

**QUESTIONS – Part 2
SHBP-RFA-2013**

#	SERVICE	QUESTION	SECTION	ANSWER
Medical Claims Third Party Administration and Network Services				
1	Medical TPA	Please specify what specific data we are expected to send and or receive and from which vendor.	Medical Background 2.1.	This will be determined during implementation.
295		Please confirm how Finalist Interviews/Site Visits factor into the overall scoring as it does not appear they are included in the 2000 points. Please also confirm the process in which finalist interviews and site visits will be chosen and will every vendor have the ability to participate in both if the DCH-SHBP chooses to include them in the evaluation criteria.	Evaluation Criteria 3.1	Finalists Interviews/site visits are optional and if conducted will be used to confirm/verify business operations. Site visits/interviews are not considered during the evaluation process.
296		Confirm if the 100% member and provider call recording requirements applies to the Account Management team. Also, please confirm if there is a requirement to record calls for instances when an Account Management team member may be requested by DCH-SHBP to make direct contact with a member or provider while working remotely (from cell phone when not in the office).	Minimum Business Capabilities 4	No, not required of the account management team and it is not required for direct contact calls.
297		Please confirm if the intent is to have all levels of appeals reviewed independent of the Offeror. Citation Minimum Business Capabilities 4.1 Provide an appeals process to independently review member appeals, including voluntary independent reviews		No, this applies to the external voluntary reviews only.
298		Please confirm which staff is included in this requirement.	Staffing 5.3.2	Account Management staff to be available at a minimum 8:00 am to 6:00 pm. Member Service Representatives to be available at a minimum 8:00 am to 8:00 pm.
299		For policies and procedures that are maintained in an online Citation library, would view access onsite at the DCH office be acceptable, versus submission of policies and procedures in paper form?	Member Service 6.1.8	Yes.
300		Does this requirement include all inbound and	Member Service	Yes.

**QUESTIONS – Part 2
SHBP-RFA-2013**

		outbound calls? Does it include areas other than Member Services? Please define other areas, if applicable.	6.1.12	Yes, include provider calls.
301		Please confirm that this requirement is based on eligibility information provided by DCH-SHBP within agreed upon timeframes.	Member Identification Card (ID) 6.4.1	Confirmed.
302		Please define HRA forfeitures.	Citation Finance and Banking 6.11.10	Examples of an HRA forfeiture are: Member changes from an HRA option to a non-HRA option, member terminates coverage.
303		Please clarify the type of raw claims data feed that will be provided to the PBM, Medical Management and Wellness Vendor. What is the frequency of the feed for Medical Management and Wellness and what will each of those vendors do with these claim feeds?	Citation 6.9.2	This will be determined during implementation.
304		Is it SBHP's intent to reserve the right to approve or deny every "potential" network gap exception based on any network deficiencies? An also should we assume that DCH-SHBP will approve the Offeror process?	Citation Provider Credentials 9.5.6	Yes and yes.
305		Please confirm if we should respond for our national network or Georgia specific>	Provider Contracts 9.8.9	Both – or the one that best services the SHBP membership.
306		Please define "lesser of" within this question.	Non-Network Providers	The methodology that pays the lesser amount.
307		What is recognized as an acceptable to demonstrate successful negotiations?	Non Network Providers 9.9.2	A description that demonstrates that the Offeror obtained the best savings for the client.
308		Please define the term and process "auto-deduct.	Claims Processing 10.26	Auto-deduct means to deduct overpayments automatically from future claim payments to providers.
309		Do the requirements above only apply to Overpayment Recoveries, or do they also apply to Subrogation and COB? And please list the type of refunds that this reporting requirement applies to.	Claims Processing 10.46	The term 'recoveries' include all recoveries except subrogation.
310		Please confirm if this requirement can be satisfied by other technology solutions other than remote view only access to the claims adjudication system, assuming that all claims data used by claims	Claims Administration System 11.1.18	Unable to confirm. Please reference the minimum requirements.

**QUESTIONS – Part 2
SHBP-RFA-2013**

		processors is viewable by DCH-SHBP.		
311		Define Avoidable Admissions.	13.3.5	Inpatient admissions that could have been avoided through appropriate risk identification, education, primary care intervention, appropriate pharmacy usage, etc.
312		Explain what type of PBM electronic update will be sent to TPA Offeror for the DSM database and how that DSM database will be managed under the TPA contract.	13.6e.	This will be determined during implementation.
313		Please confirm which staff is included in this requirement.	Staffing 16.5.1	Account Management staff to be available at a minimum 8:00 am to 6:00 pm. Member Service Representatives to be available at a minimum 8:00 am to 8:00 pm.
314		Please confirm which staff is included in this requirement. Clarify which staff at DCH would require access for the call monitoring.	Member Services 16.7.6	Staff from DCH will be from the vendor management unit, Clinical unit, and office of inspector general. The number of individuals will be decided during implementation.
315		Does the chart at the top of PG attachment define additional penalties in column “ E” and frequency in column “G”? Is additional calculation based on membership amounts per plan/ product? Please provide clarification with an example. Citation	Attachment 7 – Performance Guarantees- chart on top	Column E represents the penalties associated with the Service Level Targets (SLTs). How often the SLTs are measured are represented in Column G. The penalty amounts will be multiplied by the value associated with the Contractor’s membership level. Example: Contractor has 125,000 members = .75 penalty factor PG Line 26 - Daily Eligibility Updates. Daily update eligibility files will be loaded within 12 hours of receipt. Files must be received by 12:00 midnight EST. For each hour that goal is not met, the Contractor will be assessed \$5,000 multiplied by penalty factor of .75 = \$3,750 for each hour the goal is not met – to a maximum of \$500,00*.75 = Max \$375,000
316		Please confirm the following control totals for the GeoAccess reports in section 8.1. The control totals are 578,986 for Active Full Time, 66,907 for Early Retiree, 3,603 COBRA Continuee, and 241 for	Section 8.1 of the Medical TPA RFA	Confirmed. The Attachment numbering in the Data Dictionary is not correct. Attachment 17 in the Data Dictionary should read Attachment 10. Attachment 28 in the Data Dictionary should read Attachment

