costs associated with such notifications; The User further agrees to indemnify and hold MCHCP harmless from any and all penalties or damages associated with any breach caused by the User organization.

17. The User hereby acknowledges the criminal and civil penalties for violations under HIPAA. If User is a covered entity under HIPAA, its receipt of MCHCP's limited data set and violation of this data use agreement may cause the User to be in noncompliance with the standards, implementation specifications, and requirements of 45 CFR § 164.514 (e).

18. By signing this Agreement, the User agrees to abide by all provisions set out in this Agreement for protection of the data file specified in section 6, and acknowledges having received notice of potential criminal and civil penalties for violation of the terms of the Agreement.

19. On behalf of the User, the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein. This Agreement shall be effective upon signature by both parties. The duration of this Agreement is one year from the effective date. The User also acknowledges that this Agreement may be terminated at any time with the consent of both parties involved. Either party may independently terminate the Agreement upon written request to the other party, in which case the termination shall be effective 60 days after the date of the notice, or at a later date specified in the notice.

_____
(Name/Title of Individual)

_____
(State Agency/Organization)

_____
(Street Address)

_____
(City/State/ZIP Code)

_____
(Phone Number Including Area Code)

_____
(E-mail Address)

Signature _____ Date

20. On behalf of MCHCP, the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

_____ _____
Judith Muck, Executive Director Date
Missouri Consolidated Health Care Plan

EXHIBIT A-3
BIDDER'S PROPOSED MODIFICATIONS TO THE RFP
2019 MCHCP GROUP MEDICARE ADVANTAGE RFP

The bidder must utilize this document to clearly identify by subsection number any exceptions to the provisions of the Request for Proposal (RFP) and include an explanation as to why the bidder cannot comply with the specific provision. Any desired modifications should be kept as succinct and brief as possible. **Failure to confirm acceptance of the mandatory contract provisions will result in the bidder being eliminated from further consideration as its proposal will be considered non-compliant.**

Any modification proposed shall be deemed accepted as a modification of the RFP if and only if this proposed modification exhibit is countersigned by an authorized MCHCP representative on or before the effective date of the contract awarded under this RFP.

_____
Name/Title of Individual

_____
Organization

_____
Signature

_____
Date

On behalf of MCHCP, the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

_____
Executive Director Date
Missouri Consolidated Health Care Plan

Exhibit A-4

Confirmation Document

2019 MCHCP Group Medicare Advantage RFP

Please complete this form following the steps listed below:

1) Confirm that you have read and understand all of MCHCP's instructions included in the DirectPath application.

   ☐ Yes

   ☐ No

2) Bidders are required to submit a firm, fixed price for CY2019 and not-to-exceed prices for CY2020 and CY2021. Prices will be subject to best and final offer which may result from subsequent negotiation. Pricing for 2022, 2023 and 2024 will be negotiated. You are advised to review all proposal submission requirements stated in the original RFP and in any amendments, thereto. Confirm that you hereby agree to provide the services and/or items at the prices quoted, pursuant to the requirements of the RFP, including any and all RFP amendments.

   ☐ Yes

   ☐ No

3) Completion of the signature block below constitutes your company's acceptance of all terms and conditions of the original RFP plus any and all RFP amendments, and confirmation that all information include in this response is truthful and accurate to the best of your knowledge. You also hereby expressly affirm that you have the requisite authority to execute this Agreement on behalf of the Vendor and to bind such respective party to the terms and conditions set forth herein.

_____

Name/Title of Individual

_____

Organization

_____

Signature

_____

Date

EXHIBIT A-5

CONTRACTOR CERTIFICATION
OF COMPLIANCE WITH FEDERAL EMPLOYMENT LAWS
2019 MCHCP GROUP MEDICARE ADVANTAGE RFP

_____ (hereafter referred to as "Contractor") hereby certifies that all of Contractor's employees and its subcontractors' employees assigned to perform services for Missouri Consolidated Health Care Plan ("MCHCP") and/or its members are eligible to work in the United States in accordance with federal law.

Contractor acknowledges that MCHCP is entitled to receive all requested information, records, books, forms, and any other documentation ("requested data") in order to determine if Contractor is in compliance with federal law concerning eligibility to work in the United States and to verify the accuracy of such requested data. Contractor further agrees to fully cooperate with MCHCP in its audit of such subject matter.

Contractor also hereby acknowledges that MCHCP may declare Contractor has breached its Contract if MCHCP has reasonable cause to believe that Contractor or its subcontractors knowingly employed individuals not eligible to work in the United States. MCHCP may then lawfully and immediately terminate its Contract with Contractor without any penalty to MCHCP and may suspend or debar Contractor from doing any further business with MCHCP.

THE UNDERSIGNED PERSON REPRESENTS AND WARRANTS THAT HE/SHE IS DULY AUTHORIZED TO SIGN THIS DOCUMENT AND BIND THE CONTRACTOR TO SUCH CERTIFICATION.

_____

Name/Title of Individual

_____

Organization

_____

Signature

_____

Date

Exhibit A-6

Documentation of Intent to Participate
2019 MCHCP Group Medicare Advantage RFP

If the bidder is proposing to include the participation of a Minority Business Enterprise/Women Business Enterprise (MBE/WBE) in the provision of the products/services required in the RFP, the bidder must either provide a recently dated letter of intent, signed and dated no earlier than the RFP issuance date, from each organization documenting the following information, or complete and provide this Exhibit with the bidder's proposal.

~ Copy This Form For Each Organization Proposed ~

Bidder Name: _____

This Section To Be Completed by Participating Organization:

By completing and signing this form, the undersigned hereby confirms the intent of the named participating organization to provide the products/services identified herein for the bidder identified above.

Name of Organization: (Name of MBE, WBE)			
Contact Name:		Email:	
Address:		Phone #:	
City:		Fax #:	
State/Zip:		Certification #	
Type of Organization (MBE or WBE):		Certification Expiration Date:	(or attach copy of certification)

PRODUCTS/SERVICES PARTICIPATING ORGANIZATION AGREED TO PROVIDE

Describe the products/services you *(as the participating organization)* have agreed to provide:

_____

_____

_____

_____

Authorized Signature:

_____ _____

Authorized Signature of Participating Organization (MBE, WBE)

Date (Dated no earlier than the RFP issuance date)

EXHIBIT A-7
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") between the Missouri Consolidated Health Care Plan (hereinafter "Covered Entity" or "MCHCP") and Medicare Advantage Company. (hereinafter "Business Associate") is entered into as a result of the business relationship between the parties in connection with services requested and performed in accordance with the 2019 Group Medicare Advantage RFP ("RFP") and under Contract *#19-MA-01*, as renewed and amended, (hereinafter the "Contract").

This Agreement supersedes all other agreements, including any previous business associate agreements, between the parties with respect to the specific matters addressed herein. In the event the terms of this Agreement are contrary to or inconsistent with any provisions of the Contract or any other agreements between the parties, this Agreement shall prevail, subject in all respects to the Health Insurance Portability and Accountability Act of 1996, as amended (the "Act"), and the HIPAA Rules, as defined in Section 2.1 below.

1 **Purpose**.

The Contract is for Medicare Advantage Insurance.

The purpose of this Agreement is to comply with requirements of the Act and the implementing regulations enacted under the Act, 45 CFR Parts 160 - 164, as amended, to the extent such laws relate to the obligations of business associates, and to the extent such laws relate to obligations of MCHCP in connection with services performed by Medicare Advantage Company for or on behalf of MCHCP under the Contract. This Agreement is required to allow the parties to lawfully perform their respective duties and maintain the business relationship described in the Contract.

2 **Definitions**.

2.1 For purposes of this Agreement:

"Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and in reference to this Agreement, shall mean Medicare Advantage Company.

"Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and in reference to this Agreement, shall mean MCHCP.

"HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules set forth in 45 CFR Parts 160 and 164, as amended.

2.2 Unless otherwise expressly stated in this Agreement, all words, terms, specifications, and requirements used or referenced in this Agreement which are defined in the HIPAA Rules shall have the same meanings as described in the HIPAA Rules, including but not limited to: breach; data aggregation; designated record set; disclose or disclosure; electronic media; electronic protected health information ("ePHI"); family member; genetic information; health care; health information; health care operations; individual; individually identifiable health information; marketing; minimum necessary; notice of privacy practices; person; protected health information ("PHI"); required by law; Secretary; security incident; standard; subcontractor; transaction; unsecured PHI; use; violation or violate; and workforce.

2.3 To the extent a term is defined in the Contract and this Agreement, the definition in this Agreement, subject in all material respects to the HIPAA Rules, shall govern.

2.4 Notwithstanding the forgoing, for ease of reference throughout this Agreement, Business Associate understands and agrees that wherever PHI is referenced in this Agreement, it shall be deemed to include all MCHCP-related PHI in any format or media including paper, recordings, electronic media, emails, and all forms of MCHCP-related ePHI in any data state, be it data in motion, data at rest, data in use, or otherwise.

3 **Obligations and Activities of Business Associate**.

3.1 Business Associate agrees to not use or disclose PHI other than as permitted or required by this Agreement or as required by law.

3.2 Appropriate Safeguards. Business Associate agrees to implement, maintain, and use appropriate administrative, physical, and technical safeguards, and fully comply with all applicable standards, implementation specifications, and requirements of Subpart C of 45 CFR Part 164 with respect to ePHI, in order to: (i) ensure the confidentiality, integrity, and availability of ePHI created, received, maintained, or transmitted; (ii) protect against any reasonably anticipated threats or hazards to the security or integrity of such information; and (iii) protect against use or disclosure of ePHI by Business Associate, its workforce, and its subcontractors other than as provided for by this Agreement.

3.3 Subcontractors. Pursuant to §§ 164.308(b)(2) and 164.502(e)(1)(ii), Business Associate agrees it will not permit any subcontractors to create, receive, access, use, maintain, disclose, or transmit PHI in connection with, on behalf of, or under the direction of Business Associate in connection with performing its duties and obligations under the Contract unless and until Business Associate obtains satisfactory assurances in the form of a written contract or written agreement in accordance with §§ 164.504(e) and 164.314(a)(2) that the subcontractor(s) will appropriately safeguard PHI and in all respects comply with the same restrictions, conditions, and requirements applicable to Business Associate under the HIPAA Rules and this Agreement with respect to such information.

In addition to the forgoing, and in accordance with the Contract, Business Associate agrees it will not permit any subcontractor, or use any off-shore entity, to perform services under the Contract, including creation, use, storage, or transmission of PHI at any location(s) outside of the United States.

3.4 Reports to MCHCP. Business Associate agrees to report any use or disclosure of PHI not authorized or provided for by this Agreement, including breaches of unsecured PHI and any security incident involving MCHCP to MCHCP in accordance with the notice provisions prescribed in this Section 3.4. For purposes of the security incident reporting requirement, the term "security incident" shall not include inconsequential incidents that occur on a daily basis, such as scans, "pings," or other unsuccessful attempts to penetrate computer networks or servers containing ePHI maintained or transmitted by Business Associate.

3.4.1 The notice shall be delivered to, and confirmed received by, MCHCP without unreasonable delay, but in any event no later than three (3) business days of Business Associate's first discovery, as discovery is described under § 164.410, of the unauthorized use or disclosure, breach of unsecured PHI, or security incident.

3.4.2 The notice shall be in writing and sent to both of the following MCHCP workforce members and deemed delivered only upon personal confirmation, acknowledgement or receipt in any form, verbal or written, from one of the designated recipients:

- MCHCP's Privacy Officer → currently, Jennifer Stilabower, (573) 522-3242, Jennifer.Stilabower@mchcp.org, 832 Weathered Rock Court, Jefferson City, MO 65101

- MCHCP's Security Officer → currently, Bruce Lowe, (573) 526-3114, Bruce.Lowe@mchcp.org, 832 Weathered Rock Court, Jefferson City, MO 65101

If, and only if, Business Associate receives an email or voicemail response indicating neither of the intended MCHCP recipients are available and no designee(s) confirm receipt within eight (8) business hours on behalf of one or both of the above-named MCHCP Officers, Business Associate shall forward the written notice to their primary MCHCP contact with copies to the Privacy and Security Officers for documentation purposes.

3.4.3 The notice shall include to the fullest extent possible:

a) a detailed description of what happened, including the date, time, and all facts and circumstances surrounding the unauthorized use or disclosure, breach of unsecured PHI, or security incident;

b) the date, time, and circumstances surrounding when and how Business Associate first became aware of the unauthorized use or disclosure, breach of unsecured PHI, or security incident;

c) identification of each individual whose PHI has been, or is reasonably believed by Business Associate to have been involved or otherwise subject to possible breach;

d) a description of all types of PHI known or potentially believed to be involved or affected;

e) identification of any and all unauthorized person(s) who had access to or used the PHI or to whom an unauthorized disclosure was made;

f) all decisions and steps Business Associate has taken to date to investigate, assess risk, and mitigate harm to MCHCP and all potentially affected individuals;

g) contact information, including name, position or title, phone number, email address, and physical work location of the individual(s) designated by Business Associate to act as MCHCP's primary contact for purposes of the notice triggering event(s);

h) all corrective action steps Business Associate has taken or shall take to prevent future similar uses, disclosures, breaches, or incidents;

i) if all investigatory, assessment, mitigation, or corrective action steps are not complete as of the date of the notice, Business Associate's best estimated timeframes for completing each planned but unfinished action step; and

j) any action steps Business Associate believes affected or potentially affected individuals should take to protect themselves from potential harm resulting from the matter.

3.4.4 Business Associate agrees to cooperate with MCHCP during the course of Business Associate's investigation and risk assessment and to promptly and regularly update MCHCP in writing as supplemental information becomes available relating to any of the items addressed in the notice.

3.4.5 Business Associate further agrees to provide additional information upon and as reasonably requested by MCHCP; and to take any additional steps MCHCP reasonably deems necessary or advisable to comply with MCHCP's obligations as a covered entity under the HIPAA Rules.

3.4.6 Business Associate expressly acknowledges the presumption of breach with respect to any unauthorized acquisition, access, use, or disclosure of PHI, unless Business Associate is able to demonstrate otherwise in accordance with § 164.402(2), in which case, Business Associate agrees to fully document its assessment and all factors considered and provide MCHCP no later than ten (10) calendar days following Business Associate's discovery with its complete written risk assessment, conclusion reached, and all documentation supporting a conclusion that the unauthorized acquisition, access, use, or disclosure of PHI presents a low probability that PHI has been compromised.

3.4.7 The parties agree to work together in good faith, making every reasonable effort to reach consensus regarding whether a particular circumstance constitutes a breach or otherwise warrants notification, publication, or reporting to any affected individual, government body, or the public and also the appropriate means and content of any notification, publication, or report. Notwithstanding the foregoing, all final decisions involving questions of breach of PHI shall be made by MCHCP, including whether a breach has occurred, and any notification, publication, or public reporting required or reasonably advisable under the HIPAA Rules and MCHCP's Notice of Privacy Practices based on all objective and verifiable information provided to MCHCP by Business Associate under this Section 3.4

3.4.8 Business Associate agrees to bear all reasonable and actual costs associated with any notifications, publications, or public reports relating to breaches by Business Associate, any subcontractor of Business Associate, and any employee or workforce member of Business Associate and/or its subcontractors, as MCHCP deems necessary or advisable.

3.5 Confidential Communications. Business Associate agrees it will promptly implement and honor individual requests to receive PHI by alternative means or at an alternative location provided such request has been directed to and approved by MCHCP in accordance with § 164.522(b) applicable to covered entities. If Business Associate receives a request for confidential communications directly from an individual, Business Associate agrees to refer the individual, and promptly forward the individual's request, to MCHCP so that MCHCP can assess, accommodate, and coordinate reasonable requests of this nature in accordance with the HIPAA Rules and prepare a timely response to the individual.

3.6 Individual Access to PHI. If an individual requests access to PHI under § 164.524, Business Associate agrees it will make all PHI about the individual which Business Associate created or received for or from MCHCP that is in Business Associate's custody or control available in a designated record set to

MCHCP or, at MCHCP's direction, to the requesting individual or his or her authorized designee, in order to satisfy MCHCP's obligations as follows:

3.6.1 If Business Associate receives a request for individual PHI in a designated record set from MCHCP, Business Associate will provide the requested information to MCHCP within five (5) business days from the date of the request in a readily accessible and readable form and manner or as otherwise reasonably specified in the request.

3.6.2 If Business Associate receives a request for PHI in a designated record set directly from an individual current or former MCHCP member, Business Associate will require that the request be made in writing and will also promptly notify MCHCP that a request has been made verbally. If the individual submits a written request for PHI in a designated record set directly to Business Associate, no later than five (5) business days thereafter, Business Associate shall provide MCHCP with: (i) a copy of the individual's request to MCHCP for purposes of determining an appropriate response to the request; (ii) the designated record sets in Business Associate's custody or control that are subject to access by the requesting individual(s) requested in the form and format requested by the individual if it is readily producible in such form and format, or if not, in a readable hard copy form; and (iii) the titles of the persons or offices responsible for receiving and processing requests for access by individual(s). MCHCP will direct Business Associate in writing within five (5) business days following receipt of the information described in (i), (ii), and (iii) of this subsection 3.6.2 whether Business Associate should send the requested designated data set directly to the individual or whether MCHCP will forward the information received from Business Associate as part of a coordinated response or if for any reason MCHCP deems the response should be sent from MCHCP or another Business Associate acting on behalf of MCHCP. If Business Associate is directed by MCHCP to respond directly to the individual, Business Associate agrees to provide the designated record set requested in the form and format requested by the individual if it is readily producible in such form and format; or, if not, in a readable hard copy form or such other form and format as agreed to by Business Associate and the individual. Business Associate will provide MCHCP's Privacy Officer with a copy of all responses sent to individuals pursuant to § 164.524 and the directives set forth in this subsection 3.6.2 for MCHCP's compliance and documentation purposes.

3.7 Amendments of PHI. Business Associate agrees it will make any amendment(s) to PHI in a designated record set as directed or agreed to by MCHCP pursuant to § 164.526, and take other measures as necessary and reasonably requested by MCHCP to satisfy MCHCP's obligations under § 164.526.

3.7.1 If Business Associate receives a request directly from an individual to amend PHI created by Business Associate, received from MCHCP, or otherwise within the custody or control of Business Associate at the time of the request, Business Associate shall promptly refer the individual to MCHCP's Privacy Officer, and, if the request is in writing, shall forward the individual's request three (3) business days to MCHCP's Privacy Officer so that MCHCP can evaluate, coordinate and prepare a timely response to the individual's request.

3.7.2 MCHCP will direct Business Associate in writing as to any actions Business Associate is required to take with regard to amending records of individuals who exercise their right to amend PHI under the HIPAA Rules. Business Associate agrees to follow the direction of MCHCP regarding such amendments and to provide written confirmation of such action within seven (7)

business days of receipt of MCHCP's written direction or sooner if such earlier action is required to enable MCHCP to comply with the deadlines established by the HIPAA Rules.

3.8 PHI Disclosure Accounting. Business Associate agrees to document, maintain, and make available to MCHCP within seven (7) calendar days of a request from MCHCP for all disclosures made by or under the control of Business Associate or its subcontractors that are subject to accounting, including all information required, under § 164.528 to satisfy MCHCP's obligations regarding accounting of disclosures of PHI.

3.8.1 If Business Associate receives a request for accounting directly from an individual, Business Associate agrees to refer the individual, and promptly forward the individual's request, to MCHCP so that MCHCP can evaluate, coordinate and prepare a timely response to the individual's request.

3.8.2 In addition to the provisions of 3.8.1, all PHI accounting requests received by Business Associate directly from the individual shall be acted upon by Business Associate as a request from MCHCP for purposes of Business Associate's obligations under this section. Unless directed by MCHCP to respond directly to the individual, Business Associate shall provide all accounting information subject to disclosure under § 164.528 to MCHCP within seven (7) calendar days of the individual's request for accounting.

3.9 Privacy of PHI. Business Associate agrees to fully comply with all provisions of Subpart E of 45 CFR Part 164 that apply to MCHCP to the extent Business Associate has agreed or assumed responsibilities under the Contract or this Agreement to carry out one or more of MCHCP's obligation(s) under 45 CFR Part 164 Subpart E.

3.10 Internal Practices, Books, and Records. Upon request of MCHCP or the Secretary, Business Associate will make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of MCHCP available to MCHCP and/or the Secretary in a time and manner designated by MCHCP or the Secretary for purposes of determining MCHCP's and/or Business Associate's compliance with the HIPAA Rules.

4 **Permitted Uses and Disclosures of PHI by Business Associate**.

4.1 Contractual Authorization. Business Associate may access, create, use, and disclose PHI as necessary to perform its duties and obligations required by the Contract, including but not limited to specific requirements set forth in the Scope of Work (as such term is defined in the Contract), as amended. Without limiting the foregoing general authorization, MCHCP specifically authorizes Business Associate to access, create, receive, use, and disclose all PHI which is required to provide the services specified in the Contract. The parties agree that no provision of the Contract permits Business Associate to use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if used or disclosed in like manner by MCHCP except that:

4.1.1 This Agreement permits Business Associate to use PHI received in its capacity as a business associate of MCHCP, if necessary: (A) for the proper management and administration of Business Associate; or (B) to carry out the legal responsibilities of Business Associate.

4.1.2 This Agreement permits Business Associate to combine PHI created or received on behalf of MCHCP as authorized in this Agreement with PHI lawfully created or received by Business Associate in its capacity as a business associate of other covered entities to permit data analysis relating to the health care operations of MCHCP and other PHI contributing covered entities in order to provide MCHCP with such comprehensive, aggregate summary reports as specifically required by, or specially requested under, the Contract.

4.2 Authorization by Law. Business Associate may use or disclose PHI as permitted or required by law.

4.3 Minimum Necessary. Notwithstanding any other provision in the Contract or this Agreement, with respect to any and all uses and disclosures permitted, Business Associate agrees to request, create, access, use, disclose, and transmit PHI involving MCHCP members subject to the following minimum necessary requirements:

4.3.1 When requesting or using PHI received from MCHCP, a member of MCHCP, or an authorized party or entity working on behalf of MCHCP, Business Associate shall make reasonable efforts to limit all requests and uses of PHI to the minimum necessary to accomplish the intended purpose of the request or use. Business Associate agrees its reasonable efforts will include identifying those persons or classes of persons, as appropriate, in Business Associate's workforce who need access to MCHCP member PHI to carry out their duties under the Contract. Business Associate further agrees to identify the minimally necessary amount of PHI needed by each such person or class and any conditions appropriate to restrict access in accordance with such assessment.

4.3.2 For any type of authorized disclosure of PHI that Business Associate makes on a routine basis to third parties, Business Associate shall implement procedures that limit the PHI disclosed to the amount minimally necessary to achieve the purpose of the disclosure. For all other authorized but non-routine disclosures, Business Associate shall develop and follow criteria for reviewing requests and limiting disclosures to the information minimally necessary to accomplish the purposes for which disclosure is sought.

4.3.3 Business Associate may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose if and when:

a) Making disclosures to public officials as permitted under § 164.512, if the public official represents that the information requested is the minimum necessary for the stated purpose(s); or

b) The information is requested by a professional who is a member of its workforce or is a business associate of MCHCP for the purpose of providing professional services to MCHCP, if the professional represents that the information requested is the minimum necessary for the stated purpose(s).

4.3.4 Minimum necessary does not apply to: uses or disclosures made to the individual; uses or disclosures made pursuant to a HIPAA-compliant authorization; disclosures made to the Secretary in accordance with the HIPAA Rules: disclosures specifically permitted or required under, and made in accordance with, the HIPAA Rules.

5 **Obligations of MCHCP**.

5.1 Notice of Privacy Practices. MCHCP shall notify Business Associate of any limitation(s) that may affect Business Associate's use or disclosure of PHI by providing Business Associate with MCHCP's Notice of Privacy Practices in accordance with § 164.520, the most recent copy of which is attached to this Agreement.

5.2 Individual Authorization Changes. MCHCP shall notify Business Associate in writing of any changes in, or revocation of, the authorization by an individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.3 Confidential Communications. MCHCP shall notify Business Associate in writing of individual requests approved by MCHCP in accordance with § 164.522 to receive communications of PHI from Business Associate by alternate means or at alternative locations, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.4 Individual Restrictions. MCHCP shall notify Business Associate in writing of any restriction to the use or disclosure of PHI that MCHCP has agreed and, if applicable, any subsequent revocation or termination of such restriction, in accordance with § 164.522, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.5 Permissible Requests by MCHCP. MCHCP shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by MCHCP.

6 **Term and Termination, Expiration, or Cancellation**.

6.1 Term. This Agreement is effective upon signature of both parties, and shall terminate upon the termination, expiration, or cancellation of the Contract, as amended, unless sooner terminated for cause under subsection 6.2 below.

6.2 Termination. Without limiting MCHCP's right to terminate the Contract in accordance with the terms therein, Business Associate also authorizes MCHCP to terminate this Agreement immediately by written notice and without penalty if MCHCP determines, in its sole discretion, that Business Associate has violated a material term of this Agreement and termination of this Agreement is in the best interests of MCHCP or its members. Without limiting the foregoing authorization, Business Associate agrees that MCHCP may, as an alternative or in addition to termination, require Business Associate to end the violation of the material term(s) and cure the breach of contract within the time and manner specified by MCHCP based on the circumstances presented. With respect to this subsection, MCHCP's remedies under this Agreement and the Contract are cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

6.3 Obligations of Business Associate Upon Termination. Upon termination, expiration, or cancellation of this Agreement for any reason, Business Associate agrees to return to MCHCP or deliver to another MCHCP business associate at MCHCP's direction all PHI received from MCHCP, any current or former Business Associate or workforce member of MCHCP, or any current or former member of

MCHCP, as well as all PHI created, compiled, stored or accessible to Business Associate or any subcontractor, agent, affiliate, or workforce member of Business Associate, relating to MCHCP as a result of services provided under the Contract. All such PHI shall be securely transmitted in accordance with MCHCP's written directive in electronic format accessible and decipherable by the MCHCP designated recipient. Following confirmation of receipt and usable access of the transmitted PHI by the MCHCP designated recipient, Business Associate shall destroy all MCHCP-related PHI and thereafter retain no copies in any form for any purpose whatsoever. Within seven (7) business days following full compliance with the requirements of this subsection, an authorized representative of Business Associate shall certify in writing addressed to MCHCP's Privacy and Security Officers that Business Associate has fully complied with this subsection and has no possession, control, or access, directly or indirectly, to MCHCP-related PHI from any source whatsoever.

Notwithstanding the foregoing, Business Associate may maintain MCHCP-PHI after the termination of this Agreement to the extent return or destruction of the PHI is not feasible, provided Business Associate: (i) refrains from any further use or disclosure of the PHI; (ii) continues to safeguard the PHI thereafter in accordance with the terms of this Agreement; (iii) does not attempt to de-identify the PHI without MCHCP's prior written consent; and (iv) within seven (7) days following full compliance of the requirements of this subsection, provides MCHCP written notice describing all PHI maintained by Business Associate and certification by an authorized representative of Business Associate of its agreement to fully comply with the provisions of this paragraph.

6.4 Survival. All obligations and representations of Business Associate under this Section 6 and subsection 7.2 shall survive termination, expiration, or cancellation of the Contract and this Agreement.

7 **Miscellaneous**.

7.1 Satisfactory Assurance. Business Associate expressly acknowledges and represents that execution of this Agreement is intended to, and does, constitute satisfactory assurance to MCHCP of Business Associate's full and complete compliance with its obligations under the HIPAA Rules. Business Associate further acknowledges that MCHCP is relying on this assurance in permitting Business Associate to create, receive, maintain, use, disclose, or transmit PHI as described herein.

7.2 Indemnification. Each party shall, to the fullest extent permitted by law, protect, defend, indemnify and hold harmless the other party and its current and former trustees, employees, and agents from and against any and all losses, costs, claims, penalties, fines, demands, liabilities, legal actions, judgments, and expenses of every kind (including reasonable attorneys' fees and expenses, including at trial and on appeal) arising out of the acts or omissions of such party or any subcontractor, consultant, or workforce member of such party to the extent such acts or omissions violate the terms of this Agreement or the HIPAA Rules as applied to the Contract.

Notwithstanding the foregoing, if Business Associate maintains any MCHCP-related PHI following termination of the Contract and this Agreement pursuant to subsection 6.3, Business Associate shall be solely responsible for all PHI it maintains and, to the fullest extent permitted by law, Business Associate shall protect, defend, indemnify and hold harmless MCHCP and its current and former trustees, employees, and agents from and against any and all losses, costs, claims, penalties, fines, demands, liabilities, legal actions, judgments, and expenses of every kind (including reasonable attorneys' fees and expenses, including at trial and on appeal) arising out of the acts or omissions of Business Associate or any subcontractor, consultant, or workforce member of Business Associate

regarding such PHI to the extent such acts or omissions violate the terms of the Act or the HIPAA Rules.

7.3 No Third Party Beneficiaries. There is no intent by either party to create or establish third party beneficiary status or rights or their equivalent in any person or entity, other than the parties hereto, that may be affected by the operation of this Agreement, and no person or entity, other than the parties, shall have the right to enforce any right, claim, or benefit created or established under this Agreement.

7.4 Amendment. The parties agree to work together in good faith to amend this Agreement from time to time as is necessary or advisable for compliance with the requirements of the HIPAA Rules. Notwithstanding the foregoing, this Agreement shall be deemed amended automatically to the extent any provisions of the Act or the HIPAA Rules not addressed herein become applicable to Business Associate during the term of this Agreement pursuant to and in accordance with any subsequent modification(s) or official and binding legal clarification(s), to the Act or the HIPAA Rules.

7.5 Interpretation. Any reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

THE UNDERSIGNED PERSONS REPRESENT AND WARRANT THAT WE ARE LEGALLY FREE TO ENTER THIS AGREEMENT, THAT OUR EXECUTION OF THIS AGREEMENT HAS BEEN DULY AUTHORIZED, AND THAT UPON BOTH OF OUR SIGNATURES BELOW THIS SHALL BE A BINDING AGREEMENT TO THE FOREGOING TERMS AND CONDITIONS OF THIS BUSINESS ASSOCIATE AGREEMENT.

