STATE OF ALASKA
Department of Administration
Division of Retirement and Benefits

# Medical Claims Administrator and Managed Network, Dental Claims Administrator and Network

RFP 190000025

**Amendment #7**

November 30, 2018

**This amendment is being issued to answer questions submitted by potential offerors and to provide additional important information. In addition to adhering to any changes made to the RFP by this amendment, offerors must use Submittal Form 1 – Offeror Information to acknowledge this amendment.**

Eric Verrelli
Contracting Officer
Phone: (907) 465-5674
Email: eric.verrelli@alaska.gov

**Questions submitted by potential offerors and answers from the State:**

**Question 142:** Please provide guidance on what to do with the Retired and over age 65 claim file. We would assume they are all Medicare claims. Are we misinterpreting something?

***Answer:*** Claims for Medicare eligible retirees are to be repriced. The cost proposals will be evaluated to account for differences in network pricing for non-Medicare covered services. Please reprice the entire file.

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**Question 143:** How do we identify an individual claim using the information provided in the claims files? For example, how would we identify a single admit for a cesarean section procedure. We have the DRG and provider name but there is no other way to identify which claim line IDs should be grouped together in the same admit to apply case rate pricing. Also, for hospitals on APC pricing we need to be able to identify an individual OP claim in order to determine which claim lines are bundled and priced as a part of that claim. Similar issues arise for other claims types re-pricing as well.

***Answer:*** Please see the updated claims file released as part of Amendment 7. An additional unique "Claim ID" has been included to recognize unique claims.

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**Question 144:** Can you include a unique claim number in the claims files to help identify individual claims?

***Answer:*** This has been included with the new files released with Amendment 7.

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**Question 145:** Can you provide a data dictionary that explains fields like Type of Service?

***Answer:*** This has been included with Amendment 7.

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**Question 146:** Can you explain how to interpret the claim line ID field?

***Answer:*** Claim line ID is the individual claim / service line items. A new field has been included that recognize each unique claim.

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**Question 147:** Some provider contracts are based on the revenue code billed on the claim, can you provide revenue codes in the claims file in order to price on these types of contracts?

***Answer:*** This has been included as an additional data field (UB92 Revenue Center) in the new files released with Amendment 7.

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**Question 148:** Can you include in the file a way to identify unique members and tie all of their associated claims together, this would allow payers to consider programs related to members and their utilization?

***Answer:*** This has been included as an additional data field in the new files released with Amendment 7. Any programs related to utilization or member health status should be provided in the appropriate sections and will be considered under the technical evaluation.

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**Question 149:** Can you include the provider TIN in the claims file?

***Answer:*** This was provided with the files released with Amendment 5.

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**Question 150:** How will the discount guarantee section be adjusted given the potential changes in the re-pricing files?

***Answer:*** No adjustments to the discount guarantee section are planned at this time.

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**Question 151:** Will Segal be doing any manipulation at Providence Alaska Medical Center as well?

***Answer:*** No, Offeror's proposals will be evaluated based on their network pricing for all providers.

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**Question 152:** Regarding Dental Submittal Form 8, the State would like the GeoAccess analysis to show subscribers, but would like the Excel table of key locations to show members. Was this intentional? Or should the required Excel table show subscribers (and not members) as well? If yes, will a retiree census file showing number of dependents be provided?

***Answer:*** GeoAccess is to be completed based on subscriber. Please see updates provided in amendment 6.

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**Question 153:** SECTION 2.BACKGROUND INFORMATION; SEC. 2.04 ABOUT THE EXISTING MEDICAL ADMINISTRATION AND NETWORK MANAGEMENT SERVICES - Current medical administration services provided by Aetna include: Paper claims submission and processing.

What is the volume of paper claims submitted in 2017 and year to date 2018?

***Answer:*** The approximate volume of paper claims submitted in 2017 was 91,305. The approximate volume of paper claims anticipated to be submitted in 2018 is 97,612.