**QUESTIONS – Part 2
SHBP-RFA-2013**

		Surviving Spouse/Dependent. If the referenced control totals are not accurate, please provide the logic and filtering criteria that should be used with the documented attachment for this section, Attachment 10 Member eligibility data (CY 2011), or any additional attachments to identify the correct and reportable census.		21. The other references in the Data Dictionary on the Record Counts tab should be similarly adjusted. A revised Data Dictionary has been posted to the DCH Web site: https://dch.georgia.gov/documents/shbp-rfa-2013
317		Please provide the census/eligibility file, any filtering criteria necessary to reach the desired population to be reported, and control totals that should be used to respond to section 18.1 of Medical TPA RFA.	Section 18.1 of the Medical TPA RFA.	Utilize the information in Attachments 13, 16, 19. For the files or records that do not include zip code information, utilize the state and county information provided.
318		Please confirm that the “Updated R-S-U” column should be used when a value is present instead of the value in the “Rural_Suburban_Urban” column in the file labeled “Attachment 3: Zip Code to Urban Suburban (sic) and Rural Geo Mapping.pdf” when determining the classification of each zip code to be reported in section 8.1 of the Medical TPA RFA .	Section 8.1 of the Medical TPA RFA.	Confirmed
319		Please confirm that the process outlined in section 8.1 of the Medical TPA RFA for the assigning urban, suburban, and rural classifications to zip codes should be also used in section 10.1 of the PBM RFA.	Section 8.1 of the Medical TPA RFA and section 10.1 of the PBM RFA.	Confirmed
320		Please confirm which distance calculation method to be used for the GeoAccess Reports? Calculation methods available in the GeoAccess software include “As the Crow Flies” or “Estimated Driving Distance”.	Section 8.1 of the Medical TPA RFA, section 18.1 of the Medical TPA RFA, and section 10.1 of the PBM RFA.	“Estimated Driving Distance”.
321		Please confirm that version 10 of the GeoAccess Software (GeoNetworks) is appropriate to utilize. If version 7 is to be used, please provide direction on handling differences in geographical changes (zip code changes) between the system data for release 7 and the current version (Release 3 2012), given the time between releases is over six years	Section 8.1 of the Medical TPA RFA, section 18.1 of the Medical TPA RFA, and section 10.1 of the PBM RFA.	Confirmed, please use version 10.

**QUESTIONS – Part 2
SHBP-RFA-2013**

322		Please provide guidance on how to handle the invalid zip code in Attachment 10 (Attachment 10 Member eligibility data (CY 2011)). The invalid zip identified has a value of “~”.	Section 8.1 of the Medical TPA RFA	Utilize 30303
323		If Attachment 19 (Attachment 19 Member eligibility-Cigna_2010.txt) has been identified as necessary for any GeoAccess reporting, please provide guidance on how to handle the invalid zip codes of 30166, 30702, 30225, 30702, 30225, and 30829.	Attachment 19	Records with these zip codes may be excluded from the analysis.
324		If Attachment 13 (Attachment 13 Member eligibility-UHC_2010_2011 .txt) has been identified as necessary for any GeoAccess reporting, please provide a new file with zip codes.	Citation Attachment 13	The file includes all the information available. To the extent that some zip code information is not included, utilize the state and county information included as a basis for the analysis.
325		Please confirm that file “Attachment 19 Member eligibility data (CY 2010) – CIGNA” can be excluded from any reporting involving member age or gender, given the fields do not exist in this file.	Section 8.1 of the Medical TPA RFA, and section 10.1 of the PBM RFA	Attachment 19 includes data for the Medicare eligible membership and therefore is not relevant to the sections referenced.
326		Please confirm the attachment names and record counts that were supplied in Attachment 23 Data Dictionary and the values in the record counts are correct. Where there are inconsistencies, please provide direction	Attachment 23 and section 23 of the Medical TPA RFA.	All counts are correct; Refer to “Data Dictionary - Revised Attachment References” as attached for revised attachment number assignments.
327		In section 9.1.1, please confirm if the scope of the provider data should include providers inside and outside of the state of Georgia.	Section 9.1.1 of the Medical TPA RFA.	Confirmed
328		For section 9.1.1, Please provide further definition and data examples of the requested data elements of “provider type” and “contract type”.	Section 9.1.1 of the Medical TPA RFA.	“Provider type” refers to: Adult PCPs, Specialists, Pediatricians, Obstetricians, Hospitals, etc. “Contract type” means the type of contractual arrangement with the provider, such as full contract or Letter of Intent (or Letter of Agreement).
329		For section 9.1.1, please confirm that a single CD containing three (3) electronic copies of a Microsoft Excel “xlsx” type file, where each file could have multiple worksheets (when necessary due to data set size) with the column headings of physician name, provider ID, TIN/NPI, address, provider type	Section 9.1.1 of the Medical TPA RFA.	Please provide two copies of the requested file. One as an uploaded file to the Proposal Tech site as part of your electronic response and one on a CD with the “hard copy” to be submitted directly to DCH.

**QUESTIONS – Part 2
SHBP-RFA-2013**

		and contract type would comply with the format requested. If this is viewed as a deviation, please provide direction on how to handle data sets too large for a single worksheet in a Microsoft Excel file.		
330		It was observed that there are multiple medical and pharmacy claims files in the submission. Please confirm which attachment files should be used to respond to section 8.1.2 of the Medical TPA RFA.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to respond to 8.1.2.
331		For section 8.1.2, please confirm that a single Microsoft Excel “xlsx” type file for each category identified, Inpatient Facility, Outpatient Facility and Professional, where a row of data exists for each 3 digit zip code found in any claim file that has been identified as being necessary for a response to this section and contains a summary of members disrupted, number of claims disrupted and the total claim dollars disrupted would be considered a valid response when supplemented with text (.txt) files and data dictionaries for each claim file used that would show the original records and a new column that would indicate “Y” for in-network providers and “N” for out of network providers. If this is not the case, please provide direction on the specific layout of the file and what would be considered a valid format.	Section 8.1.2 of the Medical TPA RFA.	One file per category is acceptable. The analysis should be summarized by member 3-digit zip code.
332		If Attachment 14, Citation as attachment 21 in the data dictionary, is to be used to respond to section 8.1.2, please confirm that one line of summary data can be supplied as a valid response instead of meeting the requirement that data be broken out by 3 digit zip code, given there is no zip code or geographical data supplied in this file. If this is not the case, please provide direction on responding to this point for this file.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to respond to 8.1.2. Attachment 10 include employee zip codes and Provider Tax IDs are included in Attachment 11.

QUESTIONS – Part 2
SHBP-RFA-2013

333		If Attachment 14, Citation as attachment 21 in the data dictionary, is to be used to respond to section 8.1.2, please confirm if the unique values recorded in the column for CLAIM_ID or the sum of values in the SERVICE_UNIT column should be used for responding to the point regarding “the number of claims”. If neither is correct, please provide direction on responding to this point for this file.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to respond to 8.1.2.
334		If Attachment 14, Citation as attachment 21 in the data dictionary, is to be used to respond to section 8.1.2, please confirm that no claim dollars are available in this file and it can be excluded from the point regarding “claim dollars that will be disrupted”. If this is not the case, please provide direction on responding to this point for this file	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to respond to 8.1.2.
335		If Attachment 14, Citation as attachment 21 in the data dictionary, is to be used to respond to section 8.1.2, please confirm that the unique values recorded in the column for MEMBER_ID can be used for responding to the point regarding “number of members”. If this is not the case, please provide direction on responding to this point for this file.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to respond to 8.1.2.
336		If Attachment 17, Citation as attachment 24 in the data dictionary, is to be used to respond to section 8.1.2, please provide direction on what to use as identify disruption against a member, given no providers specific information has been given.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to respond to 8.1.2.
337		If Attachment 17, Citation as attachment 24 in the data dictionary, is to be used to respond to section 8.1.2, please confirm that the unique values recorded in the column for MEMBER_ID can be used for responding to the point regarding “number of members”. If this is not the case, please provide direction on responding to this point for this file.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to respond to 8.1.2.
338		If Attachment 17, Citation as attachment 24 in the data dictionary, is to be used to respond to section	Section 8.1.2 of the Medical TPA	The files included in Attachments 10 and 11 are all that is needed to respond to 8.1.2.