Missouri Consolidated Health Care Plan	**Medicare Advantage Company**
By: _____	By: _____
Title: Executive Director	Title: _____
Date: _____	Date: _____

Exhibit A-8
Group Medicare Advantage Plan Designs and Pricing
Instructions

1. The bidder must provide firm, fixed PEPM pricing for providing the plan designs described on the "Proposed Plan Designs" tab of this workbook.
2. Bidders must list any exceptions, deviations, or limitations to the proposed plan designs in the Assumptions/Exceptions columns of the "Propsed Plan Designs" tab of this worksheet.
3. Proposals shall include a fixed premium for program year January 1, 2019 – December 31, 2019, with guaranteed not-to-exceed maximum premiums for program years beginning January 1, 2020 and January 1, 2021. Premiums for program years beginning January 1, 2022, 2023, and 2024 will be negotiated. Any premium data submitted or related to the bidder's proposal including any premium data related to contractual extension options shall be subject to evaluation if deemed by MCHCP to be in the best interest of members of MCHCP.
4. In determining pricing points, MCHCP will consider the potential three-year cost of the contract including the full not-to-exceed premiums for Years 2 and 3 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.
5. For each plan quoted, please fill out the Year 1 components of the insured monthly premium rate in the yellow shaded cells. Please also fill in the assumed Year 1 and Year 2 trend by component and indicate in the orange shaded box to the right whether the trend rate is guaranteed or illustrative, along with any other supporting comments.
6. The worksheet labeled "Supplemental Pricing" is optional and should be completed only if there are additional fees not listed elsewhere within the bidder's pricing proposal.

Exhibit A-8 (continued)
Group Medicare Advantage Plan Designs and Pricing
Proposed Plan Designs

Plan Design Elements	Plan Design 1	Assumptions/Exceptions	Plan Design 2	Assumptions/Exceptions
Deductible	$250		$500	
Out-of-Pocket Max	$2,000		$3,000	
Coinsurance	20%		20%	
PCP/Specialist OV	$10/$20 copay		$25/$40 copay	
Preventive Services	$0 copay		$0 copay	
Telemedicine/Video Doctor Visits	$0 copay		$0 copay	
Hospital Inpatient	$250 per admit		$500 per admit	
Outpatient Surgery	$100		$150	
Mental Health/Substance Abuse - Outpatient	$20 copay		$40 copay	
Lab and X-ray	$0 copay/$25 copay		$0 copay/$40 copay	
Emergency Room	$100 copay, waived if admitted within 24 hours		$150 copay, waived if admitted within 24 hours	
Urgent Care	$50 copay, waived if admitted within 24 hours		$75 copay, waived if admitted within 24 hours	
Hearing Testing Services	$30 copay		$50 copay	
Dental Services (Medicare covered)	$30 copay		$50 copay	
Routine Eye Exam	$30 copay		$50 copay	
Non-Routine Eye	deductible and coinsurance		deductible and coinsurance	
Diabetic Eye Exam	$0 copay		$0 copay	
Eye Glasses/Contact Lenses after Cataract Surgery	$0 copay		$0 copay	
Complex Radiology (includes CAT/PET/ MRI)	$30 copay		$50 copay	
Radiation Therapy	$30 copay		$50 copay	
Outpatient Kidney Dialysis	$0 copay		$0 copay	
Therapy (Physical, Occupational & Speech)	$30 copay		$50 copay	

Plan Design Elements	Plan Design 1	Assumptions/Exceptions	Plan Design 2	Assumptions/Exceptions
Cardiac Rehabilitation Therapy	$30 copay		$50 copay	
Pulmonary Rehabilitation Therapy	$30 copay		$50 copay	
Home Health Services	$0 copay		$0 copay	
Diabetic Monitors/Supplies not covered through Prescription Drug Plan	deductible and coinsurance		deductible and coinsurance	
Durable Medical Equipment	deductible and coinsurance		deductible and coinsurance	
Prosthetic Devices (Medicare covered)	deductible and coinsurance		deductible and coinsurance	
Chiropractic Care (Medicare covered)	$30 copay		$50 copay	
Podiatry	$30 copay		$50 copay	
Ambulance	$100 copay		$150 copay	
Skilled Nursing (100 days per benefit period)	$0 copay days 1-20, $100 copay per day days 21-100		$0 copay days 1-20, deductible and coinsurance for days 21-100	
Part B Drugs	deductible and coinsurance		deductible and coinsurance	
Foreign Travel Outpatient Emergency Care	Carrier Discretion, disclose in assumptions		Carrier Discretion, disclose in assumptions	
Foreign Travel Outpatient Urgent Care	Carrier Discretion, disclose in assumptions		Carrier Discretion, disclose in assumptions	
Foreign Travel Hospital Care (60 days per lifetime)	Carrier Discretion, disclose in assumptions		Carrier Discretion, disclose in assumptions	
Care Management	Carrier Discretion, disclose in assumptions		Carrier Discretion, disclose in assumptions	
Fitness	Carrier Discretion, disclose in assumptions		Carrier Discretion, disclose in assumptions	

Plan Design Elements	Plan Design 1	Assumptions/Exceptions	Plan Design 2	Assumptions/Exceptions
Nurse Line	Carrier Discretion, disclose in assumptions		Carrier Discretion, disclose in assumptions	
Hearing Aids substantially similar to MCHCP non-Medicare Coverage	deductible and coinsurance, disclose coverage in assumptions		deductible and coinsurance, disclose coverage in assumptions	

Exhibit A-8 (continued)
Group Medicare Advantage Plan Designs and Pricing
Pricing

SAMPLE	Year 1	Trend	Year 2	Trend	Year 3	Trend Assumption or other comments
Core (Medicare A&B) incurred claims	$1,100.00	3.5%	$1,138.50	3.5%	$1,178.35	
Wrap incurred claims	$30.00	3.0%	$30.90	3.0%	$31.83	
Target Loss Ratio	90%		90%		90%	
Required premium	$1,255.56		$1,299.33		$1,344.64	
ACA Taxes and Fees	$40.84					
CMS Revenue	$1,100.00	3.0%	$1,133.00	3.0%	$1,166.99	
Net Premium	**$196.40**		**$166.33**		**$177.65**	

		Year 1		Year 2		
Plan 1	**Year 1**	**Trend**	**Year 2**	**Trend**	**Year 3**	**Trend Assumption or other comments**
Core (Medicare A&B) incurred claims			$ -		$ -	
Wrap incurred claims			$ -		$ -	
Target Loss Ratio						
Required premium	$ -		$ -		$ -	
ACA Taxes and Fees						
CMS Revenue			$ -		$ -	
Net Premium	**$ -**		**$ -**		**$ -**	

Plan 2	**Year 1**	**Trend**	**Year 2**	**Trend**	**Year 3**	**Trend Assumption or other comments**
Core (Medicare A&B) incurred claims			$ -		$ -	
Wrap incurred claims			$ -		$ -	
Target Loss Ratio						
Required premium	$ -		$ -		$ -	
ACA Taxes and Fees						
CMS Revenue			$ -		$ -	
Net Premium	**$ -**		**$ -**		**$ -**	

Instructions

For each plan quoted, please fill out the Year 1 components of the insured monthly PEPM premium rate in the yellow shaded cells. Please also fill in the assumed Year 1 and Year 2 trend by component and indicate in the orange shaded box to the right whether the trend rate is guaranteed or illustrative, along with any other supporting comments. The SAMPLE table has been populated with sample numbers.

Exhibit A-8 (continued)
Group Medicare Advantage Plan Designs and Pricing
Supplemental Pricing

Please complete the table below, listing any additional fees such as optional items or costs for customization. MCHCP reserves the right to consider these fees in the projected cost of the contract if services listed here should have been included elsewhere in the bidder's pricing. Optional items may include fees for supplemental educational or communication materials, fees for supplemental reporting, fees for self-service reporting tools, etc.

	Describe Service	Fee	Basis for Payment (one-time fee, monthly, PMPM etc.)
Service 1			
Service 2			
Service 3			
Service 4			
Service 5			
Service 6			
Service 7			
Service 8			
Service 9			
Service 10			

Introduction

Missouri Consolidated Health Care Plan (MCHCP) is the employee health benefit program for most State of Missouri employees, retirees, and their dependents covering over 96,000 members (lives). An additional 1,000 non-state local government members are covered through their public entity employer.

This contract will provide for a fully-insured Group Medicare Advantage plan on a national basis to cover Medicare primary eligible members of MCHCP as a full replacement to the plans offered currently. Medicare primary members who are eligible as a public entity member or an active state employee are not included as part of this RFP. Current Medicare primary-eligible member plan enrollment is over 15,000 lives. These members are currently enrolled in one of the self-insured PPO plans offered by MCHCP. Prescription drugs are provided through an Employer Group Waiver Plan (EGWP) Prescription Drug Plan (PDP) through Express Scripts and are not included as part of this RFP.

This document constitutes a request for sealed proposals, to provide a fully-insured Group Medicare Advantage plan. A demographic file that includes zip codes for each MCHCP Medicare enrollee is available upon receipt of a signed Limited Data Use Agreement, available as Exhibit A-2 in the response document section of DirectPath.

MCHCP's Contracting Intentions:

- Any contract awarded from this RFP will be effective January 1, 2019.
- MCHCP intends to award a one-year contract with up to five possible one-year renewals. Bidders are required to submit firm, fixed prices for 2019 and not-to-exceed prices for 2020 and 2021. Rates for 2022, 2023 and 2024 will be negotiated.
- Pricing and benefits are subject to negotiation prior to contract award and renewal each year.
- Bidders should understand that MCHCP views its foremost obligation as providing efficient and effective services to its membership. MCHCP will aggressively pursue and implement measures toward meeting this goal. Bidders are strongly encouraged to demonstrate in their response to this RFP that they share a common vision and commitment.
- MCHCP intends for the contractor to cover the cost of an implementation audit in the amount of $50,000 performed by MCHCP or its designee.

Minimum Bidder Requirements

To be considered for contract award, bidders must meet the following minimum requirements:

- The bidder must be licensed as necessary to do business in the State of Missouri in order to perform the duties described in this RFP, and be in good standing with the office of the Missouri Secretary of State and the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP).

- The bidder must be approved by the Centers for Medicare and Medicaid Services (CMS) to offer a Group Medicare Advantage plan in the State of Missouri and nationwide and have earned a minimum of three stars for plan quality and performance for a minimum of three years.

- The bidder must demonstrate the ability to operate a fully insured group Medicare Advantage plan for at least three organizations with 10,000 or more retirees.

- Bidders must be flexible and demonstrate the ability to administer benefits determined by MCHCP. This includes the ability to offer multiple plan designs at MCHCP's option.

- Bidders shall agree to provide claim-level data and capitation information electronically to MCHCP or designated data vendor on a monthly basis, including twelve (12) run-out months (i.e. months following contract expiration). Bidders may be required to demonstrate the ability to provide such data before a contract award is made.

- Bidders shall not link nor attempt to link (unless permitted by this RFP), the award of this contract to any other bids, products or contracts. The bidder may not impose participation requirement. Any bid proposal containing any participation requirements or contingency based upon MCHCP's actual or potential awards of contracts, whether or not related specifically to this RFP, or containing pricing contingencies, shall result in such bid proposal being rejected for non-responsiveness and non-compliance with this RFP.

- Bidders shall not be permitted to alter their rate or any other aspect of the proposal submission after submission except with negotiation and agreement by MCHCP.

- Timely Submission – All deadlines outlined are necessary to meet the timeline for this contract award. Submissions after respective deadlines have passed may be rejected. All bidder documents and complete proposals must be received by the proposal deadline of April 26, 2018, as outlined in the timeline of events for this RFP. Late proposals will not be accepted. MCHCP reserves the right to modify a deadline or extend a deadline for all bidders at its discretion.

- Performance Bond - The contractor must furnish an original performance security deposit in the form of check, cash, bank draft, or irrevocable letter of credit, issued by a bank or financial institution authorized to do business in Missouri, to MCHCP within ten (10) days after award of the contract and prior to performance of service under the contract. The performance security deposit must be made payable to MCHCP in the amount of $2,000,000. The contract number and contract period must be specified on the performance security deposit. In the event MCHCP exercises an option to renew the contract for an additional period, the contractor shall maintain the validity and enforcement of the security deposit for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal, not to exceed $2,000,000.

Background Information

- Missouri Consolidated Health Care Plan is governed by the provisions of Chapter 103 of the Revised Statutes of Missouri. Under the law, MCHCP is directed to procure health care benefits

for most state employees, retirees and their dependents. The law also authorizes non-state public entities to participate in the plan. Rules and regulations governing the plan can be found by following this link http://www.sos.mo.gov/adrules/csr/current/22csr/22csr.asp.

- Current Medicare-eligible state members is 15,054 covered persons. The current number of non-Medicare members who will turn age 65 in CY2019 is 799.
- MCHCP currently contributes a portion of the premium for Medicare-eligible retirees. On average, MCHCP contributes approximately 54 percent of the total premium. Decisions impacting the contribution level are reviewed annually by the MCHCP Board of Trustees. The current contribution policy can be found in 22 CSR 10-2.030 Contributions.
- MCHCP currently contributes approximately 35 percent of the premium for Medicare-eligible Long-Term Disability recipients. There are approximately 50 of these enrollees.
- MCHCP Medicare-eligible members will be required to pay the Medicare Part B premium.

Assumptions and Considerations

Please submit your proposal using the DirectPath online submission tool no later than **Thursday, April 26, 2018, 4 p.m. CT (5 p.m. ET)**. Due to the limited timeframe for proposal analysis and program implementation, **no individual deadline extensions will be granted**.

The board of trustees has final responsibility for all MCHCP contracts. Responses to the RFP and all proposals will remain confidential until awarded by the MCHCP Board of Trustees or its designee or until all proposals are rejected.

Do not contact MCHCP directly regarding this RFP. Questions about the technical procedures for participating in this on line RFP process should be addressed to DirectPath. Any questions concerning the content of the RFP should be submitted via the messaging tool of the DirectPath website.

Proposal Instructions

NOTE: READ THESE INSTRUCTIONS COMPLETELY PRIOR TO RESPONDING TO THE RFP

In order to be considered you must respond to all sections of this RFP. Bidders are strongly encouraged to read the entire RFP prior to the submission of a proposal. The bidder must comply with all stated requirements. Bidders are expected to provide complete and concise answers to all questions. Your responses to all questions must be based on your current proven capabilities. You should describe your future capabilities only as a supplement to your current capabilities.

If any information contained in the proposal is found to be falsified, the proposal will immediately be disqualified.

Proposals must be valid until January 1, 2019. If a contract(s) is awarded, prices shall remain firm for the specified contract period.

A proposal may only be modified or withdrawn by signed, written notice which has been received by MCHCP prior to the official filing date and time specified.

Contract Term

The initial agreement is for the period of January 1, 2019 through December 31, 2019, with up to five additional one year contracts renewable at the sole option of the MCHCP Board of Trustees.

Clarification of Requirements

It is assumed that bidders have read the entire RFP prior to the submission of a proposal and, unless otherwise noted by the bidder, a submission of a proposal and any applicable amendment(s) indicates that the bidder will meet all requirements stated herein.

The bidder is advised that the only official position of MCHCP is that position which is stated in writing and issued by MCHCP as a RFP and any amendments and/or clarifications thereto. No other means of communication, whether oral or written, shall be construed as a formal or official response or statement.

Schedule of Events

The timeline for the procurement is provided below. No pre-bid conference has been scheduled.

Activity	Timing
Online RFP Released	**Monday April 9, 2018** **8 a.m. CT (9 a.m. ET)**
Intent to Bid Document Due	**Friday, April 13, 2018** **4 p.m. CT (5 p.m. ET)**
Bidder Question Submission Deadline	**Friday, April 13, 2018** **4 p.m. CT (5 p.m. ET)**
MCHCP Responses to Submitted Questions	**Wednesday, April 18, 2018** **4 p.m. CT (5 p.m. ET)**

Online RFP Closes (all proposals due)	**Thursday, April 26, 2018 4 p.m. CT (5 p.m. ET)**
Finalist Interviews/Site Visits (if necessary)	**Late May, 2018**
Final Vendor Selection	**Late June, 2018**
Program Effective Date	**January 1, 2019**

Questions

During this bidding opportunity, MCHCP will be using the online messaging module of the DirectPath application for all official answers to questions from bidders, amendments to the RFP, exchange of information and notification of awards. It is the bidder's responsibility to notify MCHCP of any change in contact information of the bidder. During the bidding process you will be notified via the messaging module of the posting of any new bid-related information.

Any and all questions regarding specifications, requirements, competitive procurement process, etc., must be in writing and submitted through the online messaging module of the DirectPath application by **Friday, April 13, 2018, 4 p.m. CT (5 p.m. ET)**. Questions received after April 13 will be answered and posted through the messaging module as time permits, but there is no guarantee of a response to these questions. For step-by-step instructions, please refer to the *Downloads* section of the DirectPath Application, and click on *User Guides*.

Questions deemed universally applicable will be answered in writing and shared with all vendors who have indicated they are quoting. The team will respond to your questions as they are submitted via the messaging module, with a summary of all questions and answers provided by **Wednesday, April 18, 2018.**

Bidders or their representatives may not contact other MCHCP employees or any member of the MCHCP Board of Trustees regarding this bidding opportunity or the contents of this RFP. If any such contact is discovered to have occurred, it may result in the immediate disqualification of the bidder from further consideration.

Proposal Deadline

ALL questionnaires and pricing proposals must be submitted no later than 4 p.m. CT (5 p.m. ET), Thursday, April 26, 2018.

Disclaimers

MCHCP will not be liable under any circumstances for any expenses incurred by any respondent in connection with the selection process.

The description of coverage and plan design contained in this RFP is solely intended to allow for the preparation and submission of proposals by respondents and does not constitute a promise or guarantee of benefits to any individual.

Confidentiality and Proprietary Materials

Pursuant to Section 610.021 RSMo, proposals and related documents shall not be available for public review until a contract has been awarded or all proposals are rejected. MCHCP maintains copies of all proposals and related documents.

MCHCP is a governmental body under Missouri Sunshine Law (Chapter 610 RSMo). Section 610.011 requires that all provisions be "liberally construed and their exceptions strictly construed to promote" the public policy that records are open unless otherwise provided by law. Regardless of any claim by a bidder as to material being proprietary and not subject to copying or distribution, or how a bidder characterizes any information provided in its proposal, all material submitted by the bidder in conjunction with the RFP is subject to release after the award of a contract in relation to a request for public records under the Missouri Sunshine Law (see Chapter 610 of the Missouri Revised Statutes). Only information expressly permitted by the provisions of Missouri's Sunshine Law to be closed – strictly construed – will be redacted by MCHCP from any public request submitted to MCHCP after an award is made. Bidders should presume information provided to MCHCP in a proposal will be public following the award of the bid and made available upon request in accordance with the provisions of state law.

Evaluation Process

Any apparent clerical error may be corrected by the bidder before contract award. Upon discovering an apparent clerical error, MCHCP shall contact the bidder and request written clarification of the intended proposal. The correction shall be made in the notice of award. Examples of apparent clerical errors are: 1) misplacement of a decimal point; and 2) obvious mistake in designation of unit.

Any pricing information submitted by a bidder must be disclosed on the pricing pages as designated in this RFP. Any pricing information which appears elsewhere in the bidder's proposal shall not be considered by MCHCP.

Awards shall only be made to the bidder(s) whose proposal(s) complies with all mandatory specifications and requirements of the RFP. MCHCP reserves the right to evaluate all offers and based upon that evaluation to limit the number of contract awards or reject any and all offers.

MCHCP reserves the right to request written clarification of any portion of the bidder's response in order to verify the intent of the bidder. The bidder is cautioned, however, that its response shall be subject to acceptance or rejection without further clarification.

MCHCP reserves the right to consider historic information and fact, whether gained from the bidder's proposal, question and answer conferences, references, or any other source, in the evaluation process. The bidder is cautioned that it is the bidder's sole responsibility to submit information related to the evaluation categories and that MCHCP is under no obligation to solicit such information if it is not included with the bidder's proposal. Failure of the bidder to submit such information may cause an adverse impact on the evaluation of the bidder's proposal.

After determining that a proposal satisfies the mandatory requirements stated in the RFP, the comparative assessment of the relative benefits and deficiencies of the proposal in relationship to the published evaluation criteria shall be made by using subjective judgment. The award of a contract resulting from

this RFP shall be based on the lowest and best proposal received in accordance with the evaluation criteria stated below:

Evaluation Criteria

Non-financial:

Provider Network	130 points
Vendor Profile	60 points
Customer Service and Plan Administration	75 points
Account Management and Implementation	30 points
Claims Administration and Audits	40 points
Performance Guarantees	50 points
Utilization and Case Management	60 points
Technology and Security	70 points
Reporting	15 points
Coordination with PBM	15 points
Disease Management	10 points
Wellness, Prevention and Consumer Support	15 points
Behavioral Health	20 points
Denials/Appeals/Grievance Procedure	10 points
Sub-total – Non-financial points	600 points
Bonus Points – MBE/WBE Participation Commitment	10 points

Financial:

Price	400 points

Finalist Evaluation:

References	40 points
Finalist Interview	60 points

MCHCP will limit the number of finalists to the bidders receiving 80 percent (480 points) of the possible 600 non-financial points available or the top two bidders if less than two bidders receive 80 percent of the possible 600 non-financial points.

The bidder's proposed participation of MBE/WBE firms in meeting the targets of the RFP will be considered in the evaluation process. A maximum MBE/WBE participation points of 10 points will be awarded based on the participation amount proposed by the bidder. Awarded MBE/WBE participation points will be added to the non-financial points earned by the bidder and will be included to determine if a bidder meets the 80 percent threshold to obtain finalist status.

Minority Business Enterprise (MBE)/Women Business Enterprise (WBE) Participation

The bidder should secure participation of certified MBEs and WBEs in provider products/services required in this RFP. The targets of participation recommended by the State of Missouri are 10% MBE and 5% WBE of the total dollar value of the contract.

a) These targets can be met by a qualified MBE/WBE vendor themselves and/or through the use of qualified subcontractors, suppliers, joint ventures, or other arrangements that afford meaningful opportunities for MBE/WBE participation.

b) The services performed or the products provided by MBE/WBEs must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract. Therefore, if the services performed or the products provided by MBE/WBEs is utilized, to any extent, in the bidder's obligations outside of the contract, it shall not be considered a valid added value to the contract and shall not qualify as participation in accordance with this clause.

c) In order to be considered as meeting these targets, the MBE/WBEs must be "qualified" by the proposal opening date (date the proposal is due). (See below for a definition of a qualified MBE/WBE.)

d) If the bidder is proposing MBE/WBE participation, in order to receive evaluation consideration for MBE/WBE participation, the bidder must provide the following information with the proposal.

    a. Participation Commitment - If the bidder is proposing MBE/WBE participation, the vendor must complete Section 16 of the Group Medicare Advantage RFP Questionnaire (MBE-WBE Participation Commitment), by listing each proposed MBE and WBE, the committed percentage of participation for each MBE and WBE, and the commercially useful products/services to be provided by the listed MBE and WBE. If the vendor submitting the proposal is a qualified MBE and/or WBE, the vendor must include the vendor in the appropriate table.

    b. Documentation of Intent to Participate – The bidder must either provide a properly completed Exhibit A-6, Documentation of Intent to Participate Form, signed and dated no earlier than the RFP issuance date by each MBE and WBE proposed or must provide a letter of intent signed and dated no earlier than the RFP issuance date by each MBE and WBE proposed which: (1) must describe the products/services the MBE/WBE will provide and (2) should include evidence that the MBE/WBE is qualified, as defined herein (i.e., the MBE/WBE Certification Number or a copy of MBE/WBE certificate issued by the Missouri OEO). If the bidder submitting the proposal is a qualified MBE and/or WBE, the bidder is not required to complete Exhibit A-6, Documentation of Intent to Participate Form or provide a recently dated letter of intent.

e) Commitment – If the bidder's proposal is awarded, the percentage level of MBE/WBE participation committed to by the bidder on Exhibit A-6, Participation Commitment, shall be interpreted as a contractual requirement.

Definition -- Qualified MBE/WBE:

In order to be considered a qualified MBE or WBE for purposes of this RFP, the MBE/WBE must be certified by the State of Missouri, Office of Administration, Office of Equal Opportunity (OEO) by the proposal opening date.

MBE or WBE means a business that is a sole proprietorship, partnership, joint venture, or corporation in which at least fifty-one percent (51%) of the ownership interest is held by minorities or women and the management and daily business operations of which are controlled by one or more minorities or women who own it.

Minority is defined as belonging to one of the following racial minority groups: African Americans, Native Americans, Hispanic Americans, Asian Americans, American Indians, Eskimos, Aleuts, and other groups that may be recognized by the Office of Advocacy, United States Small Business Administration, Washington D.C.

A listing of several resources that are available to assist bidders in their efforts to identify and secure the participation of qualified MBEs and WBEs is available at the website shown below or by contacting the Office of Equal Opportunity (OEO) at:

Office of Administration, Office of Equal Opportunity (OEO)
Harry S Truman Bldg., Room 630, P.O. Box 809, Jefferson City, MO 65102-0809
Phone: (877) 259-2963 or (573) 751-8130
Fax: (573) 522-8078
Web site: http://oeo.mo.gov

Finalist Interview

After an initial screening process, a technical question and answer conference or interview may be conducted, if deemed necessary by MCHCP, to clarify or verify the bidder's proposal and to develop a comprehensive assessment of the proposal. MCHCP reserves the right to interview the proposed account management team. MCHCP may ask additional questions and/or conduct a site visit of the bidder's service center or other appropriate location.

Negotiation and Contract Award

The bidder is advised that under the provisions of this RFP, MCHCP reserves the right to conduct negotiations of the proposals received or to award a contract without negotiations. If such negotiations are conducted, the following conditions shall apply:

- Negotiations may be conducted in person, in writing, or by telephone.
- Negotiations will only be conducted with bidders who provide potentially acceptable proposals. MCHCP reserves the right to limit negotiations to those bidders which received the highest rankings during the initial evaluation phase. All bidders involved in the negotiation process will be invited to submit a best and final offer.

- Terms, conditions, prices, methodology, or other features of the bidder's proposal may be subject to negotiation and subsequent revision. As part of the negotiations, the bidder may be required to submit supporting financial, pricing, and other data in order to allow a detailed evaluation of the feasibility, reasonableness, and acceptability of the proposal.

- The mandatory requirements of the RFP shall not be negotiable and shall remain unchanged unless MCHCP determines that a change in such requirements is in the best interest of MCHCP and its members.

- Bidder understands that the terms of any negotiation are confidential until an award is made or all proposals are rejected.

Any award of a contract resulting from this RFP will be made only by written authorization from MCHCP.

Renewal of Contract

The initial agreement is for the period of January 1, 2019 through December 31, 2019, with up to five additional one-year contracts renewable at the sole option of the MCHCP Board of Trustees.

Proposed pricing for Years 2-3 (CY2020 and CY2021) of this contract, not to exceed the allowed maximum, shall be submitted prior to May 15 of the next plan year. Pricing for Years 4-6 (CY2022, CY2023 and CY2024) will be negotiated and is due prior to May 15 of the next plan year. The contractor must also provide supporting documentation that provides the rationale for any requested rate increase each year.

Using DirectPath

The 2019 MCHCP Group Medicare Advantage RFP contains 2 broad categories of items that you will need to work on via the DirectPath application:

1) Items Requiring a Response:

   a) Questionnaires (e.g., Group Medicare Advantage Questionnaire, etc.) are also online forms to collect your responses to our questions about your capabilities.

   c) Response Documents (e.g., Exhibit A-1 Intent to Bid, etc.) are attachment files (e.g., MS Word or Excel) that are posted to the DirectPath website. They should be downloaded, completed and/or signed by your organization, and then posted/uploaded back to the DirectPath application. When you upload your response, from the drop-down menu, identify each uploaded document as a *Response* document and associate it to the appropriate document by name. For step-by-step instructions, please refer to the *How to Download and Attach Files* User Guide located in the *Downloads* section on the application homepage.

2) Reference Files from Event Administrator:

   a) Documents (e.g. Exhibit B-Scope of Work) that you should download and read completely before submitting your RFP response.

All of these components can be found in the DirectPath application under the 2019 MCHCP Group Medicare Advantage RFP on the Event Details page of the application.

Note that as you use the DirectPath application to respond to this RFP, User Guides are accessible throughout the application by clicking on the help icon or from the *Downloads* area of the DirectPath application homepage. For help with data entry and navigation throughout the application, you can contact the DirectPath staff:

- Phone: 800-979-9351
- E-mail: support@directpathhealth.com

Completing Exhibit A-8 Pricing

The bidder must provide firm, fixed costs for providing services as described in this RFP.

Proposals shall include a fixed premium for program year January 1, 2019 – December 31, 2019, with guaranteed not-to-exceed maximum premiums for program years beginning January 1, 2020 and January 1, 2021. Premiums for program years beginning January 1, 2022, 2023, and 2024 will be negotiated. Any premium data submitted or related to the bidder's proposal including any premium data related to contractual extension options shall be subject to evaluation if deemed by MCHCP to be in the best interest of members of MCHCP.

In determining pricing points, MCHCP will consider the potential three-year cost of the contract including the full not-to-exceed premiums for Years 2 and 3 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.

Responding to Questionnaires

We have posted two forms for your response:

- Group Medicare Advantage Questionnaire
- Mandatory Contract Provisions Questionnaire

The questionnaires need to be completed and submitted to DirectPath by**, Thursday, April 26, 2018, 4 p.m. CT (5 p.m. ET).**

The questionnaires are located within the *Items Requiring a Response* tab. This tab contains all of the items you and your team are required to access and respond to. For step-by-step instructions, please refer to the *How to Submit a Questionnaire* User Guide located in the *Downloads* section of the DirectPath application homepage. You have the option to "respond online" or through the use of two different off-line (or desktop) tools.