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**Question 154:** For each disruption analysis requested (actives and retirees) for the Dental RFP, the State asks for 1) a Baseline analysis and 2) a Bidder Results analysis. In order to do the baseline analysis, bidders will need to know which providers listed in the claims file are in-network vs. out of network. Will new claims files be provided with indicators of in-network vs. out of network so that the baseline analysis can be done?

***Answer:*** Offerors are not required to submit a baseline result. Offerors are to complete the Bidder Results section based on their network solution. The claims file includes a section for the Offeror to indicate in / out-of-network for each provider within the file.

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**Question 155:** Follow up question to previous response regarding the Percentile used for Out of Network Reimbursement. It was stated to use our standard Out of Network Percentile.

The SOA - Repricing File lists instructions to use the current logic of 75% of the 60th Percentile of Fair Health. Should we use the 60th Percentile for our repricing response as well as our pricing or should we use our standard? We want to make sure we are providing the correct response and there is confusion of what we should use for the Out of Network reimbursement percentile for the repricing and the fees.

***Answer:*** Please review the recognized charge section and definition of the associated plan booklets. Your proposed solution should be one that most closely matches the State's current methodology. In your proposal, please describe the methodology your organization proposes uses to determine out-of-network reimbursement.

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**Question 156:** Dental Submittal Form 12 Administrative Performance Guarantees #11 Appeals reviews : State to review TPA appeal files forwarded to Division in response to a level 3 filing. Can you please confirm the Appeals are to be at a level 2 filing as it states in the RFP and the SPDs?

***Answer:*** AlaskaCare has a multi-level appeal process. Level 1 is an appeal to the claim's administrator. Level 2 may be an appeal to the claim's administrator, or if clinical in nature to an external review organization contracted by the claim's administrator. Level 3 is to the Division of Retirement and Benefits. When a Level 3 appeal is received by the Division, a full copy the Level I and Level 2/ERO appeal record will need to be provided to the State.

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**Question 157:** These three files include both claims for which Aetna is primary and those for which Medicare is primary, with no identifier to allow for exclusion of the ones where Medicare is primary. With discounts not applicable for the claims when Medicare is primary, these files need to be edited to remove the claim lines where Medicare is primary.

***Answer:*** Claim files have been separated based on Medicare eligibility. The Over 65 file represents claims that would fall underneath a Medicare primary payment, as well as claims for services not covered by Medicare, but covered by the Plan. Claims for Medicare covered services should be repriced using the Medicare allowed amount and all other claims should be repriced based on the Offeror's network pricing.

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**Question 158:** There is a large issue we came across once the files were converted into excel. When converting a text file, the data must be separated by a character in order for the programming in excel to accurately separate the data. For the text files provided, the character used is a comma, which is a very common character in a provider name. Excel picks up those commas within a provider name throughout the files, and associated them as additional data separators which results in the data being inputted into the wrong cells. It may be appropriate to update the file using a different character than a comma to delineate the columns in the text file.

***Answer:*** The delimiter was amended with the files included with Amendment 5.

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**Question 159:** The files exclude the TIN #s entirely, thus shifting respondents to rely on NPI #s. For unusable NPI #s in the repricing files, this could result in respondents having discretion in determining what discounts to use, as it will not be as exact as it would be in using a TIN.

***Answer:*** This was added to the files released with Amendment 5.

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**Question 160:** We need to confirm that we are correctly identifying the eligible billed amount in the data for the analysis. For our analysis, we need the charge amount on the claim less any non-covered, denied, or ineligible amounts (i.e., the eligible billed amount) and before any negotiated discount, member cost-sharing, or COB. The data contains only the "Net Submitted Expense" field, which we believe represents the eligible billed amount. Please confirm for us that non-covered, denied, or ineligible amounts are not included in the "Net Submitted Expense" amount.

***Answer:*** Confirmed - Net Submitted Expense is the eligible billed amount that Offerors will apply discounts / repricing methodology to.