QUESTIONS – Part 2
SHBP-RFA-2013

		8.1.2, please confirm if the unique values recorded in the column for CLAIM_ID or if the sum of values in the NBR_OF_SVC column should be used for responding to the point regarding “the number of claims”. If neither are correct, please provide direction on responding to this point for this file.	RFA.	
339		If Attachment 17, Citation as attachment 24 in the data dictionary, is to be used to respond to section 8.1.2, please confirm that no claim dollars are available in this file and it can be excluded from the point regarding “claim dollars that will be disrupted”. If this is not the case, please provide direction on responding to this point for this file.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to response to 8.1.2.
340		If Attachment 17, Citation as attachment 24 in the data dictionary, is to be used to respond to section 8.1.2, please confirm that one line of summary data can be supplied as a valid response instead of meeting the requirement that data be broken out by 3 digit zip code, given there is no zip code or geographical data supplied in this file. If this is not the case, please provide direction on responding to this point for this file.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to response to 8.1.2.
341		If Attachment 17, Citation as attachment 24 in the data dictionary, is to be used to respond to section 8.1.2, please provide direction on how to identify place of service to respond to the point regarding “information separately for Inpatient Facility, Outpatient Facility and Professional”, given that it is not clearly identifiable in the data supplied in this file.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to response to 8.1.2.
342		If Attachment 11a, Citation as attachment 18a in the data dictionary, is to be used to respond to section 8.1.2, please confirm that billed charges, the column referred to as Total_Billed_Amount, can be used to respond to the point regarding “claim dollars that will be disrupted”. If this is not the case, please provide direction on responding to this point for this	Section 8.1.2 of the Medical TPA RFA.	Confirmed

**QUESTIONS – Part 2
SHBP-RFA-2013**

		file.		
343		If Attachment 11a, Citation as attachment 18a in the data dictionary, is to be used to respond to section 8.1.2, please confirm if the unique values recorded in the column for CLAIM_ID and be used for responding to the point regarding “the number of claims”. If not correct, please provide direction on responding to this point for this file.	Section 8.1.2 of the Medical TPA RFA.	Confirmed
344		If Attachment 11a, 11b, or 11c, Citation as attachment 18a and 18b in the data dictionary, are to be used to respond to section 8.1.2, please confirm that the unique values recorded in the column for Member ID can be used for responding to the point regarding “number of members”. If this is not the case, please provide direction on responding to this point for these files.	Section 8.1.2 of the Medical TPA RFA.	Confirmed
345		If Attachment 11b and 11c, Citation as attachment 18b in the data dictionary, are to be used to respond to section 8.1.2, please confirm that submitted charges, the column referred to as Submitted Charge, can be used to respond to the point regarding “claim dollars that will be disrupted”. If this is not the case, please provide direction on responding to this point for these files.	Section 8.1.2 of the Medical TPA RFA.	Confirmed
346		If Attachment 11b and 11c, Citation as attachment 18b in the data dictionary, are to be used to respond to section 8.1.2, please confirm if the unique values recorded in the column for Claim ID, if the sum of values in the Units of Service column, or if the sum of values in the Service Count column should be used for responding to the point regarding “the number of claims”. If none of the listed are correct, please provide direction on responding to this point for these files.	Section 8.1.2 of the Medical TPA RFA.	Utilize Claim_ID
347		If Attachment 11a, 11b, or 11c, Citation as attachment 18a and 18b in the data dictionary, is to be used to respond to section 8.1.2, please confirm that one line of summary data can be supplied as a	Section 8.1.2 of the Medical TPA RFA	Summarize the information by employee 3 digit zip code.

**QUESTIONS – Part 2
SHBP-RFA-2013**

		valid response instead of meeting the requirement that data be broken out by 3 digit zip code, given there is no zip code or geographical data supplied in these files. If this is not the case, please provide direction on responding to this point for these files.		
348		If Attachment 20, Citation as attachment 27 in the data dictionary, is to be used to respond to section 8.1.2, please provide direction on how to identify place of service to respond to the point regarding “information separately for Inpatient Facility, Outpatient Facility and Professional”, given that it is not clearly identifiable in the data supplied in this file.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to response to 8.1.2.
349		If Attachment 20, Citation as attachment 27 in the data dictionary, is to be used to respond to section 8.1.2, please confirm that the unique values recorded in the column for Member ID can be used for responding to the point regarding “number of members”. If this is not the case, please provide direction on responding to this point for this file.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to response to 8.1.2.
350		If Attachment 20, Citation as attachment 27 in the data dictionary, is to be used to respond to section 8.1.2, please confirm if the unique values recorded in the column for Claim ID or the sum of values in the Svc Unit column should be used for responding to the point regarding “the number of claims”. If neither is correct, please provide direction on responding to this point for this file.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to response to 8.1.2.
351		If Attachment 20, Citation as attachment 27 in the data dictionary, is to be used to respond to section 8.1.2, please confirm that no claim dollars are available in this file and it can be excluded from the point regarding “claim dollars that will be disrupted”. If this is not the case, please provide direction on responding to this point for this file.	Section 8.1.2 of the Medical TPA RFA.	The files included in Attachments 10 and 11 are all that is needed to response to 8.1.2.
352		Please confirm that providers to be included in the	Section 8.1, 9.2,	confirmed