Completing Other Response Documents

The following exhibits must be completed, signed and uploaded to DirectPath:

- Exhibit A-1 - Intent to Bid (due 4 p.m. CT, April 13, 2018)
- Exhibit A-2 – Limited Data Use Agreement (due 4 p.m. CT, April 13, 2018)
- Exhibit A-3 – Proposed Bidder Modifications (due 4 p.m. CT, April 26, 2018)
- Exhibit A-4 – Confirmation Document (due 4 p.m. CT, April 26, 2018)
- Exhibit A-5 – Contractor Certification (due 4 p.m. CT, April 26, 2018)
- Exhibit A-6 – MBE-WBE Intent to Participate Document (due 4 p.m. CT, April 26, 2018)

The follow exhibit must be reviewed and the bidder provide any suggested red-lined changes to the document using Microsoft Word Track Changes functionality. Changes proposed may or may not be accepted by MCHCP.

- Exhibit A-7 – MCHCP Business Associate Agreement (due 4 p.m. CT, April 26, 2018)

RFP Checklist

Prior to the April 26, 2018 close date, please be sure you have completed and/or reviewed each of the documents listed below:

Type	Document Name
Questionnaire	Group Medicare Advantage Questionnaire
Questionnaire	Mandatory Contract Provisions Questionnaire
Response	Exhibit A-1 Intent to Bid.docx DUE: Friday, April 13, 2018
Response	Exhibit A-2 Limited Data Use Agreement.docx DUE: Friday, April 13, 2018
Response	Exhibit A-3 Proposed Bidder Modifications.docx
Response	Exhibit A-4 Confirmation Document.docx
Response	Exhibit A-5 Contractor Certification.docx
Response	Exhibit A-6 MBE-WBE Intent to Participate Document.docx
Response	Exhibit A-7 MCHCP Business Associate Agreement.docx
Response	Exhibit A-8 Medicare Advantage Plan Design and Pricing.xlsx
Reference	Introduction and Instructions – 2019 MCHCP Group Medicare Advantage RFP.pdf
Reference	Attachment 1 – Enrollee file layouts.docx
Reference	Attachment 2 – MCHCP Enrollee file.xlsx (access to this file is granted after receipt of the signed Limited Data Use Agreement)
Reference	Attachment 3 – Provider file layout.docx
Reference	Attachment 4 – Claims experience.xlsx
Reference	Exhibit B – Scope of Work.docx
Reference	Exhibit C – General Provisions.docx

Contact Information

We understand that content and technical questions may arise. All questions regarding this document and the selection process must be submitted through the online messaging module of the DirectPath application by **Friday, April 13, 2018, 4 p.m. CT (5 p.m. ET)**.

For technical questions related to the use of DirectPath, please contact the DirectPath customer support team at support@directpathhealth.com, or by calling the Customer Support Line at 1-800-979-9351.

EXHIBIT B
SCOPE OF WORK

B1. GENERAL REQUIREMENTS

B1.1 The contractor shall provide a fully-insured Group Medicare Advantage Plan for State members in accordance with the provisions and requirements of this document on behalf of Missouri Consolidated Health Care Plan (hereinafter referred to as MCHCP). The contractor understands that in carrying out its mandate under the law, MCHCP is bound by various statutory, regulatory and fiduciary duties and responsibilities and contractor expressly agrees that it shall accept and abide by such duties and responsibilities when acting on behalf of MCHCP pursuant to this engagement. The contractor agrees that any and all subcontracts entered into by the contractor for the purpose of meeting the requirements of this contract are the responsibility of the contractor. MCHCP will hold the contractor responsible for assuring that subcontractors meet all of the requirements of this contract and all amendments thereto. The contractor must provide complete information regarding each subcontractor used by the contractor to meet the requirements of this contract.

B1.2 The contractor must maintain sufficient liability insurance, including but not limited to general liability, professional liability, and errors and omissions coverage, to protect MCHCP against any reasonably foreseeable recoverable loss, damage or expense under this engagement.

B1.3 The contractor is obligated to follow the performance standards as agreed to in Section 20 of the Group Medicare Advantage Plan Questionnaire.

B1.4 The contractor must furnish an original performance security deposit in the form of check, cash, bank draft, or irrevocable letter of credit, issued by a bank or financial institution authorized to do business in Missouri, to MCHCP within ten (10) days after award of the contract and prior to performance of service under the contract. The performance security deposit must be made payable to MCHCP in the amount of $2,000,000. The contract number and contract period must be specified on the performance security deposit. In the event MCHCP exercises an option to renew the contract for an additional period, the contractor shall maintain the validity and enforcement of the security deposit for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal, not to exceed $2,000,000.

B2. ELIGIBILITY REQUIREMENTS - The contractor shall comply and agree with the following regarding eligibility requirements:

B2.1 The contractor shall agree that eligible Medicare-primary members are those who are eligible as defined by applicable state and federal laws, rules and regulations, including revision(s) to such. MCHCP is the sole source in determining eligibility.

B2.2 Termination: The contractor must agree that:

B2.2.1 A member's coverage under this agreement terminates under those conditions specified in MCHCP’s statutes, and Rules and Regulations.

B2.2.2 The contractor shall not regard a member as terminated until the contractor receives an official termination notice directly from MCHCP.

B3. LEVEL OF BENEFITS

B3.1 The contractor must administer the minimum benefits, in terms of covered services and member responsibility, as described in the stated plan design. If the bidder has limitations in administering the stated plan designs based on state filings, then the bidder must identify those limitations and offer an alternative that closely matches the stated plan designs. Bidders may separately propose additional services or options to be included in the plan design at MCHCP's discretion.

B3.2 The contractor must agree to include all benefits covered by Medicare Parts A and B, wraparound services MCHCP chooses to include, and benefits proposed by the contractor and agreed to by MCHCP.

B3.3 Under no circumstances shall the contractor require a member to pay for any covered services except for stated premiums, deductibles, co-payments, coinsurance and non-covered services. Members shall not be required to pay any additional enrollment fees, application fees or other charges in addition to the monthly premium.

B3.4 The contractor must coordinate, cooperate, and electronically exchange information with MCHCP's contracted pharmacy benefit manager (currently Express Scripts, Inc.) and any other MCHCP contracted vendor necessary to operate MCHCP's benefits. Frequency of electronically exchanged information can be daily.

B3.5 Plan designs and benefits requested are subject to change each plan year. MCHCP will review any request for additional fees resulting from such changes and retains final authority to make any changes. A consultant may be utilized to determine the cost impact.

B4. NETWORK

B4.1 The contractor must have in place a broad national network. If the provider will be leasing networks in areas where their own network is insufficient, this will be disclosed to MCHCP.

B4.2 The contractor shall maintain a network that is sufficient in number and types of providers, in accordance with CMS guidelines, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.

B4.3 MCHCP requires that network providers be responsible for obtaining all necessary pre-certifications and prior authorizations and for paying any assessed penalties for not obtaining necessary authorizations.

B4.4 The contractor shall have a process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of the enrolled members. In addition to looking at the needs from an overall member population standpoint, the contractor shall ensure the network is able to address the needs of those with special needs including but not limited to, visually or hearing impaired, limited English proficiency, and low health literacy. The contractor shall notify MCHCP within five business days if the network geographic access changes from what was proposed by the contractor.

B5. REPORTING REQUIREMENTS

B5.1 The contractor agrees that all data required by MCHCP shall be confidential and will not be public information. The contractor further agrees not to disclose this or similar information to any competing company, either directly or indirectly.

B5.2 MCHCP reserves the right to retain a third party contractor (currently Truven Health Analytics®, part of IBM Watson Health) to receive claims-level data from the contractor and store the data on MCHCP's behalf. This includes a full claim file including, but not limited to all financial, demographic and utilization fields. The contractor agrees to cooperate with MCHCP's designated third party contractor, if applicable, in the fulfillment of the contractor's duties under this contract, including the provision of data as specified without constraint on its use. The contractor shall agree to:

B5.2.1 Provide claims, person-level capitation and utilization data to MCHCP and/or MCHCP's data vendor in a format specified by MCHCP with the understanding that the data shall be owned by MCHCP;

B5.2.2 Provide data in an electronic form and within a timeframe specified by MCHCP;

B5.2.3 Place no restraints on use of the data provided MCHCP has in place procedures to protect the confidentiality of the data consistent with HIPAA requirements; and

B5.2.4 This obligation continues for a period of one year following contract termination at no additional cost to MCHCP.

B5.3 The contractor shall provide standard reports to MCHCP on a quarterly and annual basis. MCHCP and the contractor will negotiate the format and content upon award of this contract. A sample of the bidder's standard reports must be submitted with the proposal. The reports shall be submitted to MCHCP quarterly and are due within 30 days of the end of the quarter reported. Annual reports are due within 45 days of the end of the year. Periodic in-person meetings will be required for sharing of data and results.

B5.4 The contractor shall provide MCHCP with copies of HEDIS results, CAHPS survey results, and any other CMS required reporting for Medicare Advantage enrollees.

B5.5 At the request of MCHCP, the contractor shall submit additional ad hoc reports on information and data readily available to the contractor.

B5.6 MCHCP will determine the acceptability of all claim files and reports submitted based upon timeliness, format and content. If reports are not deemed to be acceptable or have not been submitted as requested, the contractor will receive written notice to this effect and the applicable liquidated damages, as defined in Section 20 of the Group Medicare Advantage Plan Questionnaire, will be assessed.

B6. GENERAL SERVICE REQUIREMENTS

B6.1 The contractor shall agree that any state and/or federal laws and applicable rules and regulations enacted during the terms of the contract which are deemed by MCHCP to necessitate a change in the contract shall be incorporated into the contract. MCHCP will

review any request for additional fees resulting from such changes and retains final authority to make any changes. A consultant may be utilized to determine the cost impact.

B6.2 The contractor must agree that during the life of the contract or any extension thereof, MCHCP and auditors designated by MCHCP shall have access to and the right to examine any pertinent books, documents, papers, or records of the contractor involving any and all transactions related to the performance of the contract. Also, the contractor must furnish all information necessary for MCHCP to comply with all state and/or federal regulations. MCHCP would be responsible for the cost of any such audit or review.

B6.3 The contractor must promptly inform MCHCP of any compliance actions imposed by CMS, including sanctions.

B6.4 The contractor must have an active, current website that is updated regularly. MCHCP members must be able to access this site to obtain current listings of active network providers and other information. If MCHCP discovers that provider information contained at the contractor's website is inaccurate, MCHCP will contact the contractor immediately. The contractor must correct inaccuracies within 10 days of being notified by MCHCP.

B6.5 The contractor shall agree that any products contracted for will be branded or co-branded as MCHCP products, to the extent allowed by Medicare/CMS guidelines.

B6.6 The contractor shall have appeal and grievance procedures that comply in all respects to relevant state and federal law.

B7. ACCOUNT MANAGEMENT

B7.1 The contractor shall establish and maintain throughout the term of the contract an account management team that will work directly with MCHCP staff. This team must include, but is not limited to, a dedicated account executive, a customer service manager, medical director, a clinical contact, a person responsible for preparing reports, and a management information system representative. Approval of the account management team rests with MCHCP. The account executive and service representative(s) will deal directly with MCHCP's benefit administration staff. The account management team must:

B7.1.1 Be able to devote the time needed to the account, including being available for telephone and on-site consultation with MCHCP. Bidders who are not committed to account service will not receive serious consideration.

B7.1.2 Be extremely responsive.

B7.1.3 Be comprised of individuals with specialized knowledge of the contractor's networks, claims and eligibility systems, system reporting capabilities, claims adjudication policies and procedures, administrative services, and relations with third parties.

B7.1.4 Be thoroughly familiar with virtually all of the contractor's functions that relate directly or indirectly to the MCHCP account.

B7.1.5 Act on behalf of MCHCP in cutting through the bureaucracy of the contractor's organization. The account management team must be able to effectively advance the

interest of MCHCP through the contractor's corporate structure.

B7.1.6 The contractor agrees to provide MCHCP with at least 15 days advance notice of any material change to its account management and servicing methodology or to a personnel change in the contractor's account management and servicing team.

B7.1.7 The contractor agrees to allow MCHCP to complete a formal performance evaluation of the assigned account management team annually.

B7.2 MCHCP requires the contractor to meet with MCHCP staff and/or Board of Trustees as requested to discuss the status of the MCHCP account in terms of utilization patterns and costs, as well as propose new ideas that may benefit MCHCP and its members.

B7.2.1 The contractor is expected to present actual MCHCP claims experience and offer suggestions as to ways the benefit could be modified in order to reduce costs or improve the health of MCHCP members. Suggestions must be modeled against actual MCHCP membership and claims experience to determine the financial impact as well as the number of members impacted.

B7.2.2 The contractor must also present benchmark data by using the health plan's entire book of business, a comparable client to MCHCP, and/or some other industry norm.

B8. CUSTOMER SERVICE

B8.1 The contractor must provide a high quality and experienced customer service unit. The health plan staff members must be fully trained in the MCHCP benefit design(s), and the contractor must have the ability to track and report performance in terms of telephone response time, call abandonment rate, and the number of inquiries made by type.

B8.2 The contractor shall maintain a toll-free telephone line to provide prompt access for members and physicians to qualified customer service personnel. At a minimum, customer service must be available between the hours of 8:00 a.m. and 5:00 p.m. CT, Monday through Friday except for designated holidays.

B8.3 The contractor shall refer any and all questions received from members regarding MCHCP eligibility or premiums to MCHCP.

B8.4 The contractor is responsible for developing, printing and mailing identification cards directly to the member's home. The contractor is responsible for these production and mailing costs.

B8.5 The contractor shall agree to develop, print and mail (via first class mail) all communication materials including the Summary of Benefits and Coverage (SBC) to be distributed to the MCHCP membership. MCHCP reserves the right to customize these materials to the extent allowed by Medicare/CMS, and the contractor shall agree that MCHCP reserves the right to review and approve all written communications and marketing materials developed and used by the contractor to communicate specifically with MCHCP members at any time during the contract period. This does not refer to such items as provider directories and plan-wide newsletters as long as they do not contain information on eligibility, enrollment, benefits, rates, etc., which MCHCP must review. Notwithstanding the foregoing, nothing herein prohibits contractor from communicating directly with members in the regular course of providing services under the contract (e.g., responding to member inquiries, etc.). Draft

material for open enrollment held in October of each year shall be made available to MCHCP for review and comment by July 1 of each year unless another date is agreed upon by both the contractor and MCHCP. Open Enrollment material shall be mailed by September 1 of each year unless another date is agreed upon by both the contractor and MCHCP. MCHCP may request enrollment meeting assistance from the contractor and will coordinate the utilization of contractor employees when needed.

B8.6 No provider may be listed on the contractor's website or distributed to the membership through the contractor's customer service unit unless a signed contract is in place. The contractor shall routinely monitor the provider listing for completeness and accuracy.

B8.7 The contractor must provide MCHCP members with a toll-free number to request printed provider directories. The contractor must distribute printed provider directories including lists of participating hospitals, PCPs, specialists, and mental health providers to all members that request such information. These printed directories must be mailed to the member within three business days of receipt of such request. The contractor bears all costs for printing and mailing these materials. Contractors are also required to provide this information via their website.

B8.8 The contractor(s) shall have a variety of tools and information sources for MCHCP members. This may include, but is not limited to, the following:

- New member information
- Cost transparency tools that shall utilize network provider rate information and are at a provider level detail as well as in summary
- Member ability to view claim status
- Member information to track deductible, coinsurance and out-of-pocket maximum status
- Electronic explanation of benefits
- Ability to query and download up to twenty-four (24) months of claims data

B9. INFORMATION TECHNOLOGY AND ELIGIBILITY FILE

B9.1 The contractor shall be able to accept all MCHCP eligibility information on a weekly basis utilizing the ASC X12N 834 (005010X095A1) transaction set. MCHCP will supply this information in an electronic format and the contractor must process such information within 24 hours of receipt. The contractor must provide a technical contact that will provide support to MCHCP Information Technology Department for EDI issues. MCHCP is willing to work with the contractor on these requirements after the contract is awarded.

B9.1.1 It is MCHCP's intent to send a transactional based eligibility file weekly and a periodic full eligibility reconciliation file.

B9.1.2 MCHCP will provide a recommended data mapping for the 834 transaction set to the contractor after the contract is awarded.

B9.1.3 After processing each file, the contractor will provide a report that lists any errors and exceptions that occurred during processing. The report will also provide record counts, error counts and list the records that had an error, along with an error message to indicate why it failed. A list of the conditions the contractor audits will be provided to ensure the data MCHCP is sending will pass the contractor's audit tests.

B9.1.4 The contractor shall provide access to view data on their system to ensure the file MCHCP sends is correctly updating the contractor's system.

B9.1.5 The contractor will supply a data dictionary of the fields MCHCP is updating on their system and the allowed values for each field.

B9.1.6 The contractor shall provide MCHCP with a monthly file ("eligibility audit file") in a mutually agreed upon format of contractor's eligibility records for all MCHCP members. Such file shall be utilized by MCHCP to audit contractor's records. Such eligibility audit file shall be provided to MCHCP no later than the second Thursday of each month.

B9.1.7 The preferred method of file transfer is HIPAA compliant SFTP service. No PGP required.

B9.2 The contractor must be able to support single sign-on from MCHCP's Member Portal to the contractor's Member Portal utilizing Security Assertion Markup Language (SAML).

B9.3 The contractor must work with MCHCP to develop a schedule for testing of the eligibility test record set on electronic media. MCHCP requires that the contractor accept and run an initial test record set no later than September 28, 2018. Results of the test must be provided to MCHCP by October 12, 2018.

B10. IMPLEMENTATION

B10.1 The contractor must provide a proposed written implementation plan in the response to this RFP. The final implementation schedule must be agreed to by MCHCP and the contractor within 30 days of the contract award. At a minimum, the timeline must include the required dates for the following activities:

- Testing of eligibility file;
- Acceptable date for final eligibility file;
- ID card and member material production and distribution;
- Finalization of benefit design; and
- Testing of claim file to data warehouse vendor

B10.2 The contractor must work with MCHCP to develop a schedule for testing of the eligibility test record set on electronic media. MCHCP requires that the contractor accept and run a test record set no later than September 7, 2018. Results of the test must be provided to MCHCP by September 21, 2018.

B10.3 At least forty-five (45) days prior to January 1, 2019 effective date, MCHCP or its designee will have a readiness review/pre-implementation audit of the contractor(s), including an on-site review of the contractor's facilities. The contractor shall participate in all readiness review activities conducted by MCHCP staff or its designee to ensure the contractor's operational readiness for all services (e.g. claims, eligibility, member services, network access, network management, medical management, contractor's staff education, etc.). MCHCP or its designee will provide the contractor with a summary of findings as well as

areas requiring corrective action. The contractor is responsible for all costs associated with this review/audit, including travel expenses of the MCHCP review team or its designee.

B10.4 The contractor must agree to place three (3) percent of annual premium at risk as an implementation fee guarantee for the successful implementation of MCHCP's plan on January 1, 2019.

B10.5 The contractor must agree to guarantee a control of trend increases within the plan which will not negatively impact members.

B10.6 The contractor will agree to a multi-year rate guarantee.

B11. CLINICAL MANAGEMENT

B11.1 The contractor shall integrate and coordinate the following types of services in order to utilize health care resources and achieve optimum patient outcome in the most cost effective manner: utilization management, case management, discharge planning, disease and demand management, quality management, and medical policy and technology assessment.

B11.2 The contractor shall prospectively and concurrently review the medical necessity, appropriate level-of-care and length-of-stay for scheduled hospital admissions, emergency hospital admissions, medical, surgical, mental health, and other health care services.

B11.3 The contractor shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. The contractor may develop its own clinical review criteria, or may purchase or license clinical review criteria from qualified vendors. The contractor shall make available its clinical review criteria upon request.

B11.4 The contractor shall provide physician-to-physician communication. A licensed clinical peer of the same medical specialty shall evaluate the clinical appropriateness of adverse determinations.

B11.5 The contractor shall obtain all information required to make a utilization review decision, including pertinent clinical information. The contractor shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

B11.6 Utilization management services will be conducted by licensed registered nurses and the contractor shall have available for review on a daily basis board certified specialists representing all appropriate specialties. The utilization management staff must consult with appropriate specialists and sub-specialists in conducting utilization review of hospital, physician, mental health services, and other outpatient services.

B11.7 The contractor shall provide a toll-free telephone number and adequate lines for plan members and providers to access the utilization management program.

B11.8 The contractor shall identify case management opportunities and provide case management services for members with specific health care needs which will assist patients and providers in the coordination of services across the continuum of health care services, optimizing health care outcomes and quality, while minimizing cost.

B11.9 The contractor shall have a mechanism to proactively identify and target for intensified management those cases having the potential to incur large expenditures.

B11.10 The contractor shall provide case managers who will be experienced, professional registered nurses, licensed clinical social workers, and counselors who work with patients and providers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

B11.11 Contractor is encouraged to offer disease management programs and services that the contractor may have in place.

B11.11.1 Bidder shall provide evidence of the effectiveness of its disease management programs, if applicable. Evidence should include member health improvement and the impact on costs.

B11.11.2 Contractor may be required to provide a progress report of MCHCP specific disease management programs at a minimum, after six months and one year of this contract.

B11.12 The contractor shall provide a toll-free line staffed by licensed RNs to answer medical questions from members. The nurse line must be available 24 hours a day, seven days a week.

B12. PAYMENTS

B12.1 The contractor shall agree that the monthly premiums due the contractor will be self-billed on a monthly basis and payment initiated via ACH by the tenth of the month following the month of coverage. MCHCP will remit all payments and provide all associated reports electronically.

B12.2 The contractor shall have the right to audit appropriate MCHCP records to determine the accuracy of the monthly payment.

B12.2.1 Any discrepancies must be identified by the contractor within 90 days after receipt of the payment and such discrepancy must be submitted in writing to MCHCP. Failure to identify a discrepancy within the timeframe stated shall be considered as acceptance of MCHCP's calculations and records.

B12.3 The contractor shall agree and understand that no broker commissions shall be paid by MCHCP.

B13. CLAIMS PAYMENT

B13.1 The contractor shall process all claims with incurred dates of service beginning with the contract effective date through December 31, 2019 and each subsequent year of this agreement.

B13.2 The contractor’s claim system must have processes and edits in place to identify improper provider billing. This includes, but is not limited to, up-coding, unbundling of services, “diagnosis creep”, and duplicate bill submissions.

B13.3 The contractor shall agree that if a claims payment platform change occurs throughout the course of the contract, MCHCP reserves the right to delay implementation of the new system for MCHCP members until a commitment can be made by the contractor that transition will be without significant issues. This may include requiring the contractor to put substantial fees at risk to ensure a smooth transition.

B13.4 All penalties assessed by law for failure to timely pay claims will be borne by the contractor.

B13.5 After the contract terminates, the contractor is required to continue processing claims as incurred during the insurance contract period at no additional cost to MCHCP.

B14. PERFORMANCE STANDARDS

B14.1 Performance standards are outlined in Section 20 of the Group Medicare Advantage Plan Questionnaire. The contractor shall agree that any liquidated damages assessed by MCHCP shall be in addition to any other equitable remedies allowed by the contract or awarded by a court of law including injunctive relief. The contractor shall agree that any liquidated damages assessed by MCHCP shall not be regarded as a waiver of any requirements contained in this contract or any provision therein, nor as a waiver by MCHCP of any other remedy available in law or in equity.

B14.2 Contractors are required to utilize the DirectPath Vendor Manager product that allows contractors to self-report compliance and non-compliance with performance guarantees. Unless otherwise specified, all performance guarantees are to be measured quarterly, reconciled quarterly and any applicable penalties paid quarterly. MCHCP reserves the right to audit performance standards for compliance.

B14.3 All performance guarantees must be finalized before a contract will be awarded and are subject to negotiation annually.

B15. TRANSITION ASSISTANCE

B15.1 In the event of contract termination or expiration, the contractor shall provide all reasonable and necessary assistance to MCHCP to allow for a functional transition to another contractor.

B16. MCHCP REQUIREMENTS AND SERVICE

B16.1 MCHCP will provide the following administrative services to assist the contractor:

- Certification of eligibility
- Enrollments (new, change, and terminations) in an electronic format
- Maintenance of individual eligibility and membership data
- Payment of monies due the contractor
- Coordination of open enrollment period, if necessary

EXHIBIT C
GENERAL PROVISIONS

C1. TERMINOLOGY AND DEFINITIONS

Whenever the following words and expressions appear in this Request for Proposal (RFP) document or any amendment thereto, the definition or meaning described below shall apply.

C1.1 **Amendment** means a written, official modification to an RFP or to a contract.

C1.2 **Bidder** means a person or organization who submitted an offer in response to this RFP.

C1.3 **Breach** shall mean the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI as defined, and subject to the exceptions set forth, in 45 C.F.R. 164.402.

C1.4 **Contract** means a legal and binding agreement between two or more competent parties, in consideration for the procurement of services as described in this RFP.

C1.5 **Contractor** means a person or organization who is a successful bidder as a result of an RFP and/or who enters into a contract or any subcontract of a successful bidder.

C1.6 **Employee** means a benefit-eligible person employed by the state and present and future retirees from state employment who meet the plan eligibility requirements.

C1.7 **May** means that a certain feature, component, or action is permissible, but not required.

C1.8 **Member** means any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

C1.9 **Must** means that a certain feature, component, or action is a mandatory condition. Failure to provide or comply may result in a proposal being considered non-responsive.

C1.10 **Off-shore** means outside of the United States.

C1.11 **Participant** has the same meaning as the word member.

C1.12 **PHI** shall mean Protected Health Information, as defined in 45 C.F.R. 160.103, as amended.

C1.13 **Pricing Pages** apply to the form(s) on which the bidder must state the price(s) applicable for the services required in the RFP. The pricing pages must be completed and uploaded by the bidder prior to the specified proposal filing date and time.

C1.14 **Privacy Regulations** shall mean the federal privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, codified at 45 C.F.R. Parts 160 and 164 (Subparts A & E).

C1.15 **Proposal Filing Date and Time** and similar expressions mean the exact deadline required by the RFP for the receipt of proposals by DirectPath system.

C1.16 **Provider** means a physician, hospital, medical agency, specialist or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2010(22). Other providers include but are not limited to:

C1.16.1 Audiologist (AUD or PhD);
C1.16.2 Certified Addiction Counselor for Substance Abuse (CAC);
C1.16.3 Certified Nurse Midwife (CNM) – when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;
C1.16.4 Certified Social Worker or Masters in Social Work (MSW)
C1.16.5 Chiropractor;
C1.16.6 Licensed Clinical Social Worker
C1.16.7 Licensed Professional Counselor (LPC);
C1.16.8 Licensed Psychologist (LP);
C1.16.9 Nurse Practitioner (NP);
C1.16.10 Physician Assistant (PA);
C1.16.11 Occupational Therapist;
C1.16.12 Physical Therapist;
C1.16.13 Speech Therapist;
C1.16.14 Registered Nurse Anesthetist (CRNA);
C1.16.15 Registered Nurse Practitioner (ARNP); or
C1.16.16 Therapist with a PhD or Master's Degree in Psychology or Counseling.

C1.17 **Request for Proposal (RFP)** means the solicitation document issued by MCHCP to potential bidders for the purchase of services as described in the document. The definition includes these Terms and Conditions as well as all Pricing Pages, Exhibits, Attachments, and Amendments thereto.

C1.18 **Respondent** means any party responding in any way to this RFP.

C1.19 **Retiree** means a former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020(2)(B) and is currently receiving a monthly retirement benefit from a retirement system listed in such rule.

C1.20 **RSMo (Revised Statutes of Missouri)** refers to the body of laws enacted by the Legislature, which govern the operations of all agencies of the State of Missouri. Chapter 103 of the statutes is the primary chapter governing the operations of MCHCP.

C1.21 **Shall** has the same meaning as the word must.

C1.22 **Should** means that certain feature, component and/or action is desirable but not mandatory.

C1.23 **Subscriber** means the person who elects coverage under the plan.

C2. GENERAL BIDDING PROVISIONS

C2.1 It shall be the bidder's responsibility to ask questions, request changes or clarification, or otherwise advise MCHCP if any language, specifications or requirements of an RFP appear to be ambiguous, contradictory, and/or arbitrary, or appear to inadvertently restrict or limit the requirements stated in the RFP to a single source. Any and all communication from bidders

regarding specifications, requirements, competitive procurement process, etc., must be directed to MCHCP via the messaging tool on the Direct Path web site, as indicated on the last page of the *Introduction and Instructions* document of the RFP. Such communication must be received no later than Friday, April 13 2018, 4 p.m. CT (5 p.m. ET).

Every attempt shall be made to ensure that the bidder receives an adequate and prompt response. However, in order to maintain a fair and equitable procurement process, all bidders will be advised, via the issuance of an amendment or other official notification to the RFP, of any relevant or pertinent information related to the procurement. Therefore, bidders are advised that unless specified elsewhere in the RFP, any questions received by MCHCP after the date noted above might not be answered.

It is the responsibility of the bidder to identify and explain any part of their response that does not conform to the requested services described in this document. Without documentation provided by the bidder, it is assumed by MCHCP that the bidder can provide all services as described in this document.

C2.2 Bidders are cautioned that the only official position of MCHCP is that position which is stated in writing and issued by MCHCP in the RFP or an amendment thereto. No other means of communication, whether oral or written, shall be construed as a formal or official response or statement.

C2.3 MCHCP monitors all procurement activities to detect any possibility of deliberate restraint of competition, collusion among bidders, price-fixing by bidders, or any other anticompetitive conduct by bidders, which appears to violate state and federal antitrust laws. Any suspected violation shall be referred to the Missouri Attorney General's Office for appropriate action.

C2.4 No contract shall be considered to have been entered into by MCHCP until the contract has been awarded by the MCHCP Board of Trustees and all material terms have been finalized. The contract is expected to be finalized and signed by a duly authorized representative of Contractor in less than fifteen (15) days from MCHCP's initial contact to negotiate a contract. An award will not be made until all contract terms have been accepted.

C3. PREPARATION OF PROPOSALS

C3.1 Bidders must examine the entire RFP carefully. Failure to do so shall be at the bidder's risk.

C3.2 Unless otherwise specifically stated in the RFP, all specifications and requirements constitute minimum requirements. All proposals must meet or exceed the stated specifications and requirements.

C3.3 Unless otherwise specifically stated in the RFP, any manufacturer's names, trade names, brand names, and/or information listed in a specification and/or requirement are for informational purposes only and are not intended to limit competition. Proposals that do not comply with the requirements and specifications are subject to rejection without clarification.