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**Question 161:** We need to confirm we have all the claims data for the repricing. The table below shows the list of claims data files we received for this repricing, as well as the number of rows and the sum of the dollars in the “Net Submitted Expense” field. Please confirm for us that the number of rows and sum of dollars is correct in each file.

| File Name | # of Rows | Sum of “Net Submitted Expense” field |
|---|---|---|
| Medical RFP Actives Repricing Data.txt | 431,152 | $ 194,059,503.06 |
| Medical RFP Retiree Repricing Data Less than 65.txt | 761,195 | $ 416,420,804.16 |
| Total all files | 1,192,347 | $ 610,480,307.22 |

***Answer:*** Total Submitted Expense Amount from the Claims files:

- Actives – $194,059,503.06
- Retirees Under 65 – $416,420,804.16
- Retiree 65 and Older – $1,483,938,391.61
- Total – $2,094,418,698.83

Total number of claim lines from the Claims files:

- Actives – 431,152
- Retirees Under 65 – 761,195
- Retiree 65 and Older – 2,205,406

- Total – 3,397,753

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**Question 162:** The data did not contain a Claim Number that helps us identify all claim lines associated with a particular case. We reprice inpatient hospital, ER, and outpatient hospital surgery claims at a case level. We will attempt to create a Claim Number based on other fields in the record. However, if we are unable to identify these cases, we will have to reprice the claims at the claim line level, which may skew the results.

***Answer:*** Please see answer provided in question 143 in Amendment 7.

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**Question 163:** The data contains provider ZIP code but not employee ZIP code. We prefer to use the employee ZIP code field in the analysis, and the provider ZIP codes are the billing location rather than the physical location of the provider. Is the data available with employee zip code?

***Answer:*** Please reprice based on the provider zip codes provided.

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**Question 164:** The data does not contain a COB amount or a Reason Adjustment Code. We use these fields to exclude COB and other claims from the analysis as they can skew the results. Were claims with COB amounts, as well as duplicate, ineligible, and pending claims, excluded prior to sending us the data?

***Answer:*** All claims provided in the files are eligible claims for repricing. Offerors are to submit a repriced file that is inclusive of all claims provided.

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**Question 165:** What time period was used to pull this data? Is that period defined in terms of the dates of service or the dates of payment?

***Answer:*** The file represents paid claims from July 2017 - June 2018.

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**Question 166:** The data does not contain the incumbent carrier's network indicator, which allows us to compare the network penetration rate.

***Answer:*** Offerors will be evaluated on their proposed network solutions. The claim repricing exercise will need to represent the Offeror's proposed network solution.

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**Question 167:** Regarding the recent Amendment 5, the changes outlined for Dental Submittal Form 8 – GeoAccess Analysis Retirees were made in ProposalTech to DENTAL SUBMITTAL FORM 8 - GeoAccess Analysis Active Employees. Did the State mean to change the instructions for one or

for both of the GeoAccess sections for the Dental RFP? If for only one, please confirm which one (active employees or retirees) has the new instructions?

***Answer:*** Please see Amendment 6.

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**Question 168:** Regarding Form 7, Contractual Requirements, Section 5, Item 3 of the Dental RFP (and the State's response to Question 65 in Amendment 5): Please provide an example of the type of third-party carrier the dental plan carrier would be required to coordinate with. Also, please provide further clarification on what the State expects regarding coordination with the third-party carrier. Is it the State's expectation that the health plan provide billing information to a consolidated billing vendor that will handle the billing for the retiree voluntary program?

***Answer:*** The Dental carrier would need to coordinate at the direction of the State as needed to properly administer the plan. Examples of third-party vendors include (but not limited to) direct billing services including COBRA participants, Health Flexible Spending Account participants or those members paying their premium directly through a third party vendor such as PayFlex.

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**Question 169:** For the Dental RFP Network Disruption questions (3.10 and 3.11), what is the State's expectation regarding Baseline Data vs. Bidder Results for the two disruption questions? Is the Baseline Data version supposed to show results for the entire claims file, while the bidder results is supposed show results for only providers in the file that are in network? If so, then our understanding is that the claims files uploaded for 3.10.1 and 3.10.2, for example, will be identical (since they just show in-network vs. out-of-network), and only the smaller tables requested will be different. Is this the correct interpretation of what the State wants?

***Answer:*** Offerors are not required to submit a baseline result. Offerors are to complete the Bidder Results section based on their network solution. The claims file includes a section for the Offeror to indicate in / out-of-network for each provider within the file.