**QUESTIONS – Part 2
SHBP-RFA-2013**

		requested reporting in sections 8.1, 9.2, and 18.1 of the Medical TPA RFA, can include those providers that are credentialed under the specialty being asked, even if the reported provider has been credentialed on other specialties.	and 18.1 of the Medical TPA RFA.	
353		Per the footnote for specialist reporting in section 8.1.1, please clarify if the intent is to show all specialist as a summary report as well as separate reports for the Allergy, Cardiology, Dermatology, Endocrinology, General Surgery, Gastroenterology, Hematology/Oncology, Nephrology, Neurology, Ophthalmology, Orthopedics, Otolaryngology, and Urology and the pediatric specialties of Cardiology, Endocrinology, Hematology / Oncology, Neurology, Orthopedics or if only those individuals reports by specialty are being sought.	Section 8.1.1 of the Medical TPA RFA.	Individual and Summary reports are to be provided.
354		Please confirm that no supporting documents are required as an attachment in response to 18.1.1, provided the supplied table is completed using the stated parameters. If this is not correct, please provide the specific file type and layout for how a response should be provided.	Section 18.1.1 of the Medical TPA RFA.	Relevant supporting documents (copies to be provided in both excel and pdf formats) are required. The format is left to the Offeror; however, it is the responsibility of the Offeror to provide clear backup documentation. Concise reports are preferred.
355		Please confirm that a carrier defined standard GeoAccess report in PDF format that answers the questions and meets the criteria specified in section 10.1.1 of the PBM RFA and without any additional formatting specifications can be delivered as a valid response. Please also confirm if the table supplied in this section should be populated in the word document response. If any of this is not correct, please provide direction and the specific file type and layout for how a response should be provided.	Section 10.1.1 of the PBM RFA.	Relevant supporting documents (copies to be provided in both excel and pdf formats) are required. The format is left to the Offeror; however, it is the responsibility of the Offeror to provide clear backup documentation. Concise reports are preferred.
356		Please define what is meant by the narrow network?	Section 7.9 Ability to Support DCH-SHBP Strategic Initiatives (TPA)	Per Attachment 1: Definition of Terms, "Narrow Network": means a select network of providers that is constructed to include providers that deliver high quality services and care
357		Per the Main Section of the RFA, contract is for 1	MA-PDP	DCH would like to lock in the MA rate for 3 years;

**QUESTIONS – Part 2
SHBP-RFA-2013**

		year with four renewable terms. Is DCH-SHBP only looking for 3 years for MA or is the expectation to lock in the rate for 3 years?	Minimum Requirements 15.1	the contract is for each calendar year with options to renew.
358		Please verify which positions Citation should be dedicated or designated.	Account Management 16.4.2	If the requirement does not specify dedicated, the Offeror should propose whether the position is dedicated or designated.
359		Per DCH response to the SOQ qualifying questions the remote access to listen to live calls and recorded calls did not apply to MA.	Member Services 16.7.6	Confirmed. If this service is available, please describe in your response.
360		Since Medicare is based on individual only, does this apply to Medicare? Citation Member Services	16.7.13	For those data elements Offeror can provide on the card, please confirm.
361		Please clarify what is meant by clinical analysis component Citation Medicare Risk Adjustment Process and Reporting to CMS (MA-PDP)	21.3.1	Does your risk analysis include a clinical component (i.e. are diagnosis codes factored into the determination)?
362		Please clarify if "transaction" means claims? diagnosis codes?	Medicare Risk Adjustment Process and Reporting to CMS (MA-PDP) 21.4.3	Claims
363		For our fully-insured Medicare product/plan, the Contractor is a covered entity under HIPAA and is responsible for complying with HIPAA provisions and regulations applicable to a covered entity; it is not a business associate as defined by HIPAA - for the Medicare portion of the response, will the Contractor be required to submit the Business Associate Agreement (BAA) with the RFA response? If the Contractor is required to submit the BAA with the response, may the BAA be submitted unsigned or redlined to reflect status and applicable responsibilities as a covered entity under HIPAA?	Attachment E: Business Associate Agreement; and 24.	BAA is part of the contract. Follow instructions regarding contract exceptions.
364		Definitions regarding the contract and the order of precedence appear to conflict. Please clarify the	Attachment 1 – Definition of	TPA - “ Contract ” means the portion of this document that precedes the signature page (this

**QUESTIONS – Part 2
SHBP-RFA-2013**

		<p>definitions of “this instrument”; “Contract”; and “Contract Documents”; as well as the overall ruling order of documents.</p>	<p>Terms; 34. “Contract” and 36. “Contract Documents”</p>	<p>“instrument”), and all Exhibits and Attachments placed after the signature page. These Exhibits and Attachments are incorporated in this instrument by reference as if fully restated. If provisions in the Contract conflict, the DCH Director of Contracts Administration shall determine which provisions control, following this general order of preference: this instrument; Exhibit 3, Administrative Fees and Services; Exhibit 4, Performance Guarantees; Exhibit 7, Medicare Advantage Plan Agreement; Attachment E, Business Associate Agreement; Exhibit 8, Information Security; Exhibit 1, Request for Approach; Exhibit 2, Contractor’s Approach, and all other Exhibits and Attachments.</p> <p>Wellness, PBM, Medical Management - “Contract” means the portion of this document that precedes the signature page (this “instrument”), and all Exhibits and Attachments placed after the signature page. These Exhibits and Attachments are incorporated in this instrument by reference as if fully restated. If provisions in the Contract conflict, the DCH Director of Contracts Administration shall determine which provisions control, following this general order of preference: this instrument; Exhibit 3, Administrative Fees and Services; Exhibit 4, Performance Guarantees; Attachment E, Business Associate Agreement; Exhibit 8, Information Security; Exhibit 1, Request for Approach; Exhibit 2, Contractor’s Approach, and all other Exhibits and Attachments.</p>
365		<p>Specific to our fully-insured Medicare product/plan, may the member and provider recorded calls be de-identified before being released to DCH-SHBP staff auditors or DCH-SHBP selected third party auditors?</p>	<p>1.2 Overview Of Procurement Process, Minimum Requirements (A) Medical Claims TPA/Medicare</p>	<p>No.</p>

**QUESTIONS – Part 2
SHBP-RFA-2013**

			Advantage Requirements	
366		<p>Medical TPA RFA (Report 254) Section 9.6.1 <i>Please provide latest statistics regarding on-site clinical quality audits of your contracted providers. Provide detail on the scope of work for these audits.</i></p> <p>Current industry standard typically involve the request of documents which are then audited from the offerors offices. Will DCH expand the scope of this question to include those audits completed this way ?</p>	<p>Medical TPA RFA (Report 254) Section 8.1</p>	No.
367		<p>There is no mention of the use of Provider Shortage Areas (PSAs) in the Geo Access standards. There are many geographic areas in Georgia where certain provider types simply do not exist (Ex.: pediatric subspecialties). Will DCH work with the winning offerors to mutually agree to those deviations from the standards so as to not inappropriately penalize the offeror(s) from a performance guarantee penalty when there is no viable way to attain the standard?</p>	<p>Medical TPA RFA (Report 254) Section 8.1 Geo Access Results</p>	All responses will be scored and evaluated as indicated. However, DCH would consider a reasonable proposal from the successful Offeror.
368		<p>Since the vast majority of lab services are drawn at a participating physicians office, are offerors to include those draw sites in their geo access analysis for labs?</p>	<p>Medical TPA RFA (Report 254) Section 8.1.1 Geo Access Results</p>	No, please use free-standing lab sites to complete the GEO access parameters
369		<p>Medical TPA RFA (Report 254) Section 8.1.1 - <i>Provide separate reporting for each network proposed and indicate which plan options will be served by which network.</i></p> <p>The RFA contemplates the offering of multiple networks but as mentioned in the Question # 1 above, the submission instructions and TPA_MA</p>	<p>Medical TPA RFA (Report 254) Section 8.1.1</p>	Offerors are required to submit a single network option.