C4. DISCLOSURE OF MATERIAL EVENTS

C4.1 The bidder agrees that from the date of the bidder's response to this RFP through the date for which a contract is awarded, the bidder shall immediately disclose to MCHCP:

C4.1.1 Any material adverse change to the financial status or condition of the bidder;

C4.1.2 Any merger, sale or other material change of ownership of the bidder;

C4.1.3 Any conflict of interest or potential conflict of interest between the bidder's engagement with MCHCP and the work, services or products that the bidder is providing or proposes to provide to any current or prospective customer; and

C4.1.4 (1) Any material investigation of the bidder by a federal or state agency or self-regulatory organization; (2) Any material complaint against the bidder filed with a federal or state agency or self-regulatory organization; (3) Any material proceeding naming the bidder before any federal or state agency or self-regulatory organization; (4) Any material criminal or civil action in state or federal court naming the bidder as a defendant; (5) Any material fine, penalty, censure or other disciplinary action taken against the bidder by any federal or state agency or self-regulatory organization; (6) Any material judgment or award of damages imposed on or against the bidder as a result of any material criminal or civil action in which the bidder was a party; or (7) Any other matter material to the services rendered by the bidder pursuant to this RFP.

C4.1.4.1 For the purposes of this paragraph, "material" means of a nature, or of sufficient monetary value, or concerning a subject which a reasonable party in the position of and comparable to MCHCP would consider relevant and important in assessing the relationship and services contemplated by this RFP. It is further understood that in fulfilling its ongoing responsibilities under this paragraph, the bidder is obligated to make its best faith efforts to disclose only those relevant matters which come to the attention of or should have been known by the bidder's personnel involved in the engagement covered by this RFP and/or which come to the attention of or should have been known by any individual or office of the bidder designated by the bidder to monitor and report such matters.

C4.2 Upon learning of any such actions, MCHCP reserves the right, at its sole discretion, to either reject the proposal or continue evaluating the proposal.

C5. COMPLIANCE WITH APPLICABLE FEDERAL LAWS

C5.1 In connection with the furnishing of equipment, supplies, and/or services under the contract, the contractor and all subcontractors shall comply with all applicable requirements and provisions of the Health Insurance Portability and Accountability Act (HIPAA) and The Patient Protection and Affordable Care Act (PPACA), as amended.

C5.2 Any bidder offering to provide services must sign a Business Associate Agreement (BAA) (see Exhibit A-7) due to the provisions of HIPAA. Any requested changes shall be noted and returned with the RFP**. The changes are accepted only upon MCHCP signing a revised BAA after contract award.**

C5.3 Upon awarding of the contract by the Board, the BAA shall be signed by both parties within five (5) working days of the request to sign, or the award of the contract may be rescinded.

ATTACHMENT 1
LAYOUT FOR MCHCP ENROLLEE FILE

Field Name	Description
Random Number	Random number assigned by MCHCP
Relationship	Identifies if member is subscriber, spouse, or child 01 – subscriber 02 – spouse
Plan Type	Identifies plan type member is enrolled PPO 300 – PPO 300 Plan PPO 600 – PPO 600 Plan Rx – Medicare Prescription Drug Only Plan
Medical Tier	Identifies subscriber's level of coverage MI – Employee Only MS – Employee and Spouse MC – Employee and Child(ren) MF – Employee, Spouse, and Child(ren) SC – Surviving Child
Status	Identifies status of member RTN – Retired Employee DSB – Participant on Long Term Disability SVR – Survivor VES – Vested Participant
Medicare	Indicates if subscriber is on Medicare P – Subscriber does have Medicare S – Spouse of Subscriber has Medicare B – Subscriber and Spouse both have Medicare
Zip Code	Zip code corresponding to the members' residence.
YOB	Year of birth
Gender	M – Male F – Female

Attachment 3
Provider File Layouts

Provide comma separated text files listing physicians and facilities in your network as of January 1, 2018. Limit your network files to Missouri providers. If a provider has more than one office location, provide a record for each address. Provide a crosswalk for provider specialty. The following file layout should be used:

Physician File Layout

1. Missouri License Number
2. Out of State License Number
   (if applicable and only if no Missouri License Number)
3. Last Name
4. First Name
5. Middle Initial
6. Title (MD, DO, PHD, DSS, etc.)
7. Role 1 (PCP or SPEC)
8. Role 2 (PCP or SPEC)
9. Provider Specialty (Family Practice, Urology, OB/GYN, etc.)
10. Accepting New Patients (Y or N)
11. Accepts Medicare Assignment (Y or N)
12. Street 1 (street address, no P.O. Box)
13. Street 2 (suite number, etc.)
14. City
15. State
16. Zip
17. Phone (area code & 7 digits)
18. County

Facility File Layout

1. Tax Identification Number
2. Facility Name
3. Type of Facility (Hospital, Surgery Center, DME Supplier, Home Health, etc.)
4. Street 1 (street address, no P.O. Box)
5. Street 2 (suite number, etc.)
6. City
7. State
8. Zip
9. Phone (area code & 7 digits)
10. County

Attachment 4

Claims experience

Subsets	Members with Medicare	
State or Public Entity	State	
Time Period: Incurred Plan Year	Jan 2016 - Dec 2016	Jan 2017 - Nov 2017
Allowed Amount IP Acute Fac	$35,296,555.51	$33,689,291.65
Net Pay IP Acute Fac	$3,466,676.75	$3,207,357.18
Allowed Amount IP Non Acute Fac	$22,100.02	$0.00
Net Pay IP Non Acute Fac	$10,463.26	$0.00
Allowed Amount IP LTC Fac	$10,418,517.18	$8,821,949.18
Net Pay IP LTC Fac	$1,727,719.71	$1,602,494.77
Allowed Amount OP Fac Med	$37,760,518.16	$36,598,019.50
Net Pay OP Fac Med	$5,148,120.80	$4,553,595.37
Allowed Amount OP Prof Med	$41,770,275.57	$40,017,091.19
Net Pay OP Prof Med	$8,525,689.54	$7,971,782.34
Allowed Amount IP Acute Prof	$5,907,059.82	$5,603,267.03
Net Pay IP Acute Prof	$894,271.51	$853,073.90
Allowed Amount IP Non Acute Prof	$33,558.06	$37,616.58
Net Pay IP Non Acute Prof	$4,865.16	$4,953.54
Allowed Amount IP LTC Prof	$761,123.42	$719,938.11
Net Pay IP LTC Prof	$126,318.41	$132,366.23
Allowed Amount Med	$131,969,707.74	$125,487,450.07
Net Pay Med	$19,904,125.14	$18,325,635.72

2017 Claims experience represent claims incurred through Nov. 2017 and paid through Feb. 2018.

Attachment 4

Claims experience by service category

State

Subsets	Members with Medicare					
Time Period: Incurred Plan Year	Jan 2016 - Dec 2016			Jan 2017 - Nov 2017		
Service Category	Patients Med	Allowed Amount Med	Net Pay Med	Patients Med	Allowed Amount Med	Net Pay Med
Facility Inpatient Long Term Care	558	$9,935,701.55	$1,646,449.31	482	$8,517,074.21	$1,564,547.02
Facility Inpatient Maternity				2	$23,062.72	$21,971.84
Facility Inpatient Medical	2,339	$16,457,968.17	$2,509,668.97	2,249	$16,891,280.50	$2,391,476.92
Facility Inpatient Non Acute	8	$22,100.02	$10,463.26	3	$0.00	$0.00
Facility Inpatient Surgical	943	$18,307,694.62	$866,193.34	867	$16,500,738.34	$741,324.40
Facility Outpatient DME	14	$46,478.41	$38,208.95	33	$61,080.49	$39,463.35
Facility Outpatient Diagnostic Services	3,439	$521,831.19	$63,406.31	2,123	$558,306.87	$59,204.53
Facility Outpatient Dialysis	73	$57,560.61	$2,037.92	58	$23,112.92	$6,697.44
Facility Outpatient ER	3,106	$3,416,671.99	$516,971.99	1,189	$866,026.39	$93,663.68
Facility Outpatient Home Health	945	$55,088.16	$5,795.74	110	$41,541.57	$6,579.22
Facility Outpatient Other	8,788	$20,806,755.79	$2,748,144.41	9,621	$29,527,597.68	$3,626,797.17
Facility Outpatient PT, OT, Speech Therapy	2,225	$462,723.63	$52,796.98	834	$392,363.13	$43,329.11
Facility Outpatient Pharmacy	3,337	$209,613.27	$44,190.42	1,192	$468,689.20	$117,459.91
Facility Outpatient Specialty Drugs	579	$81,615.44	$16,396.84	284	$79,478.90	$16,211.44
Facility Outpatient Supplies and Devices	1,383	$65,698.76	$17,519.91	526	$67,892.36	$12,004.29
Facility Outpatient Surgery	3,397	$10,821,206.72	$1,426,922.56	1,481	$3,451,659.06	$385,013.38
Facility Outpatient Transportation	290	$70,124.54	$13,123.05	117	$79,127.88	$11,750.21
Laboratory Outpatient Chemistry Tests	4,748	$184,214.71	$51,766.49	3,204	$176,337.08	$53,090.51
Laboratory Outpatient Other	5,658	$100,333.58	$26,283.65	4,307	$121,366.30	$32,510.29
Laboratory Outpatient Pathology	3,716	$712,029.92	$102,902.45	3,544	$680,659.75	$102,116.69
Mental Health Inpatient	364	$1,134,519.96	$189,973.97	309	$679,960.60	$105,727.61
Mental Health Office Visits	1,178	$238,798.84	$27,441.97	1,163	$223,337.49	$24,881.16
Mental Health Other Outpatient	1,178	$776,074.09	$111,134.30	1,133	$654,921.48	$85,711.73
Physician Non-Specialty ER	1,133	$165,085.00	$23,237.71	1,165	$180,558.10	$24,240.07
Physician Non-Specialty Inpatient	2,164	$1,575,475.68	$242,620.46	2,116	$1,455,281.73	$215,338.70
Physician Non-Specialty Office Visits	10,956	$3,642,287.63	$504,403.87	10,893	$3,366,483.71	$426,236.95
Physician Non-Specialty Outpatient Other	3,833	$486,606.13	$99,787.27	3,615	$398,653.46	$59,644.03
Physician Non-Specialty Outpatient Surgery	598	$298,703.20	$38,447.77	453	$207,857.38	$25,912.27
Physician Specialty ER	3,197	$713,359.29	$105,662.76	2,990	$680,017.82	$101,829.49
Physician Specialty Inpatient	2,859	$4,260,252.77	$628,781.54	2,767	$4,016,522.67	$593,483.92
Physician Specialty Office Visits	10,918	$3,966,762.94	$474,279.23	11,080	$3,779,976.03	$439,592.01
Physician Specialty Outpatient Other	8,322	$2,465,777.82	$305,160.65	8,240	$2,378,919.86	$277,367.60
Physician Specialty Outpatient Surgery	4,421	$3,570,990.23	$470,842.57	4,315	$3,521,591.81	$467,145.89
Professional Chiropractic Services	1,244	$459,272.88	$104,307.94	1,253	$424,281.21	$92,162.33
Professional DME	2,388	$4,030,855.64	$2,324,778.23	2,210	$3,449,369.39	$2,097,914.62
Professional Diagnostic Services	8,666	$1,649,632.75	$195,565.99	8,473	$1,529,851.32	$174,553.61
Professional Dialysis	87	$166,768.15	$29,593.34	79	$148,734.29	$25,663.06
Professional Home Health	304	$263,806.92	$178,205.94	281	$203,380.89	$151,951.51
Professional Injections	3,552	$1,061,728.24	$267,679.90	3,597	$1,160,161.17	$294,597.84
Professional Office Visits	5,761	$919,523.36	$121,392.86	6,126	$989,930.68	$116,871.39

Time Period: Incurred Plan Year	Jan 2016 - Dec 2016			Jan 2017 - Nov 2017		
Service Category	Patients Med	Allowed Amount Med	Net Pay Med	Patients Med	Allowed Amount Med	Net Pay Med
Professional PT, OT, Speech Therapy	1,339	$992,844.25	$244,497.09	1,309	$974,790.84	$238,026.84
Professional Services Other	7,628	$3,587,884.45	$526,819.17	7,684	$3,789,447.95	$575,552.25
Professional Specialty Drugs	841	$6,549,349.36	$1,212,361.36	858	$6,254,489.27	$1,155,092.33
Professional Supplies and Devices	3,740	$2,330,541.17	$562,047.03	3,527	$2,278,295.97	$543,208.54
Professional Transportation	1,426	$1,495,555.83	$333,490.75	1,290	$1,441,426.73	$309,771.45
Radiology Outpatient CAT Scans	2,402	$415,745.85	$58,903.21	2,332	$442,721.29	$55,930.05
Radiology Outpatient MRIs	1,883	$501,582.73	$85,028.94	1,829	$482,742.42	$60,174.77
Radiology Outpatient Mammograms	1,033	$82,310.03	$9,295.77	931	$110,225.49	$11,866.40
Radiology Outpatient Nuclear Medicine	1,116	$190,380.40	$28,750.28	941	$187,496.35	$21,156.10
Radiology Outpatient Other	1,319	$259,100.65	$34,853.12	1,319	$250,929.99	$32,916.22
Radiology Outpatient Therapeutic Radiology	147	$595,894.82	$102,138.28	143	$581,604.91	$107,232.40
Radiology Outpatient Ultrasounds	2,210	$246,891.48	$28,781.53	2,068	$212,937.15	$25,555.34
Radiology Outpatient X-Rays	6,249	$485,301.10	$65,806.59	6,099	$445,475.16	$55,597.27
Substance Abuse Inpatient	9	$40,831.85	$6,111.69	7	$35,720.03	$4,057.49
Substance Abuse Office Visits	17	$3,127.21	$521.93	26	$3,470.83	$303.34
Substance Abuse Other Outpatient	26	$10,673.96	$2,177.58	17	$18,489.25	$3,157.74

2017 Claims experience represent claims incurred through Nov. 2017 and paid through Feb. 2018.

Attachment 4

MC state members by month

State

Subsets	Members with Medicare			
Time Period: Incurred Month	Members Med	Allowed Amount Med	Net Pay Med	Third Party Amt Med
Dec 2015	14,021	$12,020,566.78	$2,111,727.41	$9,417,257.49
Jan 2016	13,980	$10,658,577.93	$1,098,107.44	$7,221,461.55
Feb 2016	14,005	$10,440,178.59	$1,235,821.15	$7,605,970.10
Mar 2016	14,040	$11,241,361.08	$1,614,329.40	$8,373,811.43
Apr 2016	14,078	$10,982,816.38	$1,526,191.64	$8,438,872.29
May 2016	14,114	$10,386,884.03	$1,536,383.86	$8,028,750.54
Jun 2016	14,162	$10,475,331.96	$1,731,913.35	$7,996,621.79
Jul 2016	14,211	$10,236,891.14	$1,630,550.94	$8,007,503.62
Aug 2016	14,279	$11,610,165.34	$1,875,399.37	$9,083,422.99
Sep 2016	14,327	$10,664,588.88	$1,716,395.67	$8,406,544.46
Oct 2016	14,393	$11,926,673.22	$1,976,527.87	$9,403,824.67
Nov 2016	14,435	$11,569,309.24	$1,856,478.99	$9,212,965.59
Dec 2016	14,473	$11,776,929.95	$2,106,025.46	$9,164,893.38
Jan 2017	14,470	$11,886,066.26	$1,179,285.25	$8,240,429.48
Feb 2017	14,512	$10,984,967.37	$1,289,788.88	$8,100,455.44
Mar 2017	14,549	$11,780,736.34	$1,497,515.35	$8,920,090.06
Apr 2017	14,597	$10,856,002.90	$1,503,324.29	$8,326,025.20
May 2017	14,638	$11,357,690.80	$1,674,525.17	$8,783,194.90
Jun 2017	14,714	$11,753,105.71	$1,889,636.48	$9,072,613.75
Jul 2017	14,778	$10,774,913.38	$1,708,360.73	$8,424,705.42
Aug 2017	14,853	$11,970,362.87	$1,886,952.91	$9,395,737.72
Sep 2017	14,913	$11,009,374.74	$1,832,254.27	$8,619,455.41
Oct 2017	14,967	$12,005,805.70	$1,968,224.64	$9,475,003.57
Nov 2017	14,994	$11,108,424.00	$1,895,767.75	$8,700,340.69

Attachment 4

Utilization

State

Subsets	Members with Medicare	
Time Period: Incurred Plan Year	Jan 2016 - Dec 2016	Jan 2017 - Nov 2017
Patients Admit	2,386	2,285
Admits	2,902	2,682
Days Admit	14,289	12,266
Admits Per 1000 Acute	204.25	198.69
Days Per 1000 Adm Acute	1,005.70	908.68
Visits Office Med	151,601	142,661
Visits Per 1000 Office Med	10,670.05	10,568.46
Visits ER	8,171	2,270
Visits Per 1000 ER	575.10	168.16
Svcs OP Lab	111,637	45,978
Svcs Per 1000 OP Lab	7,857.29	3,406.09
Svcs OP Rad	73,317	51,628
Svcs Per 1000 OP Rad	5,160.23	3,824.65

2017 Claims experience represent claims incurred through Nov. 2017 and paid through Feb. 2018.

Attachment 4

Definitions

Measure	Definition
Allowed Amount IP Acute Fac	The amount of submitted charges eligible for payment for inpatient acute facility services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay IP Acute Fac	The net amount paid for inpatient acute facility services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount IP Non Acute Fac	The amount of submitted charges eligible for payment for inpatient non-acute care facility services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts. Inpatient non-acute care settings include hospices and inpatient rehabilitation facilities.
Net Pay IP Non Acute Fac	The net amount paid for inpatient non-acute care facility services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted. Inpatient non-acute care settings include hospices and inpatient rehabilitation facilities.
Allowed Amount IP LTC Fac	The amount of submitted charges eligible for payment for inpatient long term care facility services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay IP LTC Fac	The net amount paid for inpatient long term care facility services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount OP Fac Med	The amount of submitted charges eligible for payment for outpatient facility services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay OP Fac Med	The net amount paid for outpatient facility services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount OP Prof Med	The amount of submitted charges eligible for payment for outpatient professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay OP Prof Med	The net amount paid for outpatient professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount IP Acute Prof	The amount of submitted charges eligible for payment for inpatient acute professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay IP Acute Prof	The net amount paid for inpatient acute professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.

Measure	Definition
Allowed Amount IP Non Acute Prof	The amount of submitted charges eligible for payment for inpatient non-acute care professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts. Inpatient non-acute care settings include hospices and inpatient rehabilitation facilities.
Net Pay IP Non Acute Prof	The net amount paid for inpatient non-acute care professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted. Inpatient non-acute care settings include hospices and inpatient rehabilitation facilities.
Allowed Amount IP LTC Prof	The amount of submitted charges eligible for payment for inpatient long term care professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay IP LTC Prof	The net amount paid for inpatient long term care professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount Med	The amount of submitted charges eligible for payment for facility and professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay Med	The net amount paid for facility and professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Patients Admit	The unique count of members who were admitted to an inpatient acute or non-acute facility. Patients are included in this count if they received facility or professional services included in an admission.
Admits	The number of acute and non-acute admissions.
Days Admit	The number of days from admissions. The number of days is assigned during Admission Build. It is based on the days that were reported on those facility claims containing room and board services that are included in the admission.
Admits Per 1000 Acute	The average number of acute admissions per 1000 members with medical coverage per year.
Days Per 1000 Adm Acute	The average number of days from acute admissions per 1000 members with medical coverage per year.
Visits Office Med	The number of professional visits provided in an office setting under medical coverage. The number of visits is based on the count of unique patient, service date, and provider combinations.
Visits Per 1000 Office Med	the average number of professional office visits provided under medical coverage, per 1000 members with medical coverage per year. The number of visits is based on the count of unique patient, service date, and provider combinations.
Visits ER	The number of emergency room facility visits provided under medical coverage. The number of visits is based on the count of unique patient and service date combinations. This includes both ER visits that resulted in an admission and those that did not.
Visits Per 1000 ER	The average number of emergency room facility visits provided under medical coverage, per 1000 members with medical coverage per year. The number of visits is based on the count of unique patient and service date combinations.

Measure	Definition
Svcs OP Lab	The sum of the Service Count field for outpatient facility and professional laboratory and pathology services provided under medical coverage. The Service Count field typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the Service Count is set to 1 (one).
Svcs Per 1000 OP Lab	The average number of outpatient laboratory and pathology services provided under medical coverage, per 1000 members with medical coverage per year. The Service Count field typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the Service Count is set to 1 (one).
Svcs OP Rad	The sum of the Service Count field for outpatient facility and professional radiology and imaging services provided under medical coverage. The Service Count field typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the Service Count is set to 1 (one).
Svcs Per 1000 OP Rad	The average number of outpatient radiology and imaging services provided under medical coverage, per 1000 members with medical coverage per year. The Service Count field typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the Service Count is set to 1 (one).

Group Medicare Advantage Questionnaire

All responses to questions must be based on your experience in providing Group Medicare Advantage plans to employer groups, not your commercial business or experience in the individual market. MCHCP requires that you provide concise responses to questions requiring explanation. Please note there is a 1,000 character limit on all textual responses. MCHCP expects that you will provide all explanations within the parameters of the questionnaire.

Proprietary Statement

1.1 Pursuant to Section 610.021 RSMo, proposals and related documents shall not be available for public review until a contract has been awarded or all proposals are rejected. MCHCP maintains copies of all bid file material for review by appointment. Regardless of any claim by the bidder as to material being proprietary and not subject to copying or distribution, or how a bidder characterizes any information provided in its proposal, all material submitted by the bidder in conjunction with this RFP is subject to release after the award of a contract in relation to a request for public records under the Missouri Sunshine Law (see Chapter 610 of the Missouri Revised Statutes). Neither MCHCP nor its consultant shall be obligated to return any materials submitted in response to this RFP. The use of MCHCP's name in any way is strictly prohibited. Confirm your agreement with the Confidentiality and Public Record Policy listed above.

- ◯ Confirmed
- ◯ Not confirmed (please explain)

Vendor Profile

2.1 Provide the following information about your company:

Full and legal company name	
Name of parent organization (if applicable)	
Describe your company structure including subsidiaries and affiliates	
Corporate address	
Name of contact person for questions regarding this RFP response	
Telephone	
Email address	

2.2 Provide information about your organization (for the most recent completed fiscal year) in the chart below:

	Response	Additional Comments
Fiscal year dates		
Revenue		
Operating Profit		
Debt		
Number of employees		
Ownership structure		

2.3 Describe any recent mergers, acquisition, or partnerships that have impacted or may impact the services requested in this RFP.

Response

2.4 To how many employer groups does your organization provide Group Medicare Advantage plans?

Number of groups of 10,000 or more members	
Number of groups of 5,000-9,999 members	
Number of groups of 2,000-4,999 members	
Number of groups of 500-1,999 members	
Number of groups less than 500 members	

2.5 Provide the total number of employers, number of members, and number of non-employer members covered by your organization in 2018 in the following Group Medicare Advantage products:

	Number of employers	Number of employer members	Number of non-employer members
HMO			
Group National PPO			
Regional PPO			

2.6 How many years has your organization provided Medicare Advantage products to employer groups?

Number of years

2.7 How long has your company provided Group Medicare Advantage products in Missouri?

Number of years

2.8 Is there any significant litigation and/or government action pending against your company, or has there been any action taken or proposed against your company within the last five (5) years?

- ○ Yes (describe the situation prompting the suit(s) and the outcome or current status)
- ○ No

2.9 Were you ever listed by CMS as a probationary vendor?

- ○ Yes (please explain)
- ○ No

2.10 Has your organization ever been sanctioned by CMS? Check all that apply, and provide an explanation.

- ☐ Corrective action plan (please describe)
- ☐ Civil monetary penalties (please describe)
- ☐ Suspension of marketing and enrollment (please describe)
- ☐ Other (please describe)
- ☐ Have not been sanctioned

2.11 Confirm you have uploaded details regarding your CMS star ratings for the last three years. Upload the document to the Reference Files from Vendor section, and name the file "Q2.11 CMS Star Rating".

- ○ Confirmed
- ○ Not confirmed (please explain)

2.12 Confirm you have uploaded copies of your CMS Performance Reporting for each of the last two years. Upload the file to the Reference Files from Vendor section, and name the file "Q2.12 CMS Performance Reporting (yyyy)".

- ○ Confirmed
- ○ Not confirmed (please explain)

2.13 Describe any plan accreditation and/or certifications that your organization has received (e.g. NCQA, URAC, etc.).

Response

2.14 How does your organization view the future stability of premiums for Medicare Advantage products?

Response

2.15 What has been your "typical" annual increase in Group Medicare Advantage premiums for your employer clients for each of the last two years?

	2016-17	2017-18
HMO	%	%
Regional PPO	%	%
National PPO	%	%

2.16 Identify the breakdown of your premium by component:

- Administration %
- Claim expense %
- Contracted services %
- Marketing/communications %
- Other %

2.17 Identify your company's General Liability and Errors & Omissions insurer protecting your clients. Describe the type and limits of each coverage.

	Name of Insurance Carrier	Type of Coverage	Coverage Amount	Pertinent Exclusions
Insurer				
Insurer (2nd)				

2.18 Do you subcontract any services to an outside organization? If yes, identify which services.

- ○ Yes (identify subcontractor and services provided)
- ○ No

2.19 Provide the following information for all subcontractors that will be used to fulfill the requirements of this contract:

	Company Name	Service provided	Length of relationship	Expiration date of partnership	Principal place of business	Locations where services will be provided
Subcontractor #1						
Subcontractor #2						
Subcontractor #3						
Subcontractor #4						
Subcontractor #5						

2.20 Do you expect to expand or reduce the number of Group Medicare Advantage plans you offer in the next five (5) years? If anticipating an increase, please explain plans for management of the expansion.

- ○ Expand (please explain)
- ○ Reduce (please explain)

2.21 Describe the economic advantages that will be realized as a result of your organization performing the required services by providing responses to each item below. If necessary to provide a full description, upload a document to the References Files from Vendors section, and name the file "Q2.21 Economic Impact".

Provide a description of the proposed services that will be performed and/or the proposed products that will be provided by Missourians and/or Missouri products.

Provide a description of the economic impact returned to the State of Missouri through tax revenue obligations.

Provide a description of the company's economic presence within the State of Missouri (e.g. type of facilities; sales offices; sales outlets; divisions; manufacturing; warehouse; other), including Missouri employee statistics.

Account Management and Implementation

3.1 Complete the following table regarding the team that would be compiled for MCHCP.

	Name	Location	Role for MCHCP	Brief work experience bio	Number of years at your organization	Number of years in their current role	Number of current accounts in this same role	Number of current members in accounts	Maximum number of accounts	Estimated percentage of time allocated to MCHCP
Account Management (Primary)										%
Account Management (Secondary)										%
Implementation (Primary)										%
Implementation (Secondary)										%

3.2 Confirm you have attached in the Reference Files from Vendor section an organizational chart for the proposed team, showing lines of authority up to and including the executive management level. Name the document "Q3.2 Organizational Chart". Include all functions such as claims, member services, billing, etc.

- ○ Confirmed
- ○ Not confirmed (please explain)

3.3 Confirm you have uploaded in the Reference Files from Vendor section a detailed implementation plan. The implementation plan should assume a January 1, 2019 implementation date. Name the document "Q3.3 Implementation Plan". The plan must include a list of specific implementation tasks/transition protocols and a timetable for initiation and completion of such tasks.

- ○ Confirmed
- ○ Not confirmed (please explain)

3.4 Will your implementation team and account management team commit to 8 business hour acknowledgement of phone calls and/or emails?

- ○ Yes
- ○ No (please explain)

3.5 What services, support, and information are needed from MCHCP in order to expedite implementation? Be specific.

Response

3.6 Explain the banking arrangement for the payment and reconciliation of premiums.

Confirm you agree that premiums will be paid in arrears

How is date of termination, new enrollment and payment/reconciliation of premiums managed?

Do you have flexibility to work with MCHCP if our requirements are non-standard?

Customer Service and Plan Administration

4.1 Provide the following information about your Customer/Member Services Department(s).

Location(s)

Days of operation

Hours of operation

Holidays observed

Number of customer/member services representatives assigned to MCHCP account

Number of other clients assigned customer/member service representatives are responsible for (average # per rep)

Experience level of staff (average # of yrs)

4.2 Describe how the member services team is kept apprised of any changes to MCHCP's plan.

Response

4.3 Will you provide MCHCP with a dedicated Customer/Member Services team?

- ○ Yes (please describe)
- ○ No (please explain)

4.4 Describe the training your customer/member services representatives will receive specific to MCHCP's plan.

Response

4.5 What type of information about physicians is readily available to members (check all that apply)?

	Member services department	Website
Board certification	☐	☐
Listing of specialties	☐	☐
Medical school granting degree	☐	☐
Member feedback about the provider	☐	☐
Residency information	☐	☐
Whether practice is accepting new patients	☐	☐
Consumer satisfaction survey	☐	☐
Clinical outcomes	☐	☐
Number of procedures performed, where appropriate	☐	☐

4.6 What screens and online information do member services representatives have access to (check all that apply)?

- ☐ Eligibility
- ☐ Benefits
- ☐ Pre-certification
- ☐ Claims
- ☐ Network providers
- ☐ Other (please describe)

4.7 What features are available to the member via your website (check all that apply)?

- ☐ Access provider directory
- ☐ Verify eligibility
- ☐ Check claims status
- ☐ Request ID card
- ☐ Review Explanation of Benefits

- ☐ Check status of deductibles, maximums, or limits
- ☐ Research specific medical conditions or wellness information
- ☐ Access customer service via e-mail
- ☐ Ask a plan nurse health questions via e-mail
- ☐ Obtain a history of medical claims
- ☐ Map provider locations
- ☐ Satisfaction surveys
- ☐ Develop and save a health profile
- ☐ Complete a health risk assessment
- ☐ Other (please explain)

4.8 If you marked any of the above in Q4.7, provide an overview of the security of your website to ensure confidentiality of PHI, including what information is requested to confirm the identity of the user.

