

PART I
GENERAL INFORMATION FOR THE OFFEROR

I-1. Purpose

This Request for Proposal (RFP) provides interested offerors with sufficient information to enable them to prepare and submit proposals for consideration by the Commonwealth of Pennsylvania (hereinafter referred to as the “Commonwealth”) to satisfy the need for contractors for the Adult Basic Coverage Insurance Program (hereinafter referred to as “adultBasic”). The Pennsylvania Insurance Department (hereinafter referred to as the “Department”) is the State agency with the responsibility for administration of the program.

Act 2001-77 (hereinafter referred to as the “Act”) established the Tobacco Settlement Fund (hereinafter referred to as the “Fund”) and set forth the plan for use of Pennsylvania’s share of the National Tobacco Settlement. Section 306 (b)(1)(vi) of the Act designated that thirty percent (30%) of funds appropriated from the Fund be used for “health investment insurance” (later given the trademark name of adultBasic) and for the purchase of Medicaid benefits for workers with disabilities. AdultBasic insurance coverage is available to eligible adults between the ages of 19 and 64 who: Have family income below two hundred percent (200%) of the Federal Poverty Level; meet certain non-financial requirements; and who are otherwise uninsured. Enrollees pay a monthly payment – currently \$30 – to participate.

Outreach and enrollment activities for adultBasic began in April 2002 and the first month of coverage was July 2002. Because of funding limitations, enrollment was capped by March 2003 and a waiting list was implemented. Persons on the waiting list may purchase coverage at the cost negotiated by the Department. To date, over 78,000 persons have received coverage under the program and approximately 101,500 are currently on the waiting list. Of persons on the waiting list, approximately 3100 persons are purchasing coverage at the cost negotiated by the Department.

The four insurers currently under contract to the Department to provide adultBasic insurance coverage and services are: Highmark Inc.; Capital Blue Cross; Independence Blue Cross; and First Priority Health, a subsidiary of Hospital Service Association of Northeastern Pennsylvania, d/b/a Blue Cross of Northeastern Pennsylvania. Each of the contracts currently in place expires March 14, 2005. In the event that more than one qualified technical proposal is received for a service area, e.g., county, collection of counties, etc., the Department will select the offeror who submitted the proposal providing the best value to the Commonwealth to service that area. If necessary, persons enrolled with a current contractor will be transferred to a newly selected contractor awarded a contract for a service area (see Section I-7 of this RFP).

Although funding for the program currently comes solely from the Tobacco Settlement Fund, there remains the potential for program growth during the period of the contract. The Administration views adultBasic as an important component of its goal to expand healthcare coverage options to the uninsured. A specific and final plan for expansion has not yet been completed, but offerors awarded contracts will be fully apprised of this as planning proceeds.

Corresponding contract amendments and rate adjustments may be made, if necessary, to the extent such changes expand the scope of contracts awarded under this RFP.

I-2. Issuing Office

The Commonwealth of Pennsylvania, Pennsylvania Insurance Department, Bureau of Administration, Division of Budget & Office Management, issues this RFP on behalf of the Office of CHIP and adultBasic. Proposals in response to this RFP must be delivered by the deadline date and time in the cover letter to:

Pennsylvania Insurance Department
Attn: Division of Budget and Office Management
1300 Strawberry Square
Harrisburg, PA 17120

Desk in Lobby on 13th floor will accept hand-delivered proposals. Please call (717) 787-4298 to arrange for hand delivery.

I-3. Issuing Officer for the RFP

William A. Shaffer
Pennsylvania Insurance Department
333 Market Street, Lobby Level
Harrisburg, PA 17120

The Issuing Officer is the sole point of contact in the Department for this RFP, except for inquiries related to Small Disadvantaged Business Information that must be directed to the Department of General Services as identified in Section I-17 of this RFP.

I-4. Scope

This RFP contains a description of the services to be provided, instructions regarding the preparation and submission of the proposals, requirements which must be met for the proposal to be eligible for consideration, general evaluation criteria for proposals, and other requirements to be met by each Offeror.

I-5. Problem Statement

The Act requires the Department to utilize appropriated funds for contracts to provide basic health care insurance for eligible adults and outreach activities. The Department is also charged with, to the greatest extent possible, ensuring that all eligible adults in the Commonwealth have access to the program established in the Act. To meet these requirements, the Department is soliciting for contractors to provide health care insurance and related services.

This RFP describes the work statement with which the contractors must comply. It also includes certain information on the policies and procedures the Department will follow in carrying out its program management and oversight responsibilities.

I-6. Type of Contract

The Department intends to award multiple contracts as a result of this RFP and will enter into negotiations with each selected contractor. Each contract will be effective when fully executed by all necessary Commonwealth officials as provided by law and will cover three (3) years of enrollment. Requirements of this RFP and commitments made in the proposals of selected offerors will become part of each contract and are not subject to negotiation.

I-7. Termination or Expiration of Contract

If the Department terminates a contract due to failure to perform, the Department may add that contractor's enrollment to the enrollment of other contractors. The Department will develop a transition plan should it choose to terminate, cancel, or not extend a contract.

During the final quarter of the contract resulting from this RFP, each contractor will work cooperatively with, and supply program information to, any subsequent contractor(s). The Department will define both the program information of and the working relationship among the contractors.

Upon termination or expiration of the contract resulting from this RFP, the contractor must:

- A.** Provide the Department with all information deemed necessary by the Department within thirty (30) days of the request.
- B.** Be financially responsible for claims with dates of service through the day of termination, except as provided in C. below, including those submitted within established time limits after the day of termination.
- C.** Be financially responsible for hospitalized patients through the date of discharge or ninety (90) days after termination or expiration of the contract, whichever is earlier.
- D.** Be financially responsible for services rendered through 11:59 p.m. on the day of termination, except as provided in C. above, for which payment is denied by the contractor and subsequently approved upon appeal.
- E.** Be financially responsible for enrollee grievances of adverse decisions rendered by the contractor concerning treatment of services requested prior to termination, which are subsequently overturned at a grievance proceeding.
- F.** Arrange for the orderly transfer of patient care and patient records to those providers who will be assuming care for the enrollee. For those enrollees in a

course of treatment for which a change of providers could be harmful, the contractor must continue to provide services on a fee-for-service basis until that treatment is concluded or appropriate transfer of care can be arranged.

I-8. Readiness Review

Prior to implementation of the program's enrollment procedures, and periodically thereafter, the Department may conduct Readiness Reviews of each contractor. The purpose of this Readiness Review is to determine the status of each selected contractor with respect to meeting the work statement as described in this RFP and to be sure that no contractor is permitted to begin serving eligible adults if it does not show acceptable evidence of readiness relative to each RFP/contractual requirement. The Department reserves the right to delay enrollment for any contractor who does not demonstrate to the Department's satisfaction compliance with any critical factor of the work statement at any time before or during the operational phase.

I-9. Rejection of Proposals

The Department reserves the right to reject any and all proposals received as a result of this RFP.

I-10. Rejection of Collusive Proposals

The Department shall summarily reject proposals received from any offeror who engages in collusive bidding. The terms and conditions of the Antid-Rigging Act, the Act of May 15, 1998, P.L. 358, No.57 62 Pa. C.S. §§4501 et seq. apply. Each offeror must submit the "Non-Collusive Affidavit – the Anti-Bid Rigging Act" shown in Appendix C.

I-11. Incurring Costs

The Department is not liable for any costs or expenses incurred by any offeror in