**QUESTIONS – Part 2
SHBP-RFA-2013**

		Cost Proposal spreadsheet do not appear to invite the submission of multiple options unless DCH would have offerors submit a separate Cost proposal spreadsheet for each network option. Please advise how DCH would direct offerors to handle these options ?		
370		Reference to East, Middle and West regions. This appears to be a typo as there are no references or directions anywhere else in the RFAs to break down any data by regions or any definition of those regions. Please advise if this is a mistake and reference to regions should be ignored ?	Cost Proposal 20130131.xls Tab "EX 14 Contracts Improvement" Line 5 - Submit separately for each region being proposed (West, Middle, East).	Please ignore the reference.
371		Can DCH provide the monthly CMS reimbursement and medical and Rx risk scores for the Medicare Advantage populations that tie to the claims submitted? Can DCH provide all available CY2012 data for the MA plans? Section 23.20 Attachment 11A Medical facility claims detail (CY 2011 incurred and paid through August 2012) Section 23.21 Attachment 11B Medical professional claims detail (CY 2011 incurred and paid through August 2012) Section 23.22 Attachment 11C Medical professional claims detail (CY 2011 incurred and paid through August 2012) Section 23.23 Attachment 12A Pharmacy claims detail (CY 2011 incurred and paid through August 2012) Section 23.24 Attachment 12B Pharmacy claims detail (CY 2011 incurred and paid through August		Data provided is all that is available. Please refer to Question #98 for risk scores.

**QUESTIONS – Part 2
SHBP-RFA-2013**

		<p>2012) Section 23.26 Attachment 14 Medical claims detail (CY 2011 and CY 2010 incurred) - UHC Section 23.27 Attachment 15 Pharmacy claims detail (CY 2011 and CY 2010 incurred) - UHC Section 23.29 Attachment 17 Medical claims detail (CY 2011 incurred) - Humana.tx Section 23.30 Attachment 18 Pharmacy claims detail (CY 2011 incurred) - Humana.txt Section 23.32 Attachment 20 Medical claims detail (CY 2010 incurred) - CIGNA .txt Section 23.33 Attachment 21 Pharmacy claims detail (CY 2010 incurred) - CIGNA .txt Section 23.34 Attachment 22 - Medicare Advantage Monthly Summary.xlsx</p>		
372		<p>Can DCH provide detailed Rx claims data for CY2011 and CY2012 for the MA plans?</p> <p>Section 23.23 Attachment 12A Pharmacy claims detail (CY 2011 incurred and paid through August 2012) Section 23.24 Attachment 12B Pharmacy claims detail (CY 2011 incurred and paid through August 2012) Section 23.27 Attachment 15 Pharmacy claims detail (CY 2011 and CY 2010 incurred) - UHC Section 23.30 Attachment 18 Pharmacy claims detail (CY 2011 incurred) - Humana.txt</p>		<p>2011 data have been provided. Information for 2012 is not available.</p>

**QUESTIONS – Part 2
SHBP-RFA-2013**

373		<p>Can DCH confirm if claims for ancillary benefits, i.e. vision, hearing wellness services, etc., are included in the claims data provided?</p> <p>Section 23.20 Attachment 11A Medical facility claims detail (CY 2011 incurred and paid through August 2012) Section 23.21 Attachment 11B Medical professional claims detail (CY 2011 incurred and paid through August 2012) Section 23.22 Attachment 11C Medical professional claims detail (CY 2011 incurred and paid through August 2012) Section 23.26 Attachment 14 Medical claims detail (CY 2011 and CY 2010 incurred) - UHC Section 23.29 Attachment 17 Medical claims detail (CY 2011 incurred) - Humana.txt Section 23.32 Attachment 20 Medical claims detail (CY 2010 incurred) - CIGNA .txt Section 23.34 Attachment 22 - Medicare Advantage Monthly Summary.xlsx</p>		<p>The data includes the claims indicated by the service type data fields.</p>
374		<p>Attachment 7 Medical TPA_MA PGs - Lines 8-12 <i>The performance penalties shown in this table will be adjusted for membership for active employees non-Medicare retirees, and MA-PDP retirees</i></p> <p>Will DCH entertain expanding the scale to be in line with the increments of 50,000 members as displayed in the TPA_MA Cost Proposal Ex1 - TPA Admin Fee tab so that an offeror with lower membership is not disproportionately affected?</p> <p>The MA PGs do not show a similar scale. Will DCH add a similar scale based on the MA membership as stated in the RFA ?</p>	<p>Attachment 7 Medical TPA_MA PGs - Lines 8-12</p>	<p>The Medical TPA membership based adjustment factors will not be adjusted. However, the MA-PD PG assessments will be adjusted by a factor of 0.75 for memberships below 20,000 and by a factor of 1.25 for memberships of 60,000 and above.</p>
375		<p>Attachment 7 Medical TPA_MA PGs - Lines 8-12</p>	<p>Attachment 7</p>	<p>The assessments in the Wellness, PBM and Medical</p>

**QUESTIONS – Part 2
SHBP-RFA-2013**

		<p><i>The performance penalties shown in this table will be adjusted for membership for active employees non-Medicare retirees, and MA-PDP retirees</i></p> <p>There are also no similar scales for the PBM, Wellness or Medical Management PGs. Does SHBP intend to add similar scales if for instance it were to split any of those contracts because it determines an integrated solution with an offeror is the best value of DCH ?</p>	<p>Medical TPA_MA PGs - Lines 8-12</p>	<p>Management RFAs will not be adjusted for membership.</p>
376		<p>Typically if a TPA makes a system loading issue and processes claims incorrectly they complete an audit or similar process and reprocess the claims including recoupment of overpayments. Please confirm that any assessment for this PG would only be for any net error after those dollars have been recouped.</p>	<p>Attachment 7 Medical TPA_MA PGs Claims Processing (self-funded medical plan for non-Medicare members): Accurately implement Benefits or Program Changes</p>	<p>Not confirmed.</p>
377		<p>Which plan code listing should we utilize to match up between the Eligibility data and the claims detail? Attachment 2 and Attachment 23 do not contain the same plan/option codes.</p> <p>Attachment 11A: Medical facility claims detail (CY 2011 incurred & paid thru August 2012), Attachment 11B: Medical professional claims detail (CY 2011 incurred & paid thru August 2012), Attachment 11C: Medical professional claims detail (CY 2011 incurred & paid thru August 2012), Attachment 10 Member Eligibility data (CY 2011), Attachment 2 Membership Enrollment Management System (MEMS) Eligibility File Layout,</p>		<p>Please refer to the attached Plan Code listing for Attachment 10.</p>