Response

4.9 Does your company provide member service support via a single, national toll-free telephone number?

- ○ Yes
- ○ No (please explain)

4.10 Are all calls documented and/or recorded?

	Yes (please describe)	No
Documented	○	○
Recorded	○	○

4.11 How are overflow calls handled during busy call times (check all that apply)?

- ☐ Calls transferred to another call center (list locations)
- ☐ Voice mail
- ☐ IVR
- ☐ Chat feature
- ☐ Email to customer service
- ☐ Other (please explain)

4.12 What is the ratio of member services staff per 1,000 members?

Number of staff per 1,000 members

4.13 What is the most recent annual turnover rate for your member services staff?

Percent %

4.14 For the most recently completed calendar year, provide the data requested below on the call center to be used for MCHCP:

	Average time to answer (in seconds)	Call abandonment rate	First call resolution rate
Company standard		%	%
Company actual 2017		%	%

4.15 Can member services process a claim?

- ○ Yes
- ○ No (please explain)

4.16 Provide your company's average response time (in business days) for written inquiries other than grievances and appeals over the last 12 months.

	Corporate standard (in days)	Actual results (in days)
Written inquiries		

4.17 Does your company conduct annual member satisfaction surveys?

- ○ Yes
- ○ No (please explain)

4.18 Confirm that you have uploaded results from your most recent member satisfaction survey in the Reference Files from Vendor section, and named the file "Q4.18 Satisfaction Survey Results".

○ Confirmed
○ Not confirmed (please explain)

4.19 What is the ID card turnaround time (defined as the average number of business days between enrolling a new group/member and plan mailing ID cards to members) for each of the following:

New contract
Future plan years
Newly eligible

4.20 Confirm you do not show the member's Social Security Number (SSN) on printed materials (i.e. I.D. Cards, Explanation of Benefits).

○ Confirmed
○ Not confirmed (please explain)

4.21 Can ID cards be customized for MCHCP?

○ Yes, at no additional cost
○ Yes, at an additional cost (please specify cost on Supplemental Pricing)
○ No (please explain)

4.22 Confirm you have uploaded samples of the communications materials included in your financial proposal that you use to communicate with members. Sample materials must be uploaded to the Reference Files from Vendor section, and named "Q4.22 Member Communications".

○ Confirmed
○ Not confirmed (please explain)

4.23 Are there any parts of the MCHCP program that you believe you will not be able to administer?

○ Yes (please describe)
○ No

4.24 Do you provide assistance to enrollees who may qualify for Medicaid or Low Income Subsidy assistance?

○ Yes (please describe)
○ No (please explain)

Technology and Security

5.1 Identify your planned investment in systems and technology for the next 2 years. Briefly describe the details of this planned investment.

	Investment Areas	Additional Comments
Details of investments in Year 1		
Details of investments in Year 2		

5.2 Are there any plans for other major capital investments, divestments, or system conversions during the next 12 months? If yes, please describe

○ Yes (please describe)
○ No (please explain)

5.3 MCHCP is committed to reducing member and provider fraud, waste, and abuse within the health plan. Please describe how your organization addresses this issue today, including any investments in technology to identify opportunities for improvement, root cause resolution, etc.

Response

5.4 When was the last system/platform upgrade for each of the following systems? If an upgrade is planned within the next 24 months for any of the systems listed, provide the projected date.

Customer Relation Management (CRM) (MM/YYYY)
Eligibility (MM/YYYY)
Claims (MM/YYYY)
Other (please describe)

5.5 Will MCHCP have access to update member eligibility information online?

○ Yes, at no additional cost

○ Yes, at an additional cost (include the cost in Supplemental Pricingl)
○ No (please explain)

5.6 Briefly describe your disaster recovery protocols, procedures and back-up systems for your call center and claims processing center. Can you rapidly shift service to another center if needed? Include the projected time required for full restoration of services.

Call center
Claims processing center

5.7 Has your company implemented and/or tested its disaster recovery procedure?

○ Yes (please describe specific circumstance(s) and include lessons learned)
○ No (please explain)

5.8 How frequently do you backup data?

○ Daily
○ Weekly
○ Monthly
○ Other (please explain)

5.9 Is stored backup data encrypted on media?

○ Yes (please describe)
○ No (please explain)

5.10 Is backup data stored in multiple locations?

Yes (please describe)
No (please explain)

5.11 What practices do you have in place to protect the confidentiality of individual information when electronically storing and/or transferring information?

Response

5.12 Describe the HIPAA-compliant security measures you have in place.

Response

5.13 Describe your process for addressing security breaches.

Response

5.14 Do you adhere to the latest approved accessibility guidelines developed by the Web Accessibility Initiative of World Wide Web Consortium (W3C)?

Yes (please describe)
No (please explain)

5.15 What platform do you currently utilize to deliver web content/services?

Response

5.16 Which of the following browsers/browser versions do you support (check all that apply)?

☐ Internet Explorer 9 and higher
☐ Google Chrome 48 and higher
☐ Firefox 45 and higher
☐ Safari 9 and higher
☐ Microsoft Edge
☐ Other (please list)

5.17 Are mobile apps available for use by your membership?

○ Yes (please describe)
○ No (please explain)

5.18 Confirm your email service supports TLS for secure email with MCHCP staff.

○ Confirmed (please describe, including which version)
○ Not confirmed (please explain)

5.19 Confirm you have Secure FTP (FTPS or SFTP) capabilities for ad hoc record transfers.

Confirmed (please describe)

Not confirmed (please explain)

5.20 Describe your organization's IT infrastructure and development platform.

Response

5.21 Discuss your IT system's scalability and overall capacity to sufficiently support the expected volume increase if your organization is awarded this contract.

Response

5.22 Confirm you have uploaded metrics that demonstrate the reliability of your IT systems. Upload the file to the Reference Files from Vendor section, and name the file "Q5.22 Reliability Metrics".

- ○ Confirmed
- ○ Not confirmed (please explain)

5.23 Please describe the following about your network communication services:

Identify the type of systems that will be used to communicate with MCHCP (i.e. web services, FTP, TLS).

Identify the types of software systems and applications

5.24 Have you ever experienced a security breach involving PHI?

- ○ Yes (provide details on when the breach occurred, actions taken and corrections implemented)
- ○ No

5.25 Does your web portal support single sign-on utilizing Security Assertion Markup Language (SAML)? If not, do you support single sign-on utilizing another standard? If so, please name the standard you support.

- ○ Support single sign-on using SAML
- ○ Support single sign-on using different standard (please list)
- ○ Do not support single sign-on (please explain)

5.26 Confirm you have uploaded a copy of the document describing your disaster recovery and business continuity plans in the Reference Files from Vendor section, and named the document "Q5.26 Disaster Recovery Plan".

- ○ Confirmed
- ○ Not confirmed (please explain)

5.27 Confirm you have uploaded a copy of the summary findings for your most recent testing exercise of your disaster recovery and business continuity plans. Upload the document to the Reference Files from Vendor section, and name the file "Q5.27 Disaster Recovery Plan Testing".

- ○ Confirmed
- ○ Not confirmed (please explain)

5.28 Provide contact information and alternates for the individual responsible for IT-related issues.

	Primary contact	Alternate #1 contact	Alternate #2 contact
Contact name			
Phone			
Email			

Reporting

6.1 Confirm that you have provided copies of your standard reporting package that will be made available to MCHCP. Upload the file to the Reference Files from Vendor section, and name the file "Q6.1 Sample Reports".

- ○ Confirmed
- ○ Not confirmed (please explain)

6.2 Does your organization currently provide data to Truven Health Analytics or any other decision support system vendor on behalf of clients (check all that apply)?

- ☐ Truven Health Analytics

☐ Other decision support system vendor(s) (list other vendors)

☐ No

6.3 Describe your experience and ability to provide claims-level data to third party vendors as described in Exhibit B, Section B5.2.

Response

6.4 Do you have an internet-based reporting system that MCHCP will have access to? If so, upload copies of the reporting that is available, and name the document "Q6.4 Internet-based Reporting".

- ○ Yes, at no additional cost
- ○ Yes, at an additional cost (indicate cost in Supplemental Pricing)
- ○ No (please explain)

Claims Administration and Audits

7.1 Identify the claim office location proposed to service the MCHCP account. List all locations if more than one location will service the MCHCP account.

Location(s)

7.2 Will all medical claims be handled out of this facility? If not, what other location?

- ○ Yes, including mental health claims
- ○ Yes, excluding mental health claims
- ○ No, name other location(s)

7.3 Do you provide EOBs to members? If so, upload a sample to the Reference Files from Vendor section, and name the file "Q7.3 Sample EOB".

- ○ Yes, and a sample has been uploaded
- ○ Yes, and a sample has not been uploaded (please explain)
- ○ No (please explain)

7.4 For the claims office(s) proposed, what is the average number of working days for a paper claim to be processed (check issued) from the date of receipt?

Number of working days

7.5 Provide accuracy rates for your most recent audit period for the proposed primary claim office. Include the measurement definition.

Date of last audit (MMYYYY)

Processing accuracy rate %

Processing accuracy definition

Payment accuracy rate %

Payment accuracy definition

Financial accuracy rate %

Financial accuracy definition

Coding accuracy rate %

Coding accuracy definition

7.6 Describe in detail any policies/procedures that prevent fraud and fraudulent claim submissions.

Response

7.7 Do you have medical professionals (MD/RN) physically housed in the primary claim office proposed for MCHCP? If so, how many?

- ○ Yes (how many)
- ○ No (please explain)

7.8 For your Missouri membership, what percentage of all claims are submitted electronically by your providers for similar plans?

- ○ 50% or less
- ○ 51 - 59%
- ○ 60 - 69%
- ○ 70 - 79%

- ○ 80 - 89%
- ○ 90 - 100%
- ○ None

7.9 For your Missouri membership, what percentage of claims are automatically adjudicated for similar plans?

- ○ 10% or less
- ○ 11 - 25%
- ○ 26 - 50%
- ○ 51 - 59%
- ○ 60 - 69%
- ○ 70 - 79%
- ○ 80 - 89%
- ○ 90 - 100%
- ○ None

7.10 How long are claims maintained online in full record format before being consolidated or moved to offline storage?

- ○ < 18 months
- ○ 18-24 months
- ○ 24-30 months
- ○ 30-36 months
- ○ > 36 months

7.11 Do member services and claims processing units have access to the same claims system and level of information?

- ○ Yes
- ○ No (please explain)

7.12 Describe your certified quality programs (e.g. Six Sigma, ISP, SAS 70, etc.)

Response

7.13 Does your system currently have any edits that help identify unnecessary medical treatment?

- ○ Yes (please describe)
- ○ No (please explain)

7.14 Will MCHCP be able to audit a sampling of claims for processing accuracy at your location annually?

- ○ Yes
- ○ No (please explain)

7.15 What percentage of claims per examiner is audited on a daily basis to ensure payment accuracy?

Percent %

7.16 What is the dollar amount threshold over which all claims are audited?

Dollar amount

7.17 Describe your internal audit procedures, including areas audited and frequency of audits. Give 2017 results (or last audit).

Procedures

Areas audited

Frequency of audits

7.18 Does your company engage an independent auditor to evaluate internal controls?

- ○ Yes (please describe)
- ○ No (please explain)

Utilization and Case Management

8.1 Complete the following table regarding the clinical team that would be compiled for MCHCP.

	Name	Location	Role for MCHCP	Brief work experience bio	Number of years at your organization	Number of years in their current role	Number of current accounts in this same role	Number of current members in accounts	Maximum number of accounts

Clinical Contact (Primary)									
Clinical Contact (Secondary)									

8.2 Provide a brief description for the following health management programs provided by your organization for your Medicare Advantage members.

	Description	How long in place?
Health risk management		
Chronic disease management		
High cost case management		
Care coordination		
Other		

8.3 What does the Utilization Management (UM) program include (check all that apply)?

- ☐ Written utilization management criteria
- ☐ Criteria distributed to all network physicians
- ☐ Case management triggers
- ☐ Other (please explain)

8.4 Describe your UM problem identification process, intervention process, including methods, frequency, and success rates.

Response

8.5 Will you provide a dedicated care management team? If yes, where will it be located?

- ○ Yes (please describe, including location)
- ○ No (please explain)

8.6 Are clinical guidelines implemented uniformly across geographic service areas?

- ○ Yes
- ○ No (please explain)

8.7 Describe your pre-certification program including who performs the medical review function.

Response

8.8 Describe the top three initiatives your company has implemented in the past two (2) years to improve quality and outcomes of patient care.

Initiative 1

Initiative 2

Initiative 3

8.9 Describe how your organization monitors HCC scores with CMS and any ROI that has been achieved.

Response

8.10 Describe how you assure proper payment from CMS based on the the member's true health status.

Response

8.11 Regarding case management, what is your organization's policy and procedure as it relates to communication with the member and the treating physician? Indicate any standards related to frequency of contacts.

Response

8.12 Are cases requiring discharge planning from acute care facilities handled through case management or through the utilization review process?

- ○ Case Management
- ○ Utilization review process

8.13 Confirm you have uploaded examples of your efforts to educate members and providers on your care management programs. Materials must be uploaded to the Reference Files from Vendor section, and named "Q8.13 Care Management Communications".

- ○ Confirmed

○ Not confirmed (please explain)

8.14 Provide the number of members that meet your care management criteria. Include both the number of members and the percent vs. the plan's overall membership.

Number of members

Percent of plan's overall membership %

8.15 Do you track outcomes from care management services, including member satisfaction?

○ Yes (please describe)

○ No (please explain)

8.16 Describe how new medical treatments and procedures are evaluated and recommended for coverage.

Response

8.17 Describe any initiatives you have underway to direct members to providers with the best demonstrated outcomes for specific conditions.

Response

Coordination with PBM

9.1 MCHCP intends to have pharmacy benefits for its Medicare-primary eligible members administered by Express Scripts through its existing EGWP PDP. Do you currently have a relationship with Express Scripts to allow for this coordination?

○ Yes (please describe, including length of relationship and number of clients)

○ No (please explain)

9.2 If you currently have a relationship with Express Scripts, provide references for up to three current employer clients for whom you coordinate with Express Scripts on a Group Medicare Advantage plan. If possible, use companies of similar size and needs as MCHCP. We will not contact these references without discussing it with you first; however, having information on references is critical.

	Company Name	Contact Name	Phone Number	Email address	Services provided by your organization	Number of Covered Members	Number of years working with your organization
Current Client #1							
Current Client #2							
Current Client #3							

9.3 Describe what information you need from the EGWP PDP and the frequency of the information transmitted.

Response

Disease Management

10.1 Provide the following information about your top disease management programs provided to your Medicare Advantage members.

	Disease	Program inception date (MM/YYYY)	Number of members managed in calendar year 2017	Percent of candidates enrolled	Opt-out rate
Program 1				%	%
Program 2				%	%
Program 3				%	%
Program 4				%	%
Program 5				%	%
Program 6				%	%
Program 7				%	%
Program 8				%	%

10.2 Describe your processes of managing members in the disease management programs.

Response

10.3 Provide a description of how you measure the results (ROI) of the disease management program. Give examples of results achieved in two clients of similar size.

Client 1

Client 2

10.4 For the programs listed in Q10.1, indicate if your organization has seen a resulting decrease in admissions for these diagnoses from the year prior to the program being implemented. If you have seen a decrease, indicate the percentage decrease you have seen. If your organization has not seen a decrease in hospitalizations for the diagnoses managed through disease management, provide your assessment as to why this may not have occurred.

- ○ Decrease (#.##% decrease) %
- ○ No change (please explain)
- ○ Increase (please explain)

Plan Design

11.1 Confirm you have uploaded any additional plan designs that may be available to MCHCP. Upload the documents to the Reference Files from Vendor section, and name the file "Q11.1 Additional Benefit Designs".

- ○ Confirmed
- ○ Not confirmed (please explain)

Wellness, Prevention and Consumer Support

12.1 Describe any educational materials you provide to members to assist them in being better consumers. Identify if the materials are web-based, hard copy, or both (check all that apply).

- ☐ Web-based (please describe)
- ☐ Hard copy (please describe)
- ☐ Both (please describe)
- ☐ Other (please describe)

12.2 Describe any programs dealing with wellness or consumerism you have and/or are currently developing that will be operational by 2019.

Response

12.3 Do you provide "specific" educational materials to "persons at-risk"? If yes, upload copies of the specific materials you use to the Reference Files from Vendors section, and name the document "Q12.3 Education Materials - At Risk".

- ○ Yes, at no additional cost
- ○ Yes, at an additional cost (please specify cost in Supplemental Pricing)
- ○ No

12.4 Do you provide "general" educational/prevention materials to all members? If yes, upload copies of the specific materials you use to the Reference Files from Vendors section, and name the document "Q12.4 Education Materials - General".

- ○ Yes, at no additional cost
- ○ Yes, at an additional cost (please specify cost in Supplemental Pricing)
- ○ No

Provider Network

13.1 Confirm you have uploaded a provider network file to the Reference Files from Vendor section in the format provided in Attachment 3. Name the file "Q13.1 Provider Network".

- ○ Confirmed
- ○ Not confirmed (explain)

13.2 Confirm you have uploaded to the Reference Files from Vendor section a list of hospitals and health care facilities under contract in your proposed network for each county in Missouri. Name the file "Q13.2 Hospital Network".

- ○ Confirmed
- ○ Not confirmed (please explain)

13.3 Confirm you have uploaded a complete GeoAccess study that demonstrates your organization's ability to provide access to all members in your proposed service area. As a reminder, a national offering is preferred. Upload the document to the Reference Files from Vendor section, and name the file "Q13.3 GeoAccess Reports".

○ Confirmed
○ Not confirmed (please explain)

13.4 Are you anticipating any material changes in network size (for either hospitals or physicians) in your network area during the next 18-24 months?

○ Yes, an increase in the network size (please explain)
○ Yes, a decrease in the network size (please explain)
○ No

13.5 Have you obtained the necessary waivers to provide access outside your established service area?

○ Yes (please describe)
○ No (please explain)

13.6 Describe your experience in administering an employer group program under an expanded service area waiver in order to provide national coverage.

Response

13.7 How have you met the requirements for the extended service area waiver for other employer clients?

Response

13.8 Complete the following table, indicating the percentage of your Medicare Advantage plan providers that voluntarily resigned from your plan in each of the last two (2) years. List the top three reasons for their departure.

	Percent of providers that voluntarily resigned from plan	Top three reasons for departure
2016	%	
2017	%	

13.9 What percentage of your Medicare Advantage physicians have been terminated from your plan in each of the last two years due to quality of care problems or over/under utilization?

2016 %
2017 %

13.10 What percentage of your Medicare Advantage plan primary care physicians practicing in Missouri are accepting new Medicare Advantage patients?

Percent accepting new patients %

13.11 How will you notify MCHCP of major changes in your provider network?

Response

13.12 Briefly describe your network contracting approach. At a minimum, address network access guidelines, expansion efforts, and anticipated changes in service areas where MCHCP has significant concentrations.

Response

13.13 Do you offer specialty networks (mental health, chiropractors, etc)?

○ Yes (please describe all)
○ No (please explain)

13.14 If you answered "Yes" to Q13.13 above on specialty networks, do you use subcontractors to provide these benefits or is it done internally?

○ Use subcontractors (please list)
○ Internal (please describe when networks were developed)
○ Use both subcontractors and internal network (please describe)
○ Not applicable

13.15 What types of expanded coverage beyond traditional Medicare do you provide within your Group Medicare Advantage program (e.g. hearing aid coverage/discount, chiropractic, acupuncture, etc.)? How are those services covered?

	Describe service	Description of coverage provided
Service 1		
Service 2		
Service 3		
Service 4		

Service 5			

13.16 How often do you update provider listings on your website?

- ○ Daily
- ○ Weekly
- ○ Monthly
- ○ Quarterly
- ○ Semi-annually
- ○ Other (please explain)

13.17 Describe your company's member notification procedure if a network provider terminates its contract during the plan year. Include a description of the assistance offered to plan members.

Response

13.18 If any part of your network is not wholly owned, provide the following:

- ☐ Network name
- ☐ Owner/part owner
- ☐ Length of relationship/contract
- ☐ Description of relationship/contract
- ☐ Not applicable

13.19 In the event a member seeks inpatient services at a network hospital, whose responsibility is it to ensure all services (e.g., lab/x-ray services) are provided at the network level?

- ○ Member's Responsibility
- ○ Provider's Responsibility
- ○ Other (please explain)

13.20 Do you monitor patient access to network providers (e.g. office waiting time, appointment delays or cancellations)?

- ○ Yes
- ○ No (please explain)

13.21 Do you have a Centers for Excellence Program?

- ○ Yes (please list programs available)
- ○ No (please explain)

13.22 Is the network accredited by an outside organization?

- ○ Yes (describe accreditation standing and effective date)
- ○ No (please explain)

13.23 Do you monitor provider compliance with policies and practice patterns?

- ○ Yes (please describe)
- ○ No (please explain)

Behavioral Health

14.1 Who administers the behavioral health benefits?

- ○ Same company as medical benefits
- ○ Subsidiary (please name)
- ○ Contract for services with specialty vendor (please name and provide date the contract will come up for renewal)

14.2 Are the behavioral health claims paid on the same claims system as the medical claims?

- ○ Yes
- ○ No (please explain)

14.3 Describe the clinical guidelines you use for inpatient behavioral health claims.

Response

14.4 Do you integrate behavioral diagnoses into your care management programs?

- ○ Yes (please describe)
- ○ No (please explain)

14.5 Do you integrate behavioral diagnoses into your disease management program?

- ○ Yes (please describe)
- ○ No (please explain)

14.6 How are referrals from medical management to the behavioral health unit handled? Describe the process, including what steps you take to ensure that there is a smooth transition?

Response

Denials/Appeals/Grievance Procedures

15.1 Confirm that all services and issues will follow CMS grievance and appeal procedures.

- ○ Confirmed (please describe)
- ○ Not confirmed (please explain)

15.2 Please explain in detail what services are not subject to CMS' grievance and appeal procedures.

Response

MBE-WBE Participation Committment

If the bidder is committing to participation by or if the bidder is a qualified MBE/WBE, the bidder must provide the required information in the appropriate table(s) below for the organization proposed and must submit the completed Exhibit A-6 with the bidder's proposal. For Minority Business Enterprise (MBE) and/or Woman Business Enterprise (WBE) Participation, if proposing an entity certified as both MBE and WBE, the bidder must either (1) enter the participation percentage under MBE or WBE, or must (2) divide the participation between both MBE and WBE. If dividing the participation, do not state the total participation on both the MBE and WBE Participation Commitment tables below. Instead, divide the total participation as proportionately appropriate between the tables below.

16.1 MBE Participation Committment Table

	Name of Qualified Minority Business Enterprise (MBE) Proposed	Committed Percentage of Participation for MBE	Description of Products/Services to be Provided by MBE
Company 1		%	
Company 2		%	
Company 3		%	
Company 4		%	
Total MBE Percentage		%	

16.2 WBE Participation Committment Table

	Name of Qualified Women Business Enterprise (WBE) Proposed	Committed Percentage of Participation for WBE	Description of Products/Services to be Provided by WBE
Company 1		%	
Company 2		%	
Company 3		%	
Company 4		%	
Total WBE Percentage		%	

Medicare Advantage Pricing/Underwriting

MCHCP would like to review quotes for national MA PPO plans as outlined in the proposed plan design document (Exhibit A-9 Medicare Advantage Plan Design and Pricing). Please review the provided MA plan designs and propose blended national rates for each of the three MA plans based on the proposed plan design terms assuming you are awarded all three plans. The rates should be on a per member per month (PMPM) basis and should be effective for the 2019 calendar year.

17.1 MCHCP prefers a uniform national premium rate for each requested plan design, regardless of where the member resides. Confirm that you can provide a uniform rate.

- ○ Confirmed (please describe)
- ○ Not confirmed (please explain)

17.2 Provide the following assumptions used in underwriting and rate setting:

Credibility assigned to past experience

Trend

Retention

Taxes (including PPACA national health insurance tax)

17.3 To what extent does the group-specific cost data MCHCP provided impact your quoted rates?

Response

17.4 Provide any additional detail regarding your rating methodology that is not documented in the prior questions.

Response

17.5 Confirm that 100 percent of commissions/bonus payments to brokers/agents is removed from the rates quoted in this RFP.

- ○ Confirmed
- ○ Not confirmed (please explain)

Contractual/Legal Issues

18.1 Confirm you have uploaded your standard Medicare Advantage employer group contract. Upload the file to the Reference Files from Vendor section, and name the file "Q18.1 Sample Contract". Please note that MCHCP reserves the right to negotiate any and all contract terms.

- ○ Confirmed
- ○ Not confirmed (please explain)

18.2 Confirm you have uploaded a document to the Reference Files from Vendor section describing the insurance in force that your firm has made to cover any errors and omissions claims that may arise in connection with services on behalf of a client. Who is the carrier or what is the funding mechanism? What are the policy limits? Are all of your subcontractors and/or joint venture companies bound by such coverage? Name the file "Q18.2 E&O Insurance".

- ○ Document has been uploaded (list carrier name, funding mechanism, and policy limits, and describe whether subcontractors are bound by coverage)
- ○ Not provided (please explain)

18.3 Confirm you have uploaded a document to the Reference files from Vendor section confirming appropriate licensure by the State of Missouri. Name the document "Q18.3 State of Missouri License".

- ○ Confirmed
- ○ Not confirmed (please explain)

18.4 Confirm you have uploaded documentation that you are approved by CMS to offer Medicare Advantage plans in the State of Missouri. Upload the file to the Reference Files from Vendor section, and name the document "Q18.4 CMS Documentation".

- ○ Confirmed
- ○ Not confirmed (please explain)

18.5 Confirm you have obtained the appropriate waivers to enroll Medicare beneficiaries who are entitled due to ESRD.

- ○ Confirmed
- ○ Not confirmed (please explain)

References

19.1 Provide references for three current employer clients for whom you provide a Group Medicare Advantage plan. If possible, use companies of similar size and needs as MCHCP. We will not contact these references without discussing it with you first; however, having information on references is critical.

	Company Name	Contact Name	Phone Number	Email address	Services provided by your organization	Number of Covered Members	Number of years working with your organization
Current Client #1							
Current Client #2							
Current Client #3							

19.2 Provide references for two clients who have terminated your services. If possible, use companies of similar size and needs as MCHCP. We will not contact these references without discussing it with you first; however, having information on references is critical.

	Company Name	Services provided by your organization	Number of Covered Members	Number of years working with your organization	Reason for termination of relationship
Terminated Client #1					
Terminated Client #2					

Performance Guarantees

20.1 Claims turnaround time - The following category will be reported and measured quarterly beginning at contract effective date.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Percent of claims processed within 10 business days	90%			For each full percentage point below standard, $2,000 plus $0.10 PMPM	

20.2 Claim processing accuracy - The following categories will be reported and measured quarterly beginning at contract effective date.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Percent of claims free of financial error	99%			For each full percentage point below standard, $2,000 plus $0.10 PMPM	
Percent of claims processed correctly	97%			For each full percentage point below standard, $2,000 plus $0.10 PMPM	

20.3 Member Service - Average response time. The following category will be measured and reported quarterly beginning at contract effective date.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Average number of seconds for call to be answered by a live customer service representative	30 seconds or less			For each full second above standard, $2,000 plus $0.10 PMPM	

20.4 Member Service - Average abandonment rate. The following category will be measured and reported quarterly beginning at contract effective date.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Percent of calls abandoned	< 4%			For each full percentage point above standard, $2,000 plus $0.10 PMPM	

20.5 Member service - Response to written inquiries. The following category will be measured and reported quarterly beginning at contract effective date.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Average number of days within which written inquiries will be responded to	5 days or less			For each business day above standard, $500 plus $0.10 PMPM	

20.6 Written communication with membership. The following category will be measured and reported quarterly beginning at contract effective date.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
MCHCP requires approval of all written communications and marketing material used by the contractor to communicate with MCHCP members, excluding provider directories	MCHCP must approve 100% of written communications			For each instance when material was not submitted to MCHCP for approval, $2,000 plus $0.10 PMPM	

20.7 ID Card Distribution - Initial/New Contract Year Distribution. The following category will be measured on implementation and each subsequent year.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
ID cards mailed no later than one week prior to					

effective date of each year	100% of all ID cards mailed one week prior to effective date			For each day after stated deadline, $500 plus $0.10 PMPM	

20.8 ID Card Distribution - Ongoing. The following category will be measured and reported quarterly beginning on contract effective date.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
ID cards mailed within 15 business days of receipt of eligibility data (for monthly changes) or request for replacement card	100% of all ID cards mailed within 15 business days of receipt of eligibility file or request			For each day beyond the 15th business day, $500 plus $0.10 PMPM	

20.9 Implementation - Claim readiness. The following category will be measured at Implementation.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Claim Readiness - Benefit profile and eligibility information loaded and tested on claims processing system a minimum of one month prior to the effective date	No later than one month prior to effective date			For each day after one-month deadline, $500 plus $0.10 PMPM	

20.10 Implementation - Member services center. The following category will be measured at Implementation.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Member Service Center ready to respond to member inquiries by October 1, 2018	No later than stated deadline			For each business day after stated deadline, $500 plus $0.10 PMPM	

20.11 Implementation - Data Transfer Setup. The following category will be measured at Implementation.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
All data transfer setup requirements with MCHCP's data vendor (currently Truven Health Analytics) completed by October 1, 2018	100%		MCHCP's data vendor will report to MCHCP	For each day beyond October 1, $2,000 plus $0.10 PMPM	

20.12 Eligibility - Timeliness of installations. The following category will be measured and reported quarterly beginning at Implementation.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Electronic eligibility files will be installed and eligibility status will be effective within an average of 24 hours of receipt	98% loaded within 24 hours			For each full hour beyond 24 hours, $500 plus $0.10 PMPM	

20.13 Eligibility - Accuracy of installations. The following category will be measured and reported quarterly beginning at Implementation.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Electronic eligibility records loaded with 99.5% accuracy. This standard is contingent upon receipt of clean eligibility data delivered in an agreed-upon format.	99.5%			For each full percentage point below standard, $2,000 plus $0.10 PMPM	

20.14 Provider directory on website - The following category will be measured and reported quarterly beginning at Implementation.