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**Question 170:** How does the process take into account a vendor's ability to manage claims beyond repricing including eliminating different claim lines, effectiveness in claims management, and anticipated network growth and/or discount improvements over time?

***Answer:*** An Offeror's submitted repricing file is to be inclusive of all claims provided within the file. All Offerors will be evaluated on their network solution proposed and the discount associated with that network as of 10/1/2018. If an Offeror has additional information to share on their ability to impact claims, that information should be provided in the appropriate sections within the technical response (i.e. Service Approach, Value Opportunity Assessment).

See answer provided in Amendment 5 (questions 72 - 75) addressing additional concerns / question submitted.

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**Question 171:** Upon review of the data files released on November 21 our network team has some additional clarifying questions.

How many records and total dollars are on each file, to ensure bidders have the files complete?

***Answer:*** Total Submitted Expense Amount from the Claims files:

• Actives – $194,059,503.06
• Retirees Under 65 – $416,420,804.16
• Retiree 65 and Older – $1,483,938,391.61
• Total – $2,094,418,698.83

Total number of claim lines from the Claims files:

• Actives – 431,152
• Retirees Under 65 – 761,195
• Retiree 65 and Older – 2,205,406
• Total – 3,397,753

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**Question 172:** Upon review of the data files released on November 21 our network team has some additional clarifying questions.

The disruption summary instructions require bidder information to be provided by inpatient facility, outpatient facility and professional data. Can the State please provide a column in each data file which identifies this information to ensure bidder's response is accurate?

***Answer:*** No, this indicator is not available at this time.

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**Question 173:** Upon review of the data files released on November 21 our network team has some additional clarifying questions.

Do the data files include the facilities and providers where direct contracts are in place? If so, is the State able to identify which facilities and providers those are?

***Answer:*** While the State does hold contracts with hospital arrangements, Offerors will be evaluated on their proposed network solution. The claim repricing exercise will need to be completed to reflect your proposed network.

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**Question 174:** Upon review of the data files released on November 21 our network team has some additional clarifying questions.

Amendment 5 via Proposal Tech states that all repricing information will be marked proprietary and confidential. Company policy requires a signed non-disclosure agreement (NDA). Is the state willing to sign a mutually agreed upon non-disclosure agreement?

***Answer:*** Any information that is deemed confidential or proprietary should be marked as so per the instructions in Section 7.09. Additionally, any pricing information will only be shared with the PEC in aggregate. The PEC will not be provided with pricing information based on individual contract arrangements with providers/facilities. The repricing exercise will remain confidential and only used for the purpose of developing the total cost for evaluation as described in Section 5.06.

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## Changes to ProposalTech:

Updated medical repricing files have been provided to include three additional data elements – Member ID, Claim ID and UB92 Revenue Center. No other data elements were changed or updated. In addition to these updates, we have also provided an additional data dictionary excel file. This file will provide an overview of each data element included in the medical repricing files.

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## Changes to the RFP:

**RFP Section 1.03. RFP Schedule**

The following dates have been **amended**:

| ACTIVITY | TIME | DATE |
|---|---|---|
| Educational Meeting | 10:00 am | 10/5/18 |
| Issue Date / Draft RFP Released | | 10/12/18 |
| Draft RFP Period Ends | | 10/24/18 |
| Pre-Proposal Conference and Second Educational Meeting | 9:30 am | 10/29/18 |
| Deadline to Submit Questions | 4:30 pm | 11/13/18 |
| Responses to Questions | | 11/30/18 |
| Deadline for Receipt of Proposals / Proposal Due Date | 2:00 pm | 12/21/18 |
| Initial Evaluations and Proposal Analysis Starts | | 12/24/18 |
| Shortlisting (optional) | | 1/28/19 - 1/29/19 |
| Interview Period | TBD | 2/7/19 – 2/15/19 |
| Clarification Period Begins | | 2/19/19 |
| Notice of Intent to Award | | 5/1/19 |
| Contract Issued | | 6/3/19 |
| Start Date | | 1/1/20 |

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## End of Amendment #7