**QUESTIONS – Part 2
SHBP-RFA-2013**

		Attachment 23 Data Dictionary and Record Counts		
378		<p>When matching the Member Eligibility data from Attachment 10 to the claims detail, there are over \$1.1 billion in non-matching members. Could you provide a claims summary by Paid Month by Carrier, Plan Code for Facility, Professional?</p> <p>Attachment 11A: Medical facility claims detail (CY 2011 incurred & paid thru August 2012), Attachment 11B: Medical professional claims detail (CY 2011 incurred & paid thru August 2012), Attachment 11C: Medical professional claims detail (CY 2011 incurred & paid thru August 2012), Attachment 10 Member Eligibility data (CY 2011), Attachment 2 Membership Enrollment Management System (MEMS) Eligibility File Layout, Attachment 23 Data Dictionary and Record Counts</p>		<p>After a review of the data, the member IDs contained in Attachments 10, 11, and 12 are found to reasonably match.</p>
379		<p>When matching the Member Eligibility data from Attachment 10 to the claims detail, there are 3,701 11A Facility, 7,378 11B Professional, and 5,065 11C Professional unique non-matching members. Could you provide an eligibility summary by Paid Month by Carrier, Plan Code for Employees and Members that line up with the monthly claims summary?</p> <p>Attachment 11A: Medical facility claims detail (CY 2011 incurred & paid thru August 2012), Attachment 11B: Medical professional claims detail (CY 2011 incurred & paid thru August 2012), Attachment 11C: Medical professional claims detail (CY 2011 incurred & paid thru August 2012), Attachment 10 Member Eligibility data (CY 2011), Attachment 2 Membership Enrollment Management System (MEMS) Eligibility File Layout, Attachment 23 Data Dictionary and Record Counts</p>		<p>These findings are primarily due to retro-terminations. No additional data will be provided.</p>

QUESTIONS – Part 2
SHBP-RFA-2013

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**QUESTIONS – Part 2
SHBP-RFA-2013**

380		<p>Provider TIN is included. Could you provide Provider Name, Address, City, State and Zip code to allow for a more accurate match?</p> <p>Attachment 11A: Medical facility claims detail (CY 2011 incurred & paid thru August 2012), Attachment 11B: Medical professional claims detail (CY 2011 incurred & paid thru August 2012), Attachment 11C: Medical professional claims detail (CY 2011 incurred & paid thru August 2012), Attachment 20 Medical Claims detail (CY 2010 incurred) - Cigna, Attachment 17 Medical claims detail *CY 2011 incurred) - Humana, Attachment 14 Medical claims detail (CY 2011 and CY 2010 incurred) - UHC, Attachment 23 Data Dictionary and Record Counts</p>		No additional information is available at this time.
381		<p>Could member zip, provider zip, provider name, not covered financial field be added to assist in repricing?</p> <p>Attachment 11A: Medical facility claims detail (CY 2011 incurred & paid thru August 2012), Attachment 11B: Medical professional claims detail (CY 2011 incurred & paid thru August 2012), Attachment 11C: Medical professional claims detail (CY 2011 incurred & paid thru August 2012)</p>		No additional information is available at this time.
382		<p>Section 23.25 - Can Date of Birth and ZIP Codes be added to this member eligibility file? This file appears to include State County Codes (SCC) which do not necessarily map to GA zip codes.</p>	<p>Medical TPA RFA (Report 254) Section 23.25 Attachment 13 membership eligibility data</p>	No additional information is available at this time. Utilize the SCC codes.
383		<p>Can Date of Birth and ZIP Codes be added to this member eligibility file?</p>	<p>Attachments 10, 13 & 16 Eligibility</p>	No additional information is available at this time.

**QUESTIONS – Part 2
SHBP-RFA-2013**

		This file appears to include State County Codes (SCC) which do not necessarily map to GA zip codes.	data	
		GA SHBP TPA_MA Cost Proposal Final 20130131 How does DCH wish for offerors to submit rates for both Full Replacement and a slice approach with membership bands in case DCH decides to have multiple Medicare Advantage contracts? Are offerors to submit separate exhibits marked respectively for each?		Refer to the first requirement in 15.1 of the RFA.
384		Are offerors to use column "Rural_Suburban_Urban" for their analysis or column "Updated R-S-U" ? And if "Updated R-S-U" there are some zip codes where there is no entry under this column. In those instances do offerors revert to the designation in column "Rural_Suburban_Urban"?	Attachment 3 Zip Code to Urban, Suburban and Rural Geo Mapping	Refer to Response to Q318.
385		Can DCH provide the USR exhibit in excel format?	Attachment 3 Zip Code to Urban, Suburban and Rural Geo Mapping	Yes, the excel version has been posted on the DCH website: http://dch.georgia.gov/documents/shbp-rfa-2013
386		Does DCH intend to provide any 2012 MA claim data?	Attachment 17 Medical claims detail *CY 2011 incurred) - Humana, Attachment 14 Medical claims detail (CY 2011 and CY 2010 incurred) - UHC, Attachment 23 Data Dictionary and Record	No

**QUESTIONS – Part 2
SHBP-RFA-2013**

			Counts	
387		The attachment numbers for the data don't seem to match the attachment numbers in the data dictionary and claim counts provided. Can these be corrected to match?	Attachment 23 Data Dictionary & Record Counts	Refer to "Data Dictionary - Revised Attachment References" as posted on the DCH website.
Medical Management				
388	MM	Each of the respective RFAs have certain account management requirements and in some situations have the same titled role. If an offeror is awarded multiple contracts would they be required to retain separate dedicated staff for each respective contract or where it makes logical sense and is mutually agreed by the offeror and DCH would the offeror be allowed to combine certain roles for those contracts ?	Medical Management RFA (Report 1128) Section 5.4 Account Management	The RFAs were written as separate documents and will be separate contracts. Please refer to the definitions regarding "dedicated".
Pharmacy Benefits Management and Claims Administration				
389		The PGs provided are listed with flat dollar amounts based on specific service metrics not met. If multiple TPAs are awarded contract the TPA(s) with lesser membership will be disproportionately affected by flat dollar amount penalties. Would the DCH consider charging a percent of total premium instead of a flat dollar amount for listed PGs for any of the RFAs where more than one contract is awarded ?	PBM RFA (Report 306) Section 4.13.1	No, DCH prefers flat dollar amts but will consider more aggressive PGs proposed by bidders.
390		Clarify if the 2 toll free lines for are for members,	PBM RFA (Report	SHBP is looking for the Offeror to establish two