	Guarantee				

		Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
No provider shall be listed on the contractor's website that is not under contract	All providers listed on website are currently in network and have completed credentialling process			For each instance when listed provider is not in the network, $2,000 plus $0.10 PMPM	

20.15 Account management - Satisfaction. The following category will be measured and reported on Implementation and annually beginning January, 2019.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Contractor guarantees MCHCP's satisfaction with account management services	Satisfactory or better			$2,000 plus $0.10 PMPM	

20.16 Account management - Responsiveness. The following category will be measured and reported quarterly beginning at Implementation.

	Guarantee	Will you guarantee this standard (Yes or No)	Describe your measurement process	Minimum amount at risk	Maximum dollar amount at risk
Timely issues resolution by the account management team (e.g. issues resolvable by account management are acknowledged and responded to within 8 business hours and closed within a reasonable time)	Acknowledgement and response within 8 business hours			For each incident not acknowledged within 8 business hours, $500 plus $0.10 PMPM	

20.17 Reporting - The following categories will be reported and measured quarterly beginning at Implementation. Penalties will be applied for each month the contractor fails to meet these standards.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
Claim file must be submitted to MCHCP's data vendor no later than 15th of the month for prior month's services	100%		MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PMPM	
Claim file must be submitted to MCHCP's data vendor in proper format on first submission of the month	100%		MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PMPM	
Data submission to MCHCP's data vendor must include 99 percent of all required financial fields	99%		MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PMPM	
Data submission to MCHCP's data vendor must include all required fields (subscriber SSN, member DOB, and member gender)	100%		MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PMPM	
Data submission to MCHCP's data vendor must include all required key fields (diagnostic coding, provider type, provider ID, CPT coding, etc.)	100%		MCHCP's data vendor will report to MCHCP	For each incident, $2,000 plus $0.10 PMPM	

20.18 Reporting - Customer Service. The following category will be reported and measured quarterly beginning at Implementation.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk
Customer service reporting must be submitted to MCHCP in the agreed upon format and within 30 days of end of quarter.	Due within 30 days of end of quarter		MCHCP will determine acceptability of reports	For each day beyond deadline for submission, $2,000 plus $0.10 PMPM	

20.19 Monthly eligibility audit file - The following category will be measured and reported quarterly beginning at Implementation.

	Guarantee	Will you guarantee this standard (Yes or No)	Measurement process	Minimum amount at risk	Maximum dollar amount at risk

Eligibility audit file must be provided on the second Thursday of each month in the agreed upon format	Audit file available by the second Thursday of each month		MCHCP will determine acceptability of file	For each day file was not transmitted on time, $2,000 plus $0.10 PMPM	

20.20 Confirm your willingness to submit your performance metrics results via an online tool.

- ○ Confirmed
- ○ Not confirmed (please explain)

Scope of Work

21.1 Confirm you will meet all General Requirements stated in Exhibit B, Section B1.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.2 Confirm you will meet all Eligibility Requirements stated in Exhibit B, Section B2.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.3 Confirm you will meet all Level of Benefits Requirements as stated in Exhibit B, Section B3.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.4 Confirm you will meet all Network Requirements as stated in Exhibit B, Section B4.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.5 Confirm you will meet all Reporting Requirements stated in Exhibit B, Section B5.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.6 Confirm you will meet all General Service Requirements as stated in Exhibit B, Section B6.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.7 Confirm you will meet all Account Management requirements as stated in Exhibit B, Section B7.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.8 Confirm you will meet all Customer Service requirements as stated in Exhibit B, Section B8.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.9 Confirm you will meet all Information Technology and Eligibility File requirements as stated in Exhibit B, Section B9.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.10 Confirm you will meet all Implementation Requirements as stated in Exhibit B, Section B10.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.11 Confirm you will meet all Clinical Management Requirements as stated in Exhibit B, Section B11.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.12 Confirm you will agree to all Payments requirements as stated in Exhibit B, Section B12.

- ○ Confirmed
- ○ Not confirmed (please explain)

21.13 Confirm you will meet all Claims Payment requirements as stated in Exhibit B, Section B13.

- ○ Confirmed

○ Not confirmed (please explain)

21.14 Confirm you will meet all Performance Standard requirements as stated in Exhibit B, Section B14.

○ Confirmed
○ Not confirmed (please explain)

21.15 Confirm you will meet all Transition Assistance requirements as stated in Exhibit B, Section B15.

○ Confirmed
○ Not confirmed (please explain)

Attachment Checklist

22.1 Confirm the following have been provided with your proposal. A check mark below indicates they have been uploaded to the Reference Files from Vendor section of the RFP.

☐ Q2.11 CMS Star Rating
☐ Q2.12 CMS Performance Reporting (yyyy)
☐ Q2.21 Economic Impact
☐ Q3.2 Organizational Chart
☐ Q3.3 Implementation Plan
☐ Q4.18 Satisfaction Survey Results
☐ Q4.22 Member Communications
☐ Q5.22 Reliability Metrics
☐ Q5.26 Disaster Recovery Plan
☐ Q5.27 Disaster Recovery Plan Testing
☐ Q6.1 Sample Reports
☐ Q6.4 Internet-based Reporting
☐ Q7.3 Sample EOB
☐ Q8.13 Care Management Communications
☐ Q11.1 Additional Benefit Designs
☐ Q12.3 Education Materials - At Risk
☐ Q12.4 Education Materials - General
☐ Q13.1 Provider Network
☐ Q13.2 Hospital Network
☐ Q13.3 GeoAccess Reports
☐ Q18.1 Sample Contract
☐ Q18.2 E&O Insurance Document
☐ Q18.3 State of Missouri License
☐ Q18.4 CMS Documentation

Mandatory Contract Provisions Questionnaire

Mandatory Contract Provisions

Bidders are expected to closely read the Mandatory Contract Provisions. Rejection of these provisions may be cause for rejection of a bidder's proposal. MCHCP requires that you provide concise responses to questions requiring explanation. Please note, there is a 1,000 character limit on all textual responses. MCHCP expects that you will provide all explanations within the parameters of this questionnaire.

1.1 Term of Contract: The term of this Contract is for a period of one (1) year from January 1, 2019 through December 31, 2019. This Contract may be renewed for five (5) additional one-year periods at the sole option of the MCHCP Board of Trustees. Prices for Years 1-3 must be submitted with this RFP. The submitted pricing arrangement for the first year (January 1 - December 31, 2019) is a firm, fixed price. The submitted prices for the subsequent (2nd - 3rd) years of the contract period (January 1 - December 31, 2020 and January 1 - December 31, 2021 respectively) are guaranteed not-to-exceed maximum prices and are subject to negotiation. Pricing for Years 4-6 (January 1 - December 31, 2022, January 1 - December 31, 2023, and January 1 - December 31, 2024 respectively) will be negotiated. Actual pricing for the one-year renewal periods are due to MCHCP by May 15 for the following year's renewal. All prices are subject to best and final offer which may result from subsequent negotiation.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.2 Contract Documents: The following documents will be hereby incorporated by reference as if fully set forth within the Contract entered into by MCHCP and the Contractor: (1) Written and duly executed Contract (sample is provided and final will be negotiated if necessary prior to award); (2) amendments to the executed Contract; (3) The completed and uploaded Exhibits set forth in this RFP; and (4) This Request for Proposal.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.3 Audit Rights: MCHCP and its designated auditors shall have access to and the right to examine any and all pertinent books, documents, papers, files, or records of Contractor involving any and all transactions related to the performance of this Contract. Contractor shall furnish all information necessary for MCHCP to comply with all Missouri and/or federal laws and regulations. MCHCP shall bear the cost of any such audit or review. MCHCP and Contractor shall agree to reasonable times for Contractor to make such records available for audit.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.4 Breach and Waiver: Waiver or any breach of any contract term or condition shall not be deemed a waiver of any prior or subsequent breach. No contract term or condition shall be held to be waived, modified, or deleted except by a written instrument signed by the parties thereto. If any contract term or condition or application thereof to any person(s) or circumstances is held invalid, such invalidity shall not affect other terms, condition or application. To this end, the contract terms and conditions are severable.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.5 Confidentiality: Contractor will have access to private and/or confidential data maintained by MCHCP to the extent necessary to carry out its responsibilities under this Contract. No private or confidential data received, collected, maintained, transmitted, or used in the course of performance of this Contract shall be disseminated by Contractor except as authorized by MCHCP, either during the period of this Contract or thereafter. Contractor must agree to return any or all data furnished by MCHCP promptly at the request of MCHCP in whatever form it is maintained by Contractor. On the termination or expiration of this Contract, Contractor will not use any of such data or any material

derived from the data for any purpose and, where so instructed by MCHCP, will destroy or render it unreadable.

○ Confirmed
○ Not confirmed (please explain)

1.6 Electronic Transmission Protocols:The contractor and all subcontractors shall maintain encryption standards of 2048 bits or greater for RSA key pairs, and 256 bit session key strength for the encryption of confidential information and transmission over public communication infrastructure. Batch transfers of files will be performed using SFTP or FTPS with similar standards and refined as needed to best accommodate provider configurations (i.e. port assignment, access control, etc.).

○ Confirmed
○ Not confirmed (please explain)

1.7 Force Majeure: Neither party will incur any liability to the other if its performance of any obligation under this Contract is prevented or delayed by causes beyond its control and without the fault or negligence of either party. Causes beyond a party's control may include, but aren't limited to, acts of God or war, changes in controlling law, regulations, orders or the requirements of any governmental entity, severe weather conditions, civil disorders, natural disasters, fire, epidemics and quarantines, and strikes other than by Contractor's or its subcontractor's employees.

○ Confirmed
○ Not confirmed (please explain)

1.8 Governing Law: This Contract shall be governed by the laws of the State of Missouri and shall be deemed executed at Jefferson City, Cole County, Missouri. All contractual agreements shall be subject to, governed by, and construed according to the laws of the State of Missouri.

○ Confirmed
○ Not confirmed (please explain)

1.9 Jurisdiction: All legal proceedings arising hereunder shall be brought in the Circuit Court of Cole County in the State of Missouri.

○ Confirmed
○ Not confirmed (please explain)

1.10 Independent Contractor: Contractor represents itself to be an independent contractor offering such services to the general public and shall not represent itself or its employees to be an employee of MCHCP. Therefore, Contractor shall assume all legal and financial responsibility for taxes, FICA, employee fringe benefits, worker's compensation, employee insurance, minimum wage requirements, overtime, etc. and agrees to indemnify, save, and hold MCHCP, its officers, agents, and employees, harmless from and against, any and all loss; cost (including attorney fees); and damage of any kind related to such matters. Contractor assumes sole and full responsibility for its acts and the acts of its personnel.

○ Confirmed
○ Not confirmed (please explain)

1.11 Injunctions: Should MCHCP be prevented or enjoined from proceeding with this Contract before or after contract execution by reason of any litigation or other reason beyond the control of MCHCP, Contractor shall not be entitled to make or assess claim for damage by reason of said delay.

○ Confirmed
○ Not confirmed (please explain)

1.12 Integration: This Contract, in its final composite form, shall represent the entire agreement between the parties and shall supersede all prior negotiations, representations or agreements, either written or oral, between the parties relating to the subject matter hereof. This Contract between the parties shall be independent of and have no effect on any other contracts of either party.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.13 Modification of the Contract: This Contract shall be modified only by the written agreement of the parties. No alteration or variation in terms and conditions of the Contract shall be valid unless made in writing and signed by the parties. Every amendment shall specify the date on which its provisions shall be effective.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.14 Notices: All notices, demands, requests, approvals, instructions, consents or other communications (collectively "notices") which may be required or desired to be given by either party to the other during the course of this contract shall be in writing and shall be made by personal delivery or by overnight delivery, prepaid, to the other party at a designated address or to any other persons or addresses as may be designated by notice from one party to the other. Notices to MCHCP shall be addressed as follows: Missouri Consolidated Health Care Plan, ATTN: Executive Director, P.O. Box 104355, Jefferson City, MO 65110-4355.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.15 Ownership: All data developed or accumulated by Contractor under this Contract shall be owned by MCHCP. Contractor may not release any data without the written approval of MCHCP. MCHCP shall be entitled at no cost and in a timely manner to all data and written or recorded material pertaining to this Contract in a format acceptable to MCHCP. MCHCP shall have unrestricted authority to reproduce, distribute, and use any submitted report or data and any associated documentation that is designed or developed and delivered to MCHCP as part of the performance of this Contract.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.16 Payment: Upon implementation of the undertaking of this Contract and acceptance by MCHCP, Contractor shall be paid as stated in this Contract.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.17 Rights and Remedies: If this Contract is terminated, MCHCP, in addition to any other rights provided for in this Contract, may require Contractor to deliver to MCHCP in the manner and to the extent directed, any completed materials. In the event of termination, Contractor shall receive payment prorated for that portion of the contract period services were provided to and/or goods were accepted by MCHCP subject to any offset by MCHCP for actual damages. The rights and remedies of MCHCP provided for in this Contract shall not be exclusive and are in addition to any other rights and remedies provided by law.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.18 Solicitation of Members: Contractor shall not use the names, home addresses or any other information contained about members of MCHCP for the purpose of offering for sale any property or services which are not directly related to services negotiated in this RFP without the express written consent of MCHCP's Executive Director.

○ Confirmed
○ Not confirmed (please explain)

1.19 Statutes: Each and every provision of law and clause required by law to be inserted or applicable to the services provided in the Contract shall be deemed to be inserted herein and the Contract shall be read and enforced as though it were included herein. If through mistake or otherwise any such provision is not inserted, or is not correctly inserted, then on the application of either party the Contract shall be amended to make such insertion or correction.

○ Confirmed
○ Not confirmed (please explain)

1.20 Termination Right: Notwithstanding any other provision, MCHCP reserves the right to terminate this Contract at the end of any month by giving thirty (30) days' notice.

○ Confirmed
○ Not confirmed (please explain)

1.21 Off-shore Services: All services under this Contract shall be performed within the United States. Contractor shall not perform, or permit subcontracting of services under this Contract, to any off-shore companies or locations outside of the United States. Any such actions shall result in the Contractor being in breach of this Contract.

○ Confirmed
○ Not confirmed (please explain)

1.22 Compliance with Laws: Contractor shall comply with all applicable federal and state laws and regulations and local ordinances in the performance of this Contract, including but not limited to the provisions listed below.

○ Confirmed
○ Not confirmed (please explain)

1.23 Non-discrimination, Sexual Harassment and Workplace Safety: Contractor agrees to abide by all applicable federal, state and local laws, rules and regulations prohibiting discrimination in employment and controlling workplace safety. Contractor shall establish and maintain a written sexual harassment policy and shall inform its employees of the policy. Contractor shall include the provisions of this Nondiscrimination/Sexual Harassment Clause in every subcontract so that such provisions will be binding upon each subcontractor. Any violations of applicable laws, rules and regulations may result in termination of the Contract.

○ Confirmed
○ Not confirmed (please explain)

1.24 Americans with Disabilities Act (ADA): Pursuant to federal regulations promulgated under the authority of The Americans with Disabilities Act (ADA), Contractor understands and agrees that it shall not cause any individual with a disability to be excluded from participation in this Contract or from activities provided for under this Contract on the basis of such disability. As a condition of accepting this Contract, Contractor agrees to comply with all regulations promulgated under ADA which are applicable to all benefits, services, programs, and activities provided by MCHCP through contracts with outside contractors.

○ Confirmed
○ Not confirmed (please explain)

1.25 Patient Protection and Affordable Care Act (PPACA): If applicable, Contractor shall comply with the Patient Protection and Affordable Care Act (PPACA) and all regulations promulgated under the authority of PPACA, including any future regulations promulgated under PPACA, which are

applicable to all benefits, services, programs, and activities provided by MCHCP through contracts with outside contractors.

○ Confirmed
○ Not confirmed (please explain)

1.26 Health Insurance Portability and Accountability Act of 1996 (HIPAA): Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations, as amended, including compliance with the Privacy, Security and Breach Notification regulations and the execution of a Business Associate Agreement with MCHCP.

○ Confirmed
○ Not confirmed (please explain)

1.27 Genetic Information Nondiscrimination Act of 2008: Contractor shall comply with the Genetic Information Nondiscrimination Act of 2008 (GINA) and implementing regulations, as amended.

○ Confirmed
○ Not confirmed (please explain)

1.28 Contractor shall be responsible for and agrees to indemnify and hold harmless MCHCP from all losses, damages, expenses, claims, demands, suits, and actions brought by any party against MCHCP as a result of Contractor's, or any associate's or subcontractor's of Contractor, failure to comply with paragraphs 1.23, 1.24, 1.25, 1.26, and 1.27 above.

○ Confirmed
○ Not confirmed (please explain)

1.29 Prohibition of Gratuities: Neither Contractor nor any person, firm or corporation employed by Contractor in the performance of this Contract shall offer or give any gift, money or anything of value or any promise for future reward or compensation to any employee of MCHCP at any time.

○ Confirmed
○ Not confirmed (please explain)

1.30 Subcontracting: Subject to the terms and conditions of this section, this Contract shall be binding upon the parties and their respective successors and assigns. Contractor shall not subcontract with any person or entity to perform all or any part of the work to be performed under this Contract without the prior written consent of MCHCP. Contractor may not assign, in whole or in part, this Contract or its rights, duties, obligations, or responsibilities hereunder without the prior written consent of MCHCP. Contractor agrees that any and all subcontracts entered into by Contractor for the purpose of meeting the requirements of this Contract are the responsibility of Contractor. MCHCP will hold Contractor responsible for assuring that subcontractors meet all the requirements of this Contract and all amendments thereto. Contractor must provide complete information regarding each subcontractor used by Contractor to meet the requirements of this Contract.

○ Confirmed
○ Not confirmed (please explain)

1.31 Industry Standards: If not otherwise provided, materials or work called for in this Contract shall be furnished and performed in accordance with best established practice and standards recognized by the contracted industry and comply with all codes and regulations which shall apply.

○ Confirmed
○ Not confirmed (please explain)

1.32 Hold Harmless: Contractor shall hold MCHCP harmless from and indemnify against any and all claims for injury to or death of any persons; for loss or damage to any property; and for

infringement of any copyright or patent to the extent caused by Contractor or Contractor's employee or its subcontractor. MCHCP shall not be precluded from receiving the benefits of any insurance Contractor may carry which provides for indemnification for any loss or damage to property in Contractor's custody and control, where such loss or destruction is to MCHCP's property. Contractor shall do nothing to prejudice MCHCP's right to recover against third parties for any loss, destruction or damage to MCHCP's property.

○ Confirmed
○ Not confirmed (please explain)

1.33 Insurance and Liability: Contractor must maintain sufficient liability insurance, including but not limited to general liability, professional liability, and errors and omissions coverage, to protect MCHCP against any reasonably foreseeable recoverable loss, damage or expense under this engagement. Contractor shall provide proof of such insurance coverage upon request from MCHCP. MCHCP shall not be required to purchase any insurance against loss or damage to any personal property to which this Contract relates. Contractor shall bear the risk of any loss or damage to any personal property in which Contractor holds title.

○ Confirmed
○ Not confirmed (please explain)

1.34 Access to Records: Upon reasonable notice, Contractor must provide, and cause its subcontractors to provide, the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are directly pertinent to the performance of the services. Such access must be provided to MCHCP and, upon execution of a confidentiality agreement, to any independent auditor or consultant acting on behalf of MCHCP; and any other entity designated by MCHCP. Contractor agrees to provide the access described wherever Contractor maintains such books, records, and supporting documentation. Further, Contractor agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, or other conveniences deemed reasonably necessary to fulfill the purposes described in this section. Contractor shall require its subcontractors to provide comparable access and accommodations. MCHCP shall have the right, at reasonable times and at a site designated by MCHCP, to audit the books, documents and records of Contractor to the extent that the books, documents and records relate to costs or pricing data for this Contract. Contractor agrees to maintain records which will support the prices charged and costs incurred for performance of services performed under this Contract. To the extent described herein, Contractor shall give full and free access to all records to MCHCP and/or their authorized representatives.

○ Confirmed
○ Not confirmed (please explain)

1.35 Acceptance: No contract provision or use of items by MCHCP shall constitute acceptance or relieve Contractor of liability in respect to any expressed or implied warranties.

○ Confirmed
○ Not confirmed (please explain)

1.36 Termination for Cause: MCHCP may terminate this contract, or any part of this contract, for cause under any one of the following circumstances: 1) Contractor fails to make delivery of goods or services as specified in this Contract; 2) Contractor fails to satisfactorily perform the work specified in this Contract; 3) Contractor fails to make progress so as to endanger performance of this Contract in accordance with its terms; 4) Contractor breaches any provision of this Contract; 5) Contractor assigns this Contract without MCHCP's approval; or 6) Insolvency or bankruptcy of the Contractor. MCHCP shall have the right to terminate this Contract, in whole or in part, if MCHCP determines, at its sole discretion, that one of the above listed circumstances exists. In the event of termination, Contractor shall receive payment prorated for that portion of the contract period services were provided to and/or goods were accepted by MCHCP, subject to any offset by MCHCP for actual damages including loss of any federal matching funds. Contractor shall be liable to MCHCP for any

reasonable excess costs for such similar or identical services included within the terminated part of this Contract.

○ Confirmed
○ Not confirmed (please explain)

1.37 Arbitration, Damages, Warranties: Notwithstanding any language to the contrary, no interpretation shall be allowed to find MCHCP has agreed to binding arbitration, or the payment of damages or penalties upon the occurrence of a contingency. Further, MCHCP shall not agree to pay attorney fees and late payment charges beyond those available under this Contract, and no provision will be given effect which attempts to exclude, modify, disclaim or otherwise attempt to limit implied warranties of merchantability and fitness for a particular purpose.

○ Confirmed
○ Not confirmed (please explain)

1.38 Assignment: Contractor shall not assign, convey, encumber, or otherwise transfer its rights or duties under this Contract without prior written consent of MCHCP. This Contract may terminate in the event of any assignment, conveyance, encumbrance or other transfer by Contractor made without prior written consent of MCHCP. Notwithstanding the foregoing, Contractor may, without the consent of MCHCP, assign its rights to payment to be received under this Contract, provided that Contractor provides written notice of such assignment to MCHCP together with a written acknowledgment from the assignee that any such payments are subject to all of the terms and conditions of this Contract. For the purposes of this Contract, the term "assign" shall include, but shall not be limited to, the sale, gift, assignment, pledge, or other transfer of any ownership interest in the Contractor provided, however, that the term shall not apply to the sale or other transfer of stock of a publicly traded company. Any assignment consented to by MCHCP shall be evidenced by a written assignment agreement executed by Contractor and its assignee in which the assignee agrees to be legally bound by all of the terms and conditions of this Contract and to assume the duties, obligations, and responsibilities being assigned. A change of name by Contractor, following which Contractor's federal identification number remains unchanged, shall not be considered to be an assignment hereunder. Contractor shall give MCHCP written notice of any such change of name.

○ Confirmed
○ Not confirmed (please explain)

1.39 Compensation/Expenses: Contractor shall be required to perform the specified services at the price(s) quoted in this Contract. All services shall be performed within the time period(s) specified in this Contract. Contractor shall be compensated only for work performed to the satisfaction of MCHCP. Contractor shall not be allowed or paid travel or per diem expenses except as specifically set forth in this Contract.

○ Confirmed
○ Not confirmed (please explain)

1.40 Contractor Expenses: Contractor will pay and will be solely responsible for Contractor's travel expenses and out-of-pocket expenses incurred in connection with providing the services. Contractor will be responsible for payment of all expenses related to salaries, benefits, employment taxes, and insurance for its staff.

○ Confirmed
○ Not confirmed (please explain)

1.41 Conflicts of Interest: Contractor shall not knowingly employ, during the period of this Contract or any extensions to it, any professional personnel who are also in the employ of the State of Missouri or MCHCP and who are providing services involving this Contract or services similar in nature to the scope of this Contract to the State of Missouri. Furthermore, Contractor shall not knowingly employ, during the period of this Contract or any extensions to it, any employee of

MCHCP who has participated in the making of this Contract until at least two years after his/her termination of employment with MCHCP.

○ Confirmed
○ Not confirmed (please explain)

1.42 Patent, Copyright, and Trademark Indemnity: Contractor warrants that it is the sole owner or author of, or has entered into a suitable legal agreement concerning either: a) the design of any product or process provided or used in the performance of this Contract which is covered by a patent, copyright, or trademark registration or other right duly authorized by state or federal law or b) any copyrighted matter in any report document or other material provided to MCHCP under this Contract. Contractor shall defend any suit or proceeding brought against MCHCP on account of any alleged patent, copyright or trademark infringement in the United States of any of the products provided or used in the performance of this Contract. This is upon condition that MCHCP shall provide prompt notification in writing of such suit or proceeding; full right, authorization and opportunity to conduct the defense thereof; and full information and all reasonable cooperation for the defense of same. As principles of governmental or public law are involved, MCHCP may participate in or choose to conduct, in its sole discretion, the defense of any such action. If information and assistance are furnished by MCHCP at the Contractor's written request, it shall be at Contractor's expense, but the responsibility for such expense shall be only that within Contractor's written authorization. Contractor shall indemnify and hold MCHCP harmless from all damages, costs, and expenses, including attorney's fees that the Contractor or MCHCP may pay or incur by reason of any infringement or violation of the rights occurring to any holder of copyright, trademark, or patent interests and rights in any products provided or used in the performance of this Contract. If any of the products provided by Contractor in such suit or proceeding are held to constitute infringement and the use is enjoined, Contractor shall, at its own expense and at its option, either procure the right to continue use of such infringement products, replace them with non-infringement equal performance products or modify them so that they are no longer infringing. If Contractor is unable to do any of the preceding, Contractor agrees to remove all the equipment or software which are obtained contemporaneously with the infringing product, or, at the option of MCHCP, only those items of equipment or software which are held to be infringing, and to pay MCHCP: 1) any amounts paid by MCHCP towards the purchase of the product, less straight line depreciation; 2) any license fee paid by MCHCP for the use of any software, less an amount for the period of usage; and 3) the pro rata portion of any maintenance fee presenting the time remaining in any period of maintenance paid for. The obligations of Contractor under this paragraph continue without time limit. No costs or expenses shall be incurred for the account of Contractor without its written consent.

○ Confirmed
○ Not confirmed (please explain)

1.43 Tax Payments: Contractor shall pay all taxes lawfully imposed on it with respect to any product or service delivered in accordance with this Contract. MCHCP is exempt from Missouri state sales or use taxes and federal excise taxes for direct purchases. MCHCP makes no representation as to the exemption from liability of any tax imposed by any governmental entity on Contractor.

○ Confirmed
○ Not confirmed (please explain)

1.44 Disclosure of Material Events: Contractor agrees to immediately disclose any of the following to MCHCP to the extent allowed by law for publicly traded companies: (*) Any material adverse change to the financial status or condition of Contractor; (*) Any merger, sale or other material change of ownership of Contractor; (*) Any conflict of interest or potential conflict of interest between Contractor's engagement with MCHCP and the work, services or products that Contractor is providing or proposes to provide to any current or prospective customer; and (1) Any material investigation of Contractor by a federal or state agency or self-regulatory organization; (2) Any material complaint against Contractor filed with a federal or state agency or self-regulatory organization; (3) Any material proceeding naming Contractor before any federal or state agency or self-regulatory organization; (4) Any material criminal or civil action in state or federal court naming Contractor as a defendant; (5) Any material fine, penalty, censure or other disciplinary action taken

against Contractor by any federal or state agency or self-regulatory organization; (6) Any material judgment or award of damages imposed on or against Contractor as a result of any material criminal or civil action in which Contractor was a party; or (7) Any other matter material to the services rendered by Contractor pursuant to this Contract. For the purposes of this paragraph, "material" means of a nature or of sufficient monetary value, or concerning a subject which a reasonable party in the position of and comparable to MCHCP would consider relevant and important in assessing the relationship and services contemplated by this Contract. It is further understood that in fulfilling its ongoing responsibilities under this paragraph, Contractor is obligated to make its best faith efforts to disclose only those relevant matters which to the attention of or should have been known by Contractor's personnel involved in the engagement covered by this Contract and/or which come to the attention of or should have been known by any individual or office of Contractor designated by Contractor to monitor and report such matters. Upon learning of any such actions, MCHCP reserves the right, at its sole discretion, to terminate this Contract.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.45 MCHCP's rights Upon Termination or Expiration of Contract: If this Contract is terminated, MCHCP, in addition to any other rights provided under this Contract, may require Contractor to transfer title and deliver to MCHCP in the manner and to the extent directed, any completed materials. MCHCP shall be obligated only for those services and materials rendered and accepted prior to termination.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.46 Termination by Mutual Agreement: The parties may mutually agree to terminate this Contract or any part of this Contract at any time. Such termination shall be in writing and shall be effective as of the date specified in such agreement.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.47 Retention of Records: Unless MCHCP specifies in writing a shorter period of time, Contractor agrees to preserve and make available all of its books, documents, papers, records and other evidence involving transactions related to this contract for a period of seven (7) years from the date of the expiration or termination of this contract. Matters involving litigation shall be kept for one (1) year following the termination of litigation, including all appeals, if the litigation exceeds seven (7) years. Contractor agrees that authorized federal representatives, MCHCP personnel, and independent auditors acting on behalf of MCHCP and/or federal agencies shall have access to and the right to examine records during the contract period and during the seven (7) year post contract period. Delivery of and access to the records shall be at no cost to MCHCP.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.48 Change in Laws: Contractor agrees that any state and/or federal laws, applicable rules and regulations enacted during the terms of the Contract which are deemed by MCHCP to necessitate a change in the contract shall be deemed incorporated into the Contract. MCHCP will review any request for additional fees resulting from such changes and retains final authority to make any changes. In consultation with Contractor, a consultant may be utilized to determine the cost impact.

- ○ Confirmed
- ○ Not confirmed (please explain)

1.49 Response/Compliance with Audit or Inspection Findings: Contractor must take action to ensure its subcontractors' compliance with or correction of any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle relating to the services or any other deficiency contained in any audit, review, or inspection. This action will include

Contractor's delivery to MCHCP, for MCHCP's approval, a corrective action plan that address deficiencies identified in any audit(s), review(s), or inspection(s) within thirty (30) calendar days of the close of the audit(s), review(s), or inspection(s).

- ○ Confirmed
- ○ Not confirmed (please explain) _____

1.50 Inspections: Upon notice from MCHCP, Contractor will provide, and will cause its subcontractors to provide, such auditors and/or inspectors as MCHCP may from time to time designate, with access to Contractor service locations, facilities or installations. The access described in this section shall be for the purpose of performing audits or inspections of the Services and the business of MCHCP. Contractor must provide as part of the services any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

- ○ Confirmed
- ○ Not confirmed (please explain) _____

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These responses are provided by MCHCP to questions received from potential bidders for the 2019 Group Medicare Advantage RFP.

	General	Response
1	Please provide the most current Summary Plan Document containing the Medicare benefits available to retirees today. If the SPD is not available, please provide a summary of these benefits with as much detail as possible. This will help ensure claims analysis is appropriate.	The Summary of Benefits And Coverage for the 2018 Plan Year is found at http://www.mchcp.org/documents/st_sbc_2018.pdf. The 2018 Benefit Guide can be found at http://www.mchcp.org/documents/st_benefitGuide_2018.pdf. All the details of coverage can be found in state regulations for Missouri Consolidated Health Care plan Title 22, Chapter 2 at https://www.sos.mo.gov/adrules/csr/current/22csr/22csr.asp
2	If any benefits changed from the claims experience period, please indicate what changes were made. If this list is not available, please provide the benefit summaries that would correspond with each claims experience period.	Any changes over the last 2 years to preventive care and screenings services recommended by the U.S. Preventive Services Task Force (categories A and B) were adopted by MCHCP for all plans. Added coverage of the following to both the PPO 300 and PPO 600 Plans: Breast tomosynthesis (three-dimensional (3D) mammography) 100% coverage for 4 Diabetes Education visits, when taught by a Certified Diabetes Educator through a medical network provider. Must be ordered by a provider.
3	Has a cap been placed on the employer contribution? If so, what is the cap level and has it been met?	The current formula for contribution is found in state regulation in 22 CSR 10-2.030 (6) Contributions https://www.sos.mo.gov/cmsimages/adrules/csr/current/22csr/22c10-2.pdf
4	Please indicate whether retirees are allowed to come back on the plan if they have previously opted out.	Once a retiree terminates coverage, s/he is not eligible to re-enroll with MCHCP.
5	Please confirm if the population is a closed group with no newly retired members eligible to join.	Newly retired members are eligible to join.
6	Will the members be eligible to remain on the active (commercial) plan in addition to the Medicare Advantage offering?	No.
7	If available, please provide the medical claims data split by plan/benefit option.	MCHCP has provided an additional reference file, Attachment 5, that includes the information requested.

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8	To ensure that we are analyzing claims data appropriately, we will need to better understand how the member's current plan coordinates with Medicare. If the Summary Plan Documents are available, we may be able to determine the method of coordination from the language within the SPD. We need to understand what the member's liability is after Medicare and the Plan have both paid. Please confirm which of the following examples best describe how the Medicare Retiree plan design works today. Some examples of coordination we see most often are as follows: <u>Example 1</u> - Medicare Pays 80% - Plan document states the Plan will pay remaining amount up to allowed amount and up to a percentage listed on summary. In this simple scenario, the plan would pay the remaining 20% coinsurance; the member would be responsible for no out of pocket costs. If there are any plan deductibles or copayment amounts, please confirm if the members are still responsible for these amounts. <u>Example 2</u> - Medicare Pays 80% - Plan document states the Plan will pay on remaining amount after Medicare pays (20%). Plan will then pay the percentage that is listed on the summary and apply it to the remaining amount. In this scenario, the plan would pay 80% of the remaining 20% of the charge. This would result in the member being responsible for a 4% coinsurance after both Medicare and the plan have paid. <u>Example 3</u> - Medicare Pays 80% - Plan document states the Plan will only make payment if the amount paid by Medicare is less than what the plan would have paid if it were primary. In this scenario, the plan would have paid 80%, but because Medicare had already paid the 80%, the plan will pay nothing and the member will be responsible for 20%.	The Summary of Benefits And Coverage for the 2018 Plan Year is found at http://www.mchcp.org/documents/st_sbc_2018.pdf. The 2018 Benefit Guide can be found at http://www.mchcp.org/documents/st_benefitGuide_2018.pdf. All the details of coverage can be found in state regulations for Missouri Consolidated Health Care plan Title 22, Chapter 2 https://www.sos.mo.gov/adrules/csr/current/22csr/22csr.asp. A description of how coordination of benefits work with Medicare and PPO plans can be found at MCHCP's website at http://www.mchcp.org/stateMembers/coordinationOfBenefits.asp
9	Are the current rates and/or prior year rate history available for the two PPO plans?	Please see attached.

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10	Have there been any changes to the PPO 300 or PPO 600 plans in the past two years? If so, could you list these changes?	There have been no changes to the structure (e.g. deductible, coinsurance) of the PPO 300 and PPO 600 Plan in the last 2 years. Subscribers may choose to not have contraception coverage if such items or procedures are contrary to his/her religious beliefs or moral convictions. Any changes over the last 2 years to preventive care and screenings services recommended by the U.S. Preventive Services Task Force (categories A and B) were adopted by MCHCP for all plans. Added coverage of the following to both the PPO 300 and PPO 600 Plans: Breast tomosynthesis (three-dimensional (3D) mammography) 100% coverage for 4 Diabetes Education visits, when taught by a Certified Diabetes Educator through a medical network provider. Must be ordered by a provider.
11	Do members get to choose between the two plans as they age in?	As members become eligible for Medicare, today, they stay in the plan they were enrolled in before they turned 65 or otherwise become eligible for Medicare.
12	Can members switch between plans before the start of each plan year?	Members can currently switch between plans during Open Enrollment of each year.
13	Will MCHCP accept stipulations on premium increases in 2020 and 2021 tied to items outside of the carrier's control, such as CMS controlled changes in year over year revenue?	That can be negotiated.
14	Please confirm which example below best describes how the retiree plans coordinate with Medicare: » After Medicare pays 80%, the plan subtracts what it would have paid from the actual amount Medicare paid if it were Primary. Since the plan would have paid 80% as Primary, the same as Medicare did, the plan will pay nothing. » After Medicare pays 80%, the plan pays 80% of the remaining 20% of the charge. After both Medicare and the plan have paid out, the member would pay 4% coinsurance. » After Medicare pays 80%, the retiree plan will pay up to 100% of the remaining amount so the member incurs no out-of-pocket costs.	A description of how coordination of benefits work with Medicare and PPO plans can be found at MCHCP's website at http://www.mchcp.org/stateMembers/coordinationOfBenefits.asp

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15	Please provide clarity on the instructions related to pricing guarantees. The Instructions file indicates, “Bidders are required to submit firm, fixed prices for 2019 and not-to-exceed prices for 2020 and 2021. Rates for 2022, 2023 and 2024 will be negotiated.” The instructions in form A-8 states: “The bidder must provide firm, fixed PEPM pricing for providing the plan designs described on the "Proposed Plan Designs" tab of this workbook.” However, the instructions in A-8 tab Pricing Submission states “For each plan quoted, please fill out the Year 1 components of the insured monthly premium rate in the yellow shaded cells. Please also fill in the assumed Year 1 and Year 2 trend by component and indicate in the orange shaded box to the right whether the trend rate is guaranteed or illustrative, along with any other supporting comments”. Is MCHCP looking for trends by component or on the total premium?	MCHCP is looking for not-to-exceed total fees for 2020 and 2021, but would like to see how those total fees are derived by component.
16	In the file ‘Reference_State of Missouri-Introduction and Instructions – 2019’, it says, “Prescription drugs are provided through an Employer Group Waiver Plan (EGWP) Prescription Drug Plan (PDP) through Express Scripts and are not included as part of this RFP”. Will the same pharmacy plan be paired with both of the PPO plans? If not, please outline the difference between the pharmacy plans and which one is paired with each PPO plan.	There is only one prescription drug plan.
17	Please confirm this is a full replacement opportunity, meaning the only plans that will be available to eligible retirees are the Medicare Advantage plans, effective 1/1/19. Additionally, please confirm your intent to select a single Medicare Advantage carrier.	It is MCHCP's intent that this is a full replacement. MCHCP reserves the right to award to multiple vendors.
18	We know that MCHCP currently offers two plans; your RFP details two plans that will replace them. Is your plan to default members to their “like” plan for purposes of the transition? Or will you require an “active enrollment” this fall?	The RFP ask for 2 plans to be quoted. That does not mean that two plans will necessarily be offered. There will be a default plan chosen for those that were enrolled and did not make an active choice.
19	For claims data provided, can you please provide member paid amount broken down by month (same format/time period as other claims information provided)?	MCHCP has provided an additional reference file, Attachment 5, that includes the information requested.
20	For claims data provided, can you please provide a definition and explanation for “Third Party Amt Med?”	Third Party Amt Med is the amount paid by all third party payers for facility and professional services provided under medical coverage.
21	Will MCHCP make available a provider file to allow bidders to prepare a provider match report?	As it is MCHCP’s strong preference to have for a passive PPO network, there isn’t a need for a provider match exercise.
22	Will MCHCP provide a claim file to assist bidders in preparing pricing?	MCHCP has provided extensive information on an aggregate level. MCHCP may consider providing more detailed data for finalists if warranted.

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Minimum Bidder Requirements		Response
1	Does a surety bond meet the minimum requirements for a Performance Bond?	A performance bond is a type of surety bond.

Scope of Work		Response
1	Section B10.4 states "The contractor must agree to place three (3) percent of annual premium at risk as an implementation fee guarantee for the successful implementation of MCHCP's plan on January 1, 2019. Please confirm this applies to the employee annual premium.	This applies to the total premium rate for the coverage regardless of the portion of the premium funded by MCHCP or the covered retiree.
2	Can you provide a sample file layout from Truven?	MCHCP has provided an additional reference file, Attachment 6, that includes the kinds of information expected to be submitted to Truven from the contractor. The specific layout and format will be agreed upon with Truven.
3	The timetables laid out for eligibility testing in B9.3 and B10.2 seem to conflict. Are the test results desired by September 21 or October 12?	There is a conflict on the dates. Please use the dates provided in B9.3.
4	Regarding item B6.2 from the Scope of Work, will there be a prior notice and if so what is the notice time frame for an audit? How many audits can be expected during life of contract?	There will be prior notice. MCHCP does not expect to audit more than annually.
5	Regarding item B6.3 from the Scope of Work, what is considered promptly?	As defined: done, performed, delivered, etc. at once or without delay.

Questionnaire		
1	Regarding Q2.5, please define “non-employer members”.	These would be the number of members covered on an individual basis under the specified product category. In determining these counts, please consider all plans and not just those offered on a group basis.
2	So that we can generate a useful implementation timetable in response to Q3.3, please provide the following background information: 1. Will the selected carrier be the sole carrier? 2. Of the total membership, what is the expected enrollment in the Medicare Advantage plan(s)? 3. Is there an open enrollment period? If so, what are the dates? 4. What is the expected enrollment process (e.g., paper, spreadsheet, automated, etc.)? 5. Do you expect a dedicated open enrollment/customer service phone number? 6. How is the group billing currently done (e.g., group billed, member billed, etc.)? 7. Are customizations going to be needed for member materials (e.g., co-branding, MCHCP logo, etc.)?	1. MCHCP reserves the right to award to multiple vendors. 2. Refer to information in the Introduction and Instruction and attachments in reference documents. 3. Open enrollment is held in October of each year as indicated in Scope of Work, B8.5. 4. Enrollment is completed electronically or by paper at the member's choice. 5. Reference Scope of Work, B8.2. 6. Reference Scope of Work, B12 7. Reference Scope of Work B8.5

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3	For Q8.2 regarding how long our clinical programs have been in place, can we indicate “More than 10 years” rather than specifying a date? Also, is the question about wellness initiatives we have in place or is it about how we handle high-risk members?	You may indicate the length of time in the way you wish. Question 8.2 is about health management programs as indicated in the list of type of programs.
4	Is Q8.4 asking how we monitor our UM process or what we do if our UM team identifies a potential issue with a member from a clinical standpoint?	Q8.4 is from the perspective of the member.
5	Regarding Q13.3, what are the parameters we should use for the GeoAccess analysis?	Bidders should use the access standard of 2 primary care physicians within 15 miles, 1 specialist within 20 miles, and 1 hospital within 20 miles.
6	Regarding Q17.2, 17.3 and 17.4, are the questions regarding the methodology to be answered for the initial 2019 pricing or for future renewal ratings?	17.3 refers to the initial 2019 pricing; 17.2 and 17.4 apply to both the initial pricing and future renewal ratings. If appropriate, please provide separate responses to question 17.2 and 17.4 for initial and renewal calculations.
7	For 2.12, what is meant by CMS Performance Reporting? What specific data is MCHCP interested in here?	This question refers to publicly-available carrier reporting required by CMS around plan performance.
8	For 2.20, what is meant by “number of plans?” Does it mean the number of different plan design options? Or does it mean the number of Group Medicare Advantage clients we expect to be providing services for?	The question is referring to the number of Group Medicare Advantage clients you expect to be providing services for.
9	Regarding question 2.21, can you provide additional detail and clarification on what is desired for a “description of the economic impact returned to the State of Missouri through tax revenue obligations?”	Please refer to Section 34.010, RSMo.
10	For question 2.19, what if we have more than 5 vendors to list. Can we upload a supplementary file as a response document?	Yes. Supplementary exhibits may be uploaded.
11	For question 3.6, we certainly have flexibility to work with MCHCP on non-standard banking requirements; however, it would be helpful to have clarification. Can MCHCP provide any additional details on what non-standard requirements might be needed?	Pursuant to Exhibit B, Section B12.1; MCHCP will initiate the self-billed payment electronically to the contractor's financial institution by the 10th of the month following coverage. As the self-billed payment is initiated by MCHCP and transmitted via ACH to the contractor, no debit draws from the contractor will be necessary.
12	For question 4.21, beyond MCHCP’s logo, what other potential ID card customizations does MCHCP require?	MCHCP is asking if cards can be customized; there are no specific details on issues for customization at this time.
13	Regarding question 9.3, can MCHCP provide any additional detail regarding the nature of the coordination with ESI?	MCHCP is asking what information you need from the EGWP PDP to properly manage the MA Plan and the frequesncy you need the information. The bidder needs to identify its data needs.
14	Regarding Q8.4, what is meant by “problem identification process"? Is this question asking about our peer-to-peer process, or appeals, or something else? What is meant by “success rate?”	This question is specifically referring to utilization management and the process the carrier has in place to identify and intervene to resolve issues. Success rate refers to how often these interventions are successful.
15	Regarding Q8.7, does the plan sponsor want to know about pre-certification specifically or the UM process for making determinations for unplanned care?	The bidder can answer both.
16	Regarding Q8.9, please clarify what is meant by “monitoring HCC scores.” Very importantly, please clarify the distinction between what the plan sponsor would like to know in questions 8.9 and 8.10	We are interested in how carriers monitor and work within the constructs of the HCC risk adjustment model, and the ROI associated with monitoring of HCC scores.

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17	Regarding Q8.10, is this question asking how we get accurate information about members' conditions so we get accurate CMS payments?	Confirmed.
18	Regarding Q8.14, please clarify what is meant by "care management criteria." Is the plan sponsor asking how many members are identified for any care management activity (e.g., CM, UM, Stars, etc.), or how many members are identified for a specific care management activity or activities?	This question is specifically asking for how many members meet your definition of identification for a care management activity.

Mandatory Contract Provisions		**Response**
1	Regarding Q1.21, does "off-shore services" refer to all services, or only to member-facing services?	Off shore services refers to all services which are to be requried to be performed under the contract.

Exhibit A-8		**Response**
1	The two Medicare Advantage plan grids provided do not indicate an out of network benefit. Is the desire of MCHCP to have both plans operate as passive PPOs, or would MCHCP be interested in reviewing a tiered plan where out-of-network benefits are reduced?	For the 2 plans quoted, MCHCP is looking at a passive PPO. The bidder may propose another plan design in the supplement pricing section.
2	In the member out of pocket maximum, is the deductible included in these amounts?	The deductible is included.
3	The instructions state PEPM pricing is to be supplied. Please confirm that PMPM pricing is acceptable.	PMPM is acceptable.
4	Routine Eye Exam benefit: Please confirm if this is a non-Medicare covered annual exam.	Confirmed.
5	Non-Routine Eye Exam benefit: Please confirm if this is a Medicare covered exam.	Confirmed.
6	Foreign Travel Hospital Care (60 days per lifetime) – Please confirm if this is Emergency (Post- ER) care only, or Non-emergency hospitalization (i.e. traveling to a different country for surgery)?	This benefit is meant to cover emergency care.
7	Regarding the pricing exhibit, may we upload supplementary exhibits and stipulations as response documents, or are we limited solely to the provided Excel exhibit?	Yes. Supplementary exhibits may be uploaded.
8	Please confirm that lab cost share is intended to be $0 on both plans while the x-ray cost share is $25 in Plan 1 and $40 in Plan 2. (Given CMS guidelines, the $40 copay for Plan 2 is likely too high given their 50% rule.)	Our intent is that lab cost share be covered at $0; to the extent your interpretation of CMS guidelines requires a different copayment for x-ray in Plan 2, please quote on what you can administer and note the difference.

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9	In the Pricing Submission tab included in the "Response State of Missouri Exhibit A-8 Medicare Advantage Plan Designs and Pricing", Core (Medicare A&B) incurred claims and Wrap incurred claims are listed separately. Medicare Advantage pays first dollar with no split between Core (Medicare A&B) and Wrap incurred claims. Please advise how we should complete this exhibit.	We are looking to have the expected cost for core services (Medicare covered) and wrap services (non-Medicare covered) identified separately in the pricing document. If this is not possible the entire cost can be entered in core services with an explanatory note as to why the expected costs cannot be provided separately.

Missouri Consolidated Health Care Plan
Premium Equivalents for Medicare Members
2016-2018

PPO 300 Plan

	2016				2017				2018			
	Medical	Rx	ASO Fees	Total	Medical	Rx	ASO Fees	Total	Medical	Rx	ASO Fees	Total
Retiree Only With Medicare	$142	$185	$17	$344	$132	$178	$17	$327	$133	$188	$17	$338
Retiree/Spouse Without Medicare	880	385	35	1,300	869	377	35	1,280	986	403	35	1,424
Retiree/Spouse Without Medicare and one Child	1,087	437	39	1,564	1,075	428	39	1,543	1,225	459	39	1,724
Retiree/Spouse Without Medicare and two Children	1,294	489	44	1,827	1,282	480	44	1,806	1,464	516	44	2,024
Retiree/Spouse Without Medicare and three Children	1,501	541	49	2,091	1,488	532	49	2,069	1,703	572	49	2,323
Retiree/Spouse Without Medicare and four Children	1,708	593	54	2,355	1,694	584	54	2,332	1,942	628	54	2,623
Retiree/Spouse Without Medicare and five or more Children	2,003	667	61	2,731	1,989	657	61	2,707	2,283	708	61	3,051
Retiree/Spouse With Medicare	283	370	35	688	265	356	34	655	267	375	35	676
Retiree/Spouse With Medicare and one Child	490	422	39	952	471	408	39	918	506	431	39	976
Retiree/Spouse With Medicare and two Children	697	474	44	1,215	677	459	44	1,181	744	487	44	1,276
Retiree/Spouse With Medicare and three Children	904	526	49	1,479	883	511	49	1,443	983	543	49	1,576
Retiree/Spouse With Medicare and four Children	1,111	578	54	1,743	1,090	563	54	1,706	1,222	600	54	1,875
Retiree/Spouse With Medicare and five or more Children	1,406	652	61	2,119	1,384	636	61	2,081	1,563	679	61	2,303
Retiree and one child	349	237	22	608	339	230	22	590	372	244	22	638
Retiree and two children	555	289	27	871	545	281	27	853	611	300	27	938
Retiree and three children	762	341	32	1,135	751	333	32	1,116	850	356	32	1,237
Retiree and four children	969	393	37	1,399	957	385	37	1,379	1,089	412	37	1,537
Retiree and five or more children	1,264	467	44	1,775	1,252	458	44	1,754	1,430	492	44	1,965
Surviving Child	207	52	5	264	206	52	5	263	239	56	5	300

PPO 600 Plan

	2016				2017				2018			
	Medical	Rx	ASO Fees	Total	Medical	Rx	ASO Fees	Total	Medical	Rx	ASO Fees	Total
Retiree Only With Medicare	$119	$185	$17	$322	$112	$178	$17	$307	$112	$188	$17	$317
Retiree/Spouse Without Medicare	840	385	35	1,260	830	377	35	1,242	944	403	35	1,382
Retiree/Spouse Without Medicare and one Child	1,042	437	39	1,518	1,031	428	39	1,499	1,177	459	39	1,676
Retiree/Spouse Without Medicare and two Children	1,243	489	44	1,777	1,233	480	44	1,757	1,410	516	44	1,970
Retiree/Spouse Without Medicare and three Children	1,445	541	49	2,036	1,434	532	49	2,015	1,643	572	49	2,264
Retiree/Spouse Without Medicare and four Children	1,647	593	54	2,294	1,635	584	54	2,273	1,876	628	54	2,558
Retiree/Spouse Without Medicare and five or more Children	1,935	667	61	2,663	1,922	657	61	2,641	2,209	708	61	2,977
Retiree/Spouse With Medicare	239	370	35	643	223	356	34	613	225	375	35	635
Retiree/Spouse With Medicare and one Child	441	422	39	902	424	408	39	871	458	431	39	928
Retiree/Spouse With Medicare and two Children	642	474	44	1,161	625	459	44	1,129	691	487	44	1,222
Retiree/Spouse With Medicare and three Children	844	526	49	1,419	827	511	49	1,387	924	543	49	1,516
Retiree/Spouse With Medicare and four Children	1,046	578	54	1,678	1,028	563	54	1,644	1,157	600	54	1,810
Retiree/Spouse With Medicare and five or more Children	1,334	652	61	2,047	1,315	636	61	2,012	1,489	679	61	2,230
Retiree and one child	321	237	22	580	313	230	22	564	345	244	22	611
Retiree and two children	523	289	27	839	514	281	27	822	578	300	27	905
Retiree and three children	725	341	32	1,098	715	333	32	1,080	811	356	32	1,199
Retiree and four children	926	393	37	1,356	916	385	37	1,338	1,044	412	37	1,493
Retiree and five or more children	1,215	467	44	1,725	1,204	458	44	1,706	1,377	492	44	1,912
Surviving Child	202	52	5	259	201	52	5	258	233	56	5	294

Attachment 5
Claims experience by plan

Subsets	Members with Medicare			
State or Public Entity	State			
Plan	PPO 300 Plans		PPO 600 Plans	
Time Period: Incurred Plan Year	Jan 2016 - Dec 2016	Jan 2017 - Nov 2017	Jan 2016 - Dec 2016	Jan 2017 - Nov 2017
Allowed Amount IP Acute Fac	$24,578,900.99	$22,517,300.10	$10,717,654.52	$11,171,991.55
Net Pay IP Acute Fac	$2,372,617.16	$2,106,685.79	$1,094,059.59	$1,100,671.39
Allowed Amount IP Non Acute Fac	$12,823.42	$0.00	$9,276.60	$0.00
Net Pay IP Non Acute Fac	$8,282.76	$0.00	$2,180.50	$0.00
Allowed Amount IP LTC Fac	$6,201,848.84	$6,045,681.32	$4,216,668.34	$2,776,267.86
Net Pay IP LTC Fac	$1,035,834.56	$1,107,846.50	$691,885.15	$494,648.27
Allowed Amount OP Fac Med	$25,925,943.22	$25,564,097.37	$11,834,574.94	$11,033,922.13
Net Pay OP Fac Med	$3,436,183.88	$3,172,377.48	$1,711,936.92	$1,381,217.89
Allowed Amount OP Prof Med	$30,129,409.26	$27,770,009.26	$11,640,866.31	$12,247,081.93
Net Pay OP Prof Med	$6,253,909.39	$5,680,595.78	$2,271,780.15	$2,291,186.56
Allowed Amount IP Acute Prof	$4,057,885.62	$3,777,822.92	$1,849,174.20	$1,825,444.11
Net Pay IP Acute Prof	$619,949.13	$563,778.75	$274,322.38	$289,295.15
Allowed Amount IP Non Acute Prof	$23,014.75	$23,973.48	$10,543.31	$13,643.10
Net Pay IP Non Acute Prof	$3,396.57	$3,014.28	$1,468.59	$1,939.26
Allowed Amount IP LTC Prof	$376,852.48	$388,636.67	$384,270.94	$331,301.44
Net Pay IP LTC Prof	$66,587.35	$72,690.31	$59,731.06	$59,675.92
Allowed Amount Med	$91,306,678.58	$86,087,797.95	$40,663,029.16	$39,399,652.12
Net Pay Med	$13,796,760.80	$12,707,001.28	$6,107,364.34	$5,618,634.44

2017 Claims experience represent claims incurred through Nov. 2017 and paid through Feb. 2018.

Attachment 5

Claims experience by service category by plan
State

Subsets	Members with Medicare			
Time Period: Incurred Plan Year	Jan 2016 - Dec 2016			
Plan	PPO 300 Plans			
Service Category	Patients Med	Allowed Amount Med	Net Pay Med	Out of Pocket Med
Facility Inpatient Long Term Care	325	$5,968,869.19	$994,625.31	
Facility Inpatient Maternity				
Facility Inpatient Medical	1,599	$11,249,829.94	$1,728,979.96	
Facility Inpatient Non Acute	4	$12,823.42	$8,282.76	
Facility Inpatient Surgical	659	$13,007,841.78	$582,688.62	
Facility Outpatient DME	8	$25,948.50	$19,208.95	
Facility Outpatient Diagnostic Services	2,440	$356,860.64	$41,751.47	
Facility Outpatient Dialysis	45	$3,692.37	$621.63	
Facility Outpatient ER	2,108	$2,345,587.54	$345,667.85	
Facility Outpatient Home Health	658	$46,740.43	$4,994.39	
Facility Outpatient Other	6,057	$14,201,817.80	$1,888,506.17	
Facility Outpatient PT, OT, Speech Therapy	1,554	$280,821.94	$30,478.25	
Facility Outpatient Pharmacy	2,325	$169,507.29	$34,582.25	
Facility Outpatient Specialty Drugs	427	$66,934.20	$14,271.78	
Facility Outpatient Supplies and Devices	975	$40,447.39	$11,232.05	
Facility Outpatient Surgery	2,320	$7,614,110.36	$912,793.73	
Facility Outpatient Transportation	184	$41,533.08	$7,658.56	
Laboratory Outpatient Chemistry Tests	3,238	$118,265.01	$31,073.70	$16,953.51
Laboratory Outpatient Other	3,951	$70,630.12	$17,965.57	$8,069.08
Laboratory Outpatient Pathology	2,583	$503,842.71	$73,523.19	$52,137.17
Mental Health Inpatient	190	$625,221.04	$111,626.20	$9,685.51
Mental Health Office Visits	817	$169,180.44	$18,980.22	$36,611.42
Mental Health Other Outpatient	794	$536,269.19	$74,835.94	$39,293.07
Physician Non-Specialty ER	785	$116,874.75	$15,414.26	$17,964.67
Physician Non-Specialty Inpatient	1,412	$1,010,528.24	$159,880.85	$81,702.36
Physician Non-Specialty Office Visits	7,484	$2,562,058.70	$353,831.18	$605,503.90
Physician Non-Specialty Outpatient Other	2,641	$320,311.74	$47,796.98	$45,279.29
Physician Non-Specialty Outpatient Surgery	429	$219,093.45	$28,396.16	$21,999.80
Physician Specialty ER	2,171	$482,652.63	$68,787.31	$55,667.91
Physician Specialty Inpatient	1,908	$2,907,876.52	$432,394.48	$211,546.63
Physician Specialty Office Visits	7,600	$2,870,972.96	$344,248.41	$613,289.78
Physician Specialty Outpatient Other	5,890	$1,802,680.76	$228,135.30	$362,893.80
Physician Specialty Outpatient Surgery	3,094	$2,498,564.98	$323,267.49	$257,535.04
Professional Chiropractic Services	884	$333,501.19	$76,890.31	$71,119.94
Professional DME	1,712	$2,908,368.31	$1,721,731.71	$283,829.63
Professional Diagnostic Services	6,071	$1,190,475.27	$143,180.00	$209,825.19
Professional Dialysis	58	$96,810.17	$16,903.66	$4,659.29
Professional Home Health	212	$235,067.45	$170,925.91	$8,759.01
Professional Injections	2,549	$793,464.75	$222,697.64	$94,670.59
Professional Office Visits	4,018	$652,669.34	$86,313.65	$149,302.36
Professional PT, OT, Speech Therapy	937	$695,638.90	$170,532.34	$86,680.22

Claims experience by service category by plan

State

Subsets	Members with Medicare			
Time Period: Incurred Plan Year	Jan 2016 - Dec 2016			
Plan	PPO 300 Plans			
Service Category	Patients Med	Allowed Amount Med	Net Pay Med	Out of Pocket Med
Professional Services Other	5,213	$2,530,535.00	$374,275.43	$285,031.39
Professional Specialty Drugs	635	$5,045,247.93	$957,262.12	$187,121.60
Professional Supplies and Devices	2,682	$1,635,080.88	$392,636.39	$177,803.32
Professional Transportation	950	$989,906.68	$223,242.82	$60,753.88
Radiology Outpatient CAT Scans	1,730	$304,615.80	$43,937.02	$37,637.02
Radiology Outpatient MRIs	1,324	$350,717.48	$58,435.27	$37,290.07
Radiology Outpatient Mammograms	725	$56,107.02	$5,320.88	$7,727.76
Radiology Outpatient Nuclear Medicine	799	$130,817.05	$16,012.95	$16,003.16
Radiology Outpatient Other	1,000	$197,086.03	$26,228.14	$20,066.80
Radiology Outpatient Therapeutic Radiology	100	$371,508.23	$60,885.07	$15,306.55
Radiology Outpatient Ultrasounds	1,545	$173,928.01	$20,024.53	$21,059.03
Radiology Outpatient X-Rays	4,370	$351,408.93	$49,313.30	$51,050.78
Substance Abuse Inpatient	5	$4,155.11	$1,068.22	$197.76
Substance Abuse Office Visits	10	$1,474.14	$381.58	$341.77
Substance Abuse Other Outpatient	20	$9,705.80	$2,060.89	$361.03
Vision				

Attachment 5

Claims experience by service category by plan

State

Subsets				
Time Period: Incurred Plan Year	Jan 2016 - Dec 2016			
Plan	PPO 600 Plans			
Service Category	Patients Med	Allowed Amount Med	Net Pay Med	Out of Pocket Med
Facility Inpatient Long Term Care	233	$3,966,832.36	$651,824.00	
Facility Inpatient Maternity				
Facility Inpatient Medical	739	$5,208,138.23	$780,689.01	
Facility Inpatient Non Acute	4	$9,276.60	$2,180.50	
Facility Inpatient Surgical	284	$5,299,852.84	$283,504.72	
Facility Outpatient DME	6	$20,529.91	$19,000.00	
Facility Outpatient Diagnostic Services	999	$164,970.55	$21,654.84	
Facility Outpatient Dialysis	28	$53,868.24	$1,416.29	
Facility Outpatient ER	998	$1,071,084.45	$171,304.14	
Facility Outpatient Home Health	287	$8,347.73	$801.35	
Facility Outpatient Other	2,731	$6,604,937.99	$859,638.24	
Facility Outpatient PT, OT, Speech Therapy	670	$181,901.69	$22,318.73	
Facility Outpatient Pharmacy	1,012	$40,105.98	$9,608.17	
Facility Outpatient Specialty Drugs	152	$14,681.24	$2,125.06	
Facility Outpatient Supplies and Devices	408	$25,251.37	$6,287.86	
Facility Outpatient Surgery	1,077	$3,207,096.36	$514,128.83	
Facility Outpatient Transportation	106	$28,591.46	$5,464.49	
Laboratory Outpatient Chemistry Tests	1,510	$65,949.70	$20,692.79	$13,211.60
Laboratory Outpatient Other	1,707	$29,703.46	$8,318.08	$4,313.31
Laboratory Outpatient Pathology	1,133	$208,187.21	$29,379.26	$36,812.99
Mental Health Inpatient	174	$509,298.92	$78,347.77	$16,944.38
Mental Health Office Visits	361	$69,618.40	$8,461.75	$22,465.58
Mental Health Other Outpatient	384	$239,804.90	$36,298.36	$19,870.43
Physician Non-Specialty ER	348	$48,210.25	$7,823.45	$11,367.20
Physician Non-Specialty Inpatient	752	$564,947.44	$82,739.61	$79,355.93
Physician Non-Specialty Office Visits	3,472	$1,080,228.93	$150,572.69	$363,092.11
Physician Non-Specialty Outpatient Other	1,192	$166,294.39	$51,990.29	$29,429.03
Physician Non-Specialty Outpatient Surgery	169	$79,609.75	$10,051.61	$12,288.56
Physician Specialty ER	1,026	$230,706.66	$36,875.45	$39,814.56
Physician Specialty Inpatient	951	$1,352,376.25	$196,387.06	$136,349.50
Physician Specialty Office Visits	3,318	$1,095,789.98	$130,030.82	$336,427.96
Physician Specialty Outpatient Other	2,432	$663,097.06	$77,025.35	$203,052.84
Physician Specialty Outpatient Surgery	1,327	$1,072,425.25	$147,575.08	$150,350.95
Professional Chiropractic Services	360	$125,771.69	$27,417.63	$40,361.66
Professional DME	676	$1,122,487.33	$603,046.52	$129,192.36
Professional Diagnostic Services	2,595	$459,157.48	$52,385.99	$124,666.46
Professional Dialysis	29	$69,957.98	$12,689.68	$3,856.47
Professional Home Health	92	$28,739.47	$7,280.03	$4,379.57
Professional Injections	1,003	$268,263.49	$44,982.26	$48,231.69
Professional Office Visits	1,743	$266,854.02	$35,079.21	$86,788.87
Professional PT, OT, Speech Therapy	402	$297,205.35	$73,964.75	$49,238.04

Claims experience by service category by plan

State

Subsets				
Time Period: Incurred Plan Year	Jan 2016 - Dec 2016			
Plan	PPO 600 Plans			
Service Category	Patients Med	Allowed Amount Med	Net Pay Med	Out of Pocket Med
Professional Services Other	2,415	$1,057,349.45	$152,543.74	$176,465.30
Professional Specialty Drugs	206	$1,504,101.43	$255,099.24	$73,602.25
Professional Supplies and Devices	1,058	$695,460.29	$169,410.64	$95,040.53
Professional Transportation	476	$505,649.15	$110,247.93	$44,150.99
Radiology Outpatient CAT Scans	672	$111,130.05	$14,966.19	$21,350.54
Radiology Outpatient MRIs	559	$150,865.25	$26,593.67	$25,481.82
Radiology Outpatient Mammograms	308	$26,203.01	$3,974.89	$5,512.61
Radiology Outpatient Nuclear Medicine	317	$59,563.35	$12,737.33	$9,989.38
Radiology Outpatient Other	319	$62,014.62	$8,624.98	$7,247.00
Radiology Outpatient Therapeutic Radiology	47	$224,386.59	$41,253.21	$5,870.79
Radiology Outpatient Ultrasounds	665	$72,963.47	$8,757.00	$16,210.42
Radiology Outpatient X-Rays	1,879	$133,892.17	$16,493.29	$28,800.17
Substance Abuse Inpatient	4	$36,676.74	$5,043.47	$67.70
Substance Abuse Office Visits	7	$1,653.07	$140.35	$400.95
Substance Abuse Other Outpatient	6	$968.16	$116.69	$125.30
Vision				

Attachment 5

Claims experience by service category by plan
State

Subsets				
Time Period: Incurred Plan Year	Jan 2017 - Nov 2017			
Plan	PPO 300 Plans			
Service Category	Patients Med	Allowed Amount Med	Net Pay Med	Out of Pocket Med
Facility Inpatient Long Term Care	290	$5,969,069.26	$1,098,921.25	
Facility Inpatient Maternity	1	$10,598.72	$9,538.84	
Facility Inpatient Medical	1,539	$11,444,872.13	$1,604,920.68	
Facility Inpatient Non Acute	1	$0.00	$0.00	
Facility Inpatient Surgical	582	$10,948,592.55	$471,638.12	
Facility Outpatient DME	23	$39,400.56	$26,194.67	
Facility Outpatient Diagnostic Services	1,467	$389,721.53	$41,450.60	
Facility Outpatient Dialysis	34	$16,543.26	$898.44	
Facility Outpatient ER	806	$560,418.71	$55,522.83	
Facility Outpatient Home Health	75	$30,272.02	$5,240.68	
Facility Outpatient Other	6,498	$20,801,714.67	$2,553,650.10	
Facility Outpatient PT, OT, Speech Therapy	549	$224,595.66	$24,335.62	
Facility Outpatient Pharmacy	815	$263,030.46	$92,636.93	
Facility Outpatient Specialty Drugs	208	$63,190.63	$12,537.95	
Facility Outpatient Supplies and Devices	347	$51,865.72	$8,237.36	
Facility Outpatient Surgery	979	$2,389,874.15	$255,521.25	
Facility Outpatient Transportation	91	$64,511.59	$8,881.38	
Laboratory Outpatient Chemistry Tests	2,203	$112,690.31	$31,425.89	$15,417.42
Laboratory Outpatient Other	3,001	$70,735.99	$16,062.01	$8,874.77
Laboratory Outpatient Pathology	2,423	$461,049.42	$69,867.23	$49,950.08
Mental Health Inpatient	160	$228,920.69	$36,454.53	$5,820.17
Mental Health Office Visits	791	$153,893.87	$17,673.66	$37,190.91
Mental Health Other Outpatient	779	$460,793.86	$61,218.64	$33,668.11
Physician Non-Specialty ER	813	$127,601.30	$17,905.97	$20,682.55
Physician Non-Specialty Inpatient	1,382	$954,000.49	$138,955.16	$83,157.15
Physician Non-Specialty Office Visits	7,306	$2,325,011.68	$291,838.42	$588,452.84
Physician Non-Specialty Outpatient Other	2,501	$282,019.71	$38,219.41	$42,953.56
Physician Non-Specialty Outpatient Surgery	309	$151,145.72	$17,910.31	$15,017.52
Physician Specialty ER	2,059	$461,922.60	$67,848.10	$64,079.93
Physician Specialty Inpatient	1,827	$2,696,414.10	$392,898.81	$205,738.27
Physician Specialty Office Visits	7,524	$2,668,075.24	$309,362.10	$614,334.46
Physician Specialty Outpatient Other	5,709	$1,690,740.25	$203,960.53	$355,433.88
Physician Specialty Outpatient Surgery	2,946	$2,414,597.89	$320,800.60	$240,028.35
Professional Chiropractic Services	838	$287,716.27	$65,082.25	$64,236.78
Professional DME	1,553	$2,421,108.99	$1,510,609.12	$242,202.41
Professional Diagnostic Services	5,854	$1,108,176.48	$127,553.85	$204,720.93
Professional Dialysis	51	$94,026.28	$15,813.04	$6,413.64
Professional Home Health	185	$169,543.05	$138,707.22	$9,181.65
Professional Injections	2,550	$894,630.97	$258,116.97	$93,257.27
Professional Office Visits	4,181	$690,366.79	$82,339.73	$172,425.86
Professional PT, OT, Speech Therapy	903	$674,201.61	$171,106.74	$87,231.92

Claims experience by service category by plan

State

Subsets				
Time Period: Incurred Plan Year	Jan 2017 - Nov 2017			
Plan	PPO 300 Plans			
Service Category	Patients Med	Allowed Amount Med	Net Pay Med	Out of Pocket Med
Professional Services Other	5,117	$2,535,226.32	$384,586.69	$293,557.35
Professional Specialty Drugs	628	$4,077,623.82	$761,909.34	$181,076.57
Professional Supplies and Devices	2,500	$1,656,100.07	$401,835.29	$158,342.57
Professional Transportation	862	$981,310.85	$225,541.34	$56,190.10
Radiology Outpatient CAT Scans	1,589	$312,310.65	$38,061.98	$41,957.27
Radiology Outpatient MRIs	1,268	$334,860.02	$40,034.66	$37,489.47
Radiology Outpatient Mammograms	620	$69,994.37	$7,172.29	$8,347.93
Radiology Outpatient Nuclear Medicine	661	$136,807.85	$15,478.95	$12,072.99
Radiology Outpatient Other	923	$181,999.30	$23,918.73	$19,070.07
Radiology Outpatient Therapeutic Radiology	90	$441,167.40	$76,849.91	$19,150.21
Radiology Outpatient Ultrasounds	1,421	$145,141.41	$16,438.62	$21,691.51
Radiology Outpatient X-Rays	4,181	$309,684.32	$38,812.28	$50,260.20
Substance Abuse Inpatient	5	$20,966.43	$2,458.99	$218.79
Substance Abuse Office Visits	14	$1,621.46	$171.50	$473.37
Substance Abuse Other Outpatient	14	$15,328.50	$1,873.72	$279.67
Vision				

Attachment 5

Claims experience by service category by plan
State

Subsets				
Time Period: Incurred Plan Year	Jan 2017 - Nov 2017			
Plan	PPO 600 Plans			
Service Category	Patients Med	Allowed Amount Med	Net Pay Med	Out of Pocket Med
Facility Inpatient Long Term Care	192	$2,548,004.95	$465,625.77	
Facility Inpatient Maternity	1	$12,464.00	$12,433.00	
Facility Inpatient Medical	710	$5,446,408.37	$786,556.24	
Facility Inpatient Non Acute	2	$0.00	$0.00	
Facility Inpatient Surgical	285	$5,552,145.79	$269,686.28	
Facility Outpatient DME	10	$21,679.93	$13,268.68	
Facility Outpatient Diagnostic Services	656	$168,585.34	$17,753.93	
Facility Outpatient Dialysis	24	$6,569.66	$5,799.00	
Facility Outpatient ER	383	$305,607.68	$38,140.85	
Facility Outpatient Home Health	35	$11,269.55	$1,338.54	
Facility Outpatient Other	3,123	$8,725,883.01	$1,073,147.07	
Facility Outpatient PT, OT, Speech Therapy	285	$167,767.47	$18,993.49	
Facility Outpatient Pharmacy	377	$205,658.74	$24,822.98	
Facility Outpatient Specialty Drugs	76	$16,288.27	$3,673.49	
Facility Outpatient Supplies and Devices	179	$16,026.64	$3,766.93	
Facility Outpatient Surgery	502	$1,061,784.91	$129,492.13	
Facility Outpatient Transportation	26	$14,616.29	$2,868.83	
Laboratory Outpatient Chemistry Tests	1,001	$63,646.77	$21,664.62	$12,620.73
Laboratory Outpatient Other	1,306	$50,630.31	$16,448.28	$4,956.35
Laboratory Outpatient Pathology	1,121	$219,610.33	$32,249.46	$35,407.70
Mental Health Inpatient	149	$451,039.91	$69,273.08	$16,422.47
Mental Health Office Visits	372	$69,443.62	$7,207.50	$24,870.87
Mental Health Other Outpatient	354	$194,127.62	$24,493.09	$18,670.32
Physician Non-Specialty ER	352	$52,956.80	$6,334.10	$16,055.51
Physician Non-Specialty Inpatient	734	$501,281.24	$76,383.54	$66,502.79
Physician Non-Specialty Office Visits	3,587	$1,041,472.03	$134,398.53	$370,625.52
Physician Non-Specialty Outpatient Other	1,114	$116,633.75	$21,424.62	$27,769.78
Physician Non-Specialty Outpatient Surgery	144	$56,711.66	$8,001.96	$7,640.88
Physician Specialty ER	931	$218,095.22	$33,981.39	$41,145.83
Physician Specialty Inpatient	940	$1,320,108.57	$200,585.11	$132,987.30
Physician Specialty Office Visits	3,556	$1,111,900.79	$130,229.91	$356,650.29
Physician Specialty Outpatient Other	2,531	$688,179.61	$73,407.07	$218,869.04
Physician Specialty Outpatient Surgery	1,369	$1,106,993.92	$146,345.29	$153,521.71
Professional Chiropractic Services	415	$136,564.94	$27,080.08	$47,961.73
Professional DME	657	$1,028,260.40	$587,305.50	$124,259.18
Professional Diagnostic Services	2,619	$421,674.84	$46,999.76	$123,423.67
Professional Dialysis	28	$54,708.01	$9,850.02	$3,770.97
Professional Home Health	96	$33,837.84	$13,244.29	$3,591.71
Professional Injections	1,047	$265,530.20	$36,480.87	$53,428.65
Professional Office Visits	1,945	$299,563.89	$34,531.66	$108,571.08
Professional PT, OT, Speech Therapy	406	$300,589.23	$66,920.10	$52,080.51

Claims experience by service category by plan

State

Subsets				
Time Period: Incurred Plan Year	Jan 2017 - Nov 2017			
Plan	PPO 600 Plans			
Service Category	Patients Med	Allowed Amount Med	Net Pay Med	Out of Pocket Med
Professional Services Other	2,567	$1,254,221.63	$190,965.56	$191,948.84
Professional Specialty Drugs	230	$2,176,865.45	$393,182.99	$80,904.71
Professional Supplies and Devices	1,027	$622,195.90	$141,373.25	$94,593.19
Professional Transportation	428	$460,115.88	$84,230.11	$36,025.85
Radiology Outpatient CAT Scans	743	$130,410.64	$17,868.07	$26,783.87
Radiology Outpatient MRIs	561	$147,882.40	$20,140.11	$28,218.18
Radiology Outpatient Mammograms	311	$40,231.12	$4,694.11	$9,167.29
Radiology Outpatient Nuclear Medicine	280	$50,688.50	$5,677.15	$8,809.14
Radiology Outpatient Other	396	$68,930.69	$8,997.49	$11,189.04
Radiology Outpatient Therapeutic Radiology	53	$140,437.51	$30,382.49	$7,307.02
Radiology Outpatient Ultrasounds	647	$67,795.74	$9,116.72	$16,767.00
Radiology Outpatient X-Rays	1,918	$135,790.84	$16,784.99	$30,840.59
Substance Abuse Inpatient	2	$14,753.60	$1,598.50	$280.83
Substance Abuse Office Visits	12	$1,849.37	$131.84	$415.93
Substance Abuse Other Outpatient	3	$3,160.75	$1,284.02	$148.15
Vision				

Attachment 5

MC state members by month by plan

State

Subsets	Members with Medicare									
Plan	PPO 300 Plans					PPO 600 Plans				
Time Period: Incurred Month	Members Med	Allowed Amount Med	Net Pay Med	Out of Pocket Med	Third Party Amt Med	Members Med	Allowed Amount Med	Net Pay Med	Out of Pocket Med	Third Party Amt Med
Dec 2015	9,767	$8,929,138.86	$1,592,941.81	$358,151.70	$6,982,035.61	4,254	$3,091,427.92	$518,785.60	$139,605.14	$2,435,221.88
Jan 2016	9,464	$7,489,424.63	$808,096.42	$1,539,863.48	$5,146,364.35	4,516	$3,169,153.30	$290,011.02	$801,296.36	$2,075,097.20
Feb 2016	9,472	$7,239,271.95	$876,407.01	$1,014,733.23	$5,348,733.90	4,533	$3,200,906.64	$359,414.14	$582,650.93	$2,257,236.20
Mar 2016	9,475	$7,865,025.05	$1,151,494.16	$826,884.99	$5,930,489.14	4,565	$3,376,336.03	$462,835.24	$470,483.07	$2,443,322.29
Apr 2016	9,479	$7,505,392.74	$1,058,104.79	$644,179.99	$5,803,466.31	4,599	$3,477,423.64	$468,086.85	$374,575.18	$2,635,405.98
May 2016	9,485	$7,285,308.94	$1,081,285.51	$532,632.59	$5,675,895.81	4,629	$3,101,575.09	$455,098.35	$298,207.54	$2,352,854.73
Jun 2016	9,488	$7,186,563.05	$1,182,481.06	$471,556.54	$5,533,091.19	4,674	$3,288,768.91	$549,432.29	$277,380.92	$2,463,530.60
Jul 2016	9,493	$7,108,037.59	$1,128,434.31	$388,466.08	$5,588,225.65	4,718	$3,128,853.55	$502,116.63	$207,448.71	$2,419,277.97
Aug 2016	9,509	$7,923,685.86	$1,273,793.35	$416,709.99	$6,232,609.89	4,770	$3,686,479.48	$601,606.02	$234,060.27	$2,850,813.10
Sep 2016	9,517	$7,450,564.73	$1,180,415.51	$349,527.90	$5,919,519.72	4,810	$3,214,024.15	$535,980.16	$191,020.38	$2,487,024.74
Oct 2016	9,546	$8,281,224.17	$1,343,542.01	$353,060.16	$6,582,632.83	4,847	$3,645,449.05	$632,985.86	$191,271.14	$2,821,191.84
Nov 2016	9,555	$7,864,796.09	$1,256,111.80	$331,295.75	$6,277,378.41	4,880	$3,704,513.15	$600,367.19	$168,558.54	$2,935,587.18
Dec 2016	9,557	$8,107,383.78	$1,456,594.87	$336,395.74	$6,314,544.15	4,916	$3,669,546.17	$649,430.59	$169,767.46	$2,850,349.23
Jan 2017	9,589	$8,193,073.53	$860,809.34	$1,587,514.83	$5,744,261.77	4,881	$3,692,992.73	$318,475.91	$878,348.91	$2,496,167.71
Feb 2017	9,583	$7,356,401.21	$852,371.25	$1,007,240.19	$5,496,791.05	4,929	$3,628,566.16	$437,417.63	$587,483.94	$2,603,664.39
Mar 2017	9,573	$8,194,673.11	$1,039,125.22	$844,465.95	$6,311,081.73	4,976	$3,586,063.23	$458,390.13	$515,424.03	$2,609,008.33
Apr 2017	9,574	$7,156,728.53	$1,027,040.63	$624,171.02	$5,505,526.40	5,023	$3,699,274.37	$476,283.66	$402,492.01	$2,820,498.80
May 2017	9,580	$8,112,294.73	$1,189,843.31	$569,446.38	$6,353,004.81	5,058	$3,245,396.07	$484,681.86	$330,524.32	$2,430,190.09
Jun 2017	9,589	$8,247,051.24	$1,354,111.90	$483,336.40	$6,409,601.69	5,125	$3,506,054.47	$535,524.58	$307,517.72	$2,663,012.06
Jul 2017	9,595	$7,610,651.98	$1,222,665.85	$413,620.59	$5,974,367.20	5,183	$3,164,261.40	$485,694.88	$228,228.13	$2,450,338.22
Aug 2017	9,617	$8,319,208.73	$1,295,521.31	$418,163.28	$6,602,413.26	5,236	$3,651,154.14	$591,431.60	$266,398.35	$2,793,324.46
Sep 2017	9,633	$7,468,628.60	$1,254,523.45	$356,209.11	$5,857,896.53	5,280	$3,540,746.14	$577,730.82	$201,456.74	$2,761,558.88
Oct 2017	9,640	$7,900,561.64	$1,287,770.34	$357,045.25	$6,255,745.88	5,327	$4,105,244.06	$680,454.30	$205,532.46	$3,219,257.69
Nov 2017	9,639	$7,528,524.65	$1,323,218.68	$330,551.73	$5,874,754.37	5,355	$3,579,899.35	$572,549.07	$181,764.13	$2,825,586.32

Attachment 5

Utilization by plan

State

Subsets	Members with Medicare			
Plan	PPO 300 Plans		PPO 600 Plans	
Time Period: Incurred Plan Year	Jan 2016 - Dec 2016	Jan 2017 - Nov 2017	Jan 2016 - Dec 2016	Jan 2017 - Nov 2017
Patients Admit	1,628	1,538	758	747
Admits	1,976	1,805	926	877
Days Admit	9,733	8,212	4,556	4,054
Admits Per 1000 Acute	207.93	205.09	196.82	186.69
Days Per 1000 Adm Acute	1,024.17	933.08	968.38	862.97
Visits Office Med	110,059	100,712	41,542	41,949
Visits Per 1000 Office Med	11,581.09	11,443.25	8,829.80	8,929.59
Visits ER	5,581	1,542	2,590	728
Visits Per 1000 ER	587.27	175.21	550.51	154.97
Svcs OP Lab	77,650	32,044	33,987	13,934
Svcs Per 1000 OP Lab	8,170.82	3,640.95	7,223.98	2,966.10
Svcs OP Rad	51,421	35,876	21,896	15,752
Svcs Per 1000 OP Rad	5,410.84	4,076.35	4,654.02	3,353.09

Attachment 5

Definitions

Measure	Definition
Allowed Amount IP Acute Fac	The amount of submitted charges eligible for payment for inpatient acute facility services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay IP Acute Fac	The net amount paid for inpatient acute facility services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount IP Non Acute Fac	The amount of submitted charges eligible for payment for inpatient non-acute care facility services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts. Inpatient non-acute care settings include hospices and inpatient rehabilitation facilities.
Net Pay IP Non Acute Fac	The net amount paid for inpatient non-acute care facility services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted. Inpatient non-acute care settings include hospices and inpatient rehabilitation facilities.
Allowed Amount IP LTC Fac	The amount of submitted charges eligible for payment for inpatient long term care facility services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay IP LTC Fac	The net amount paid for inpatient long term care facility services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount OP Fac Med	The amount of submitted charges eligible for payment for outpatient facility services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay OP Fac Med	The net amount paid for outpatient facility services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount OP Prof Med	The amount of submitted charges eligible for payment for outpatient professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay OP Prof Med	The net amount paid for outpatient professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount IP Acute Prof	The amount of submitted charges eligible for payment for inpatient acute professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay IP Acute Prof	The net amount paid for inpatient acute professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.

Measure	Definition
Allowed Amount IP Non Acute Prof	The amount of submitted charges eligible for payment for inpatient non-acute care professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts. Inpatient non-acute care settings include hospices and inpatient rehabilitation facilities.
Net Pay IP Non Acute Prof	The net amount paid for inpatient non-acute care professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted. Inpatient non-acute care settings include hospices and inpatient rehabilitation facilities.
Allowed Amount IP LTC Prof	The amount of submitted charges eligible for payment for inpatient long term care professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay IP LTC Prof	The net amount paid for inpatient long term care professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount Med	The amount of submitted charges eligible for payment for facility and professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay Med	The net amount paid for facility and professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Patients Admit	The unique count of members who were admitted to an inpatient acute or non-acute facility. Patients are included in this count if they received facility or professional services included in an admission.
Admits	The number of acute and non-acute admissions.
Days Admit	The number of days from admissions. The number of days is assigned during Admission Build. It is based on the days that were reported on those facility claims containing room and board services that are included in the admission.
Admits Per 1000 Acute	The average number of acute admissions per 1000 members with medical coverage per year.
Days Per 1000 Adm Acute	The average number of days from acute admissions per 1000 members with medical coverage per year.
Visits Office Med	The number of professional visits provided in an office setting under medical coverage. The number of visits is based on the count of unique patient, service date, and provider combinations.
Visits Per 1000 Office Med	the average number of professional office visits provided under medical coverage, per 1000 members with medical coverage per year. The number of visits is based on the count of unique patient, service date, and provider combinations.
Visits ER	The number of emergency room facility visits provided under medical coverage. The number of visits is based on the count of unique patient and service date combinations. This includes both ER visits that resulted in an admission and those that did not.
Visits Per 1000 ER	The average number of emergency room facility visits provided under medical coverage, per 1000 members with medical coverage per year. The number of visits is based on the count of unique patient and service date combinations.

Measure	Definition
Svcs OP Lab	The sum of the Service Count field for outpatient facility and professional laboratory and pathology services provided under medical coverage. The Service Count field typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the Service Count is set to 1 (one).
Svcs Per 1000 OP Lab	The average number of outpatient laboratory and pathology services provided under medical coverage, per 1000 members with medical coverage per year. The Service Count field typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the Service Count is set to 1 (one).
Svcs OP Rad	The sum of the Service Count field for outpatient facility and professional radiology and imaging services provided under medical coverage. The Service Count field typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the Service Count is set to 1 (one).
Svcs Per 1000 OP Rad	The average number of outpatient radiology and imaging services provided under medical coverage, per 1000 members with medical coverage per year. The Service Count field typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the Service Count is set to 1 (one).

Attachment 6
Data fields for Claim File Transmission

Field Number	Field Name
1	Adjustment Type Code
2	Allowed Amount
3	Bill Type Code UB
4	Capitated Service Indicator
5	Charge Submitted
6	Claim ID
7	Claim Type Code
8	Coinsurance
9	Copayment
10	Date of Birth
11	Date of First Service
12	Date of Last Service
13	Date of Service Facility Detail
14	Date Paid
15	Days
16	Deductible
17	Diagnosis Code Principal
18	Diagnosis Code 2
19	Diagnosis Code 3
20	Diagnosis Code 4
21	Diagnosis Code 5
22	Diagnosis Code 6
23	Diagnosis Code 7
24	Diagnosis Code 8
25	Diagnosis Code 9
26	Diagnosis Code 10
27	Diagnosis Code 11
28	Diagnosis Code 12
29	Diagnosis Code 13
30	Diagnosis Code 14
31	Diagnosis Code 15
32	Diagnosis Code 16
33	Diagnosis Code 17
34	Diagnosis Code 18
35	Diagnosis Code 19
36	Diagnosis Code 20
37	Diagnosis Code 21
38	Diagnosis Code 22
39	Diagnosis Code 23
40	Diagnosis Code 24
41	Diagnosis Code 25
42	Discharge Status Code UB
43	Discount

Field Number	Field Name
44	Family ID/Employee SSN
45	Gender
46	Line Number
47	Net Payment
48	Network Paid Indicator
49	Network Provider Indicator
50	Ordering Provider ID
51	Ordering Provider Name
52	Ordering Provider Zip Code
53	PCP Responsibility Indicator
54	Place of Service Code
55	Procedure Code
56	Procedure Code UB Surg 1
57	Procedure Code UB Surg 2
58	Procedure Code UB Surg 3
59	Procedure Code UB Surg 4
60	Procedure Code UB Surg 5
61	Procedure Code UB Surg 6
62	Procedure Code UB Surg 7
63	Procedure Code UB Surg 8
64	Procedure Code UB Surg 9
65	Procedure Code UB Surg 10
66	Procedure Code UB Surg 11
67	Procedure Code UB Surg 12
68	Procedure Code UB Surg 13
69	Procedure Code UB Surg 14
70	Procedure Code UB Surg 15
71	Procedure Code UB Surg 16
72	Procedure Code UB Surg 17
73	Procedure Code UB Surg 18
74	Procedure Code UB Surg 19
75	Procedure Code UB Surg 20
76	Procedure Code UB Surg 21
77	Procedure Code UB Surg 22
78	Procedure Code UB Surg 23
79	Procedure Code UB Surg 24
80	Procedure Code UB Surg 25
81	Procedure Modifier Code 1
82	Provider ID
83	TIN
84	Provider Qualifier
85	Provider Type Code Claim
86	Provider Taxonomy Code
87	Provider Zip Code
88	Revenue Code UB
89	Third Party Amount
90	Units of Service

Field Number	Field Name
91	Provider Name
92	Funding Type Code
93	Account Structure
94	Provider NPI Number
95	Provider Address 1
96	Provider Address 2
97	HRA Amount
98	HSA Amount
99	Present on Admission Principal
100	Present on Admission 02
101	Present on Admission 03
102	Present on Admission 04
103	Present on Admission 05
104	Present on Admission 06
105	Present on Admission 07
106	Present on Admission 08
107	Present on Admission 09
108	Present on Admission 10
109	Present on Admission 11
110	Present on Admission 12
111	Present on Admission 13
112	Present on Admission 14
113	Present on Admission 15
114	Present on Admission 16
115	Present on Admission 17
116	Present on Admission 18
117	Present on Admission 19
118	Present on Admission 20
119	Present on Admission 21
120	Present on Admission 22
121	Present on Admission 23
122	Present on Admission 24
123	Present on Admission 25
124	DRG MS Payment Code
125	ICD Version
126	Tax Amount
127	Tax Type Code
128	NDC Number Code
129	Filler
130	Record Type