**QUESTIONS – Part 2
SHBP-RFA-2013**

		client or health care providers. Would one line with a prompt for either call type not meet the caller's need ?	306) Section 4.7.2	separate toll free lines, unique to our plan: one for technical questions and one for clinical issues (prior authorization requests). Each phone line should go to a separate team – one team that handles technical calls and one team that handles clinical calls. Each team is expected to have been trained specifically on our plans and have available tools to assist in responding to the type of call they may handle (technical or clinical). Both phone lines are available for members, pharmacies, and physicians to utilize.
391		Please confirm the lessor of logic required for the RFA. Is SHBP requiring lessor of copay, discounted cost and U&C logic?	PBM RFA (Report 306) Section 6.1.7	SHBP is asking the Offerors to identify what parameters can be included in your lessor of logic for processing of claims in response to that question.
392		In order to provide the most accurate GeoAccess results, please indicate if SHBP will be considering narrow or limited pharmacy network options.	PBM RFA (Report 306) Section 10.1	The parameters for coverage outlined in the RFA must be met for purposes of scoring the access provided by the network proposed.
393		The volume of paper PBM claims is extremely small and even a few claims not meeting the standard could cause the PG to be missed. Could this PG be scaled in some way relative to the volume of electronic claims so that the impact is not disproportionate to the actual volume of claims it addresses ?	Attachment 7 PBM PGs Claims Processing: Turnaround time (TAT) for SHBP Paper Claims Processed	The PG will remain as posted.
394		Would DCH agree to combine the PGs for Financial Accuracy of point-of-sale, mail order and specialty claims ?	Attachment 7 PBM PGs Financial Accuracy	No.
Wellness Programs				
	Wellness			
395		What is the timeline for reporting health effectiveness Data and Information Set (HEDIS)	Appendix C – Minimum	See question #245

**QUESTIONS – Part 2
SHBP-RFA-2013**

		Wellness and Health Promotion measures as required by NCQA?	Requirements	
396		Can DCH-SHBP provide more detail on what would constitute a “real-time fashion such as the exact frequency required to meet that reporting standard? Citation 4.1 Minimum Business Capabilities, “Monitor, track, and report member participation data for each Plan Option in a real-time fashion to DCH-SHBP.”	4.1 Minimum Business Capabilities	See question #246
397		Can you expand on what is meant by “duplicating services? Citation RFA Document, Part 2 – Minimum Capabilities and Expectations, Item 2.1, Special Note	RFA Document	See question #247
398		What is the definition of “eligible DCH-SHBP members” as it relates to telephonic wellness coaching?	Attachment 7 GA DCH-SHBP Wellness PGs, Rows 28 & 29	See question #248
399		What is the definition of “eligible DCH-SHBP members” as it relates to the preventive care screenings PG?	Attachment 7 GA DCH-SHBP Wellness PGs, Row 30	See question #249
400		The “Basic Fee” contains an asterisk that refers to a note/statement on row 36 of the cost proposal document. That note/statement appears to include wellness coaching on a per subscriber basis, but then row 9 also identifies wellness coaching and it is based on a per participant basis. Please clarify if your intent is to have wellness coaching provided as a cost in row 7 or row 9.	GA DCH-SHBP Wellness Cost Proposal, Row 7	See question #250
401		These rows refer to biometric screenings with participants of greater than 50 and less than 50, respectively. How many sites would have more than 50 participants and how many sites would have less than 50, and how many total sites do you expect to conduct biometric screening events?	GA DCH-SHBP Wellness Cost Proposal, Rows 17 and 18	See question #251
402		Please provide further detail about methods	RFA Document,	See question #252

**QUESTIONS – Part 2
SHBP-RFA-2013**

		vendors could use to satisfy this requirement. For example, is web-based access required? Are there particular individuals within DCH-SHBP who would require this access?	Part 5 –Appeals and Grievances, Item 5.6.5	
403		Please provide expectations and what is included in the Wellness Quality Management Program?	RFA Document – Section 8 – Question 8.5.1 Quality Management Program	See question #253
404		If DCH awards the Wellness contract to more than one offeror on a stand alone basis or if DCH awards contracts on an integrated bases to multiple offerors would SHBP change the funding methodology on a percent of membership basis to still equate the \$1M annual fund?	Wellness RFA (Report 571) Section 6.1.1	No.
405		If an offeror wins more than one contract will the duplicative PGs be combined ? And will the amounts at risk be adjusted respectively ? For example, there is an eligibility load penalty in each RFA for \$100k each day standard is not met. If and integrated offeror has two contracts but uses the same eligibility feed and misses by one day would the penalty be \$100k or \$200k ?	Attachment 7 PGs	No and no.
406		Is 2014 the baseline year ?	Attachment 7 Wellness PGs Reduce BMI in adults	No.
407		Is 2014 the baseline year ? The measurement requests 2% improvement but the Assessment mentions .25%. Which is correct ? This measurement can be affected by the surcharge amount, newly identified surcharge contracts and any required testing. Will the baseline be those	Attachment 7 Wellness PGs Tobacco Cessation PG	No. Both are correct. Both currently identified and newly identified. DCH will consider proposals from the Offeror.

**QUESTIONS – Part 2
SHBP-RFA-2013**

		currently identified or will newly identified contracts be added each year ? and will DCH assist in attainment of the metric with suggested actions by the offeror ?		
408		The Target level states "Increase the percentage of SHBP members actively participating in at least one interactive telephonic coaching session <u>by</u> 20% in 2014, 30% in 2015, 40% in 2016." Should "by" be changed to "to" so as to read "Increase the percentage of SHBP members actively participating in at least one interactive telephonic coaching session <u>to</u> 20% in 2014, 30% in 2015, 40% in 2016." Is this metric to apply to all SHBP members ? or just those identified through some measure as needing telephonic coaching ? Does this metric apply to subscribers and covered spouses ? and are dependent children included ?	Attachment 7 Wellness PGs Telephonic Wellness Coaching	Yes, the word 'to' is correct. Applies to those who are identified as needing telephonic coaching. Applies to subscribers and spouses. However, DCH will consider any proposals that include dependent children.
409		Is 2014 the baseline year ?	Attachment 7 Wellness PGs Preventive cancer Screening	No.
410		Are the various biometric screenings listed in the Cost proposal required to be submitted and paid as claims or as an administrative fee ?	GA SHBP Wellness Cost Proposal	This is an option that will be negotiated prior to contract signing. Please provide a quote for your most efficient option.
411		Wellness RFA (Report 571) Section 8.4.3 Provide your recommended methodology for measuring the performance and results for these programs for each of the last two (2) years. Describe how each metric is tracked, how the baseline is determined, and how the measurement period is evaluated vs. the baseline. a. Wellness Services ROI – Provide your proposed population-based ROI calculation methodology to be		Unlikely the five clinical metrics will change annually. However, additions may be added to the clinical metrics each year based on the Offeror's recommendations.

**QUESTIONS – Part 2
SHBP-RFA-2013**

		<p>used to measure wellness services. Upon review, SHBP will establish a target.</p> <p>b. Improved Clinical Measures – Provide the clinical metrics you propose to use to measure improvement. Confirm your agreement that SHBP will be able to select five (5) clinical metrics each year for measurement.</p> <p>Will the five clinical metrics change on an annual basis? Will the five clinical metrics remain constant for life of contract to progress/improvement over the contract life?</p>		
412		<p>Wellness RFA (Report 571) Section 6.1.1 <i>SHBP requires the Offer or to provide an allowance of \$1M annually to fund, as approved by SHBP, member outreach and communications, health challenges, targeted interventions, promotions, incentives, etc. What recommendations do you have for utilizing this allowance?</i></p> <p>What incentives will SHBP offer its Plan members to engage in the Wellness Plan requirements? And will SHBP entertain suggestions from the offeror on member incentives to drive engagement ?</p>		Currently, SHBP uses HRA contributions as incentives; the Offeror should propose additional incentives to be provided in the annual allowance. Yes, SHBP will entertain suggestions.
General				
413	General	Confirm the Medicare Advantage program should be provided on a fully insured program only.	Citation Purpose for Request for Approach 1.1	Confirmed.
414		What is the current DCH-SHBP utilization and specific goal metric for the 14 strategic goals for the DCH-SHBP outlined on page 4?	Citation Purpose for Request for Approach 1.1	Data that is available is contained in the beginning sections of the RFA and as part of the performance guarantees.

**QUESTIONS – Part 2
SHBP-RFA-2013**

415		Please confirm if the Letter of Credit referenced in this section and the sample contract is requested upon award or during this RFA process	Letter of Credit 3.2	See question #276
416		Please confirm if DCH -SHBP will allow fees to be quoted using a tiered approach based on final membership enrolled. year	Cost Proposal 5.1	See question #277.
417		Please confirm pricing for additional services that may be proposed as described and encouraged in Exhibit 1 – TPA Administration Fees may be offered in addition to the standard fees that include the minimum requirements required by DCH -SHBP as outlined in the RFA.	Cost Proposal 5.1	See question #278.
418		Please confirm DCH -SHBP's fee negotiation process for services requested after the RFA contract award yet are services not clearly specified or included in the RFA or contract with the Offeror.	Cost Proposal 5.1	See question #279.
419		Please share your scoring methodology.	Review of Scored Technical Questions 6.2.2	See question #280.
420		Please confirm the process in which DCH -SHBP will evaluate services provided by a particular Offeror on an integrated versus non-integrated basis for that Offeror understanding that Offeror has qualified to provide services for each of the areas of the RFA to be integrated (for example. Integration of TPA with Medical Management)	Review of Scored Technical Questions 6.2.2	See question #281.
421		How should an Offeror respond to questions throughout the technical questionnaire where the Offeror is able to provide services on both an integrated and non-integrated basis?	Review of Scored Technical Questions 6.2.2	See question #282.
422		When will cost scoring methodology be determined and shared with Offerors?	Cost Scoring 6.3.1	See question #283.
423		In addition to the information provided in 6.3 General Overview please provide the methodology to evaluate and negotiate non-integrated versus integrated cost proposals?	Cost Scoring 6.3.1	See question #284.
424		Please describe how many of the highest ranking	Overview of	See question #285.

**QUESTIONS – Part 2
SHBP-RFA-2013**

		Offerors DCH-SHBP will be able to enter into negotiations with DCH.	Negotiations 6.5.1	
425		Please clarify if mandatory and minimum requirements may be amended during negotiations with the highest ranking Offeror as described in the last sentence of the first paragraph of this section.	Overview of Negotiations 6.5.1	See question #286.
426		Please confirm if DCH-SHBP is interested in both a single vendor or multiple vendor award for each of the four RFA proposals.	Citation 6.6	See question #287.
427		There are inherent efficiencies gained by some offerors who administer integrated services that cross over each of the four respective RFAs. The way the financial responses are currently structured appear to only allow for cost proposals for each separate RFA. Since the value of an integrated approach is contemplated in the RFA Main Section are there alternate directions for offerors to show those savings without jeopardizing a rejection of their submissions?	RFA Main Section - Section 1.2	Each section of the RFA will be evaluated separately. Offerors should bid their most competitive pricing for each of the four RFAs.
428		<p>RFA Main Section - Section 5.2 - <i>DCH's intent is to structure the cost format in order to facilitate comparison among all Offerors and foster competition to obtain the best market pricing. Consequently, DCH requires that each Offeror's cost be in the format outlined in the specific cost proposals provided for each RFA service. Additional alternative cost structures will not be considered. Each Offeror is cautioned that failure to comply with the cost proposal instructions, submission of an incomplete offer, or submission of an offer in a different format than the one requested may result in the rejection of the Offeror's proposal</i></p> <p>Without knowing who those winning offerors are, how many offerors are chosen for that RFA or particular services proposed by those offerors it is difficult to determine the cost implications. The</p>	RFA Main Section - Section 5.2	The final number of successful Offerors will be determined at the conclusion of the bid process. The final number will be based on the quality and content of the bids received and how those bids can best support SHBP.

**QUESTIONS – Part 2
SHBP-RFA-2013**

		templates provided do not appear to provide for that input. How and where should offerors account for those costs and will the costs be borne by the vendor requiring the data feeds or other requirements ?		
429		This section appears to indicate that the procurement is for a contract of one year with up to four renewals making the total possible length of the contract five years. The contract shells also refer to a five year period but the Statement of Qualifications referred to a three year period. Is five years or three years correct ?	RFA Main Section - Section 1.6	The current year with three renewals.
430		Each of the respective RFAs have certain account management requirements and in some situations have the same titled role. If an offeror is awarded multiple contracts would they be required to retain separate dedicated staff for each respective contract or where it makes logical sense and is mutually agreed by the offeror and DCH would the offeror be allowed to combine certain roles for those contracts ?	Medical Management RFA (Report 1128) Section 5.4 Account Management	See response to question #388.
431		If an offeror wins more than one RFA will the contracts be combined into one agreement?	Contract Shells	No.
432		What is the process to update users' access to grant or remove additional functionalities – view, edit, email? Also are there a set number of users that can have edit/email, etc.? If so, what is the limit?		Only read /respond access will be provided to Bidders. To request access for additional users to read/respond to the RFAs, submit the request(s) to the Issuing Officer. There is no limit to the number of users that can have access. All parties with access can edit responses from other users. However, care should be taken when 2 users are editing the same question. The later time-stamped submission will be the response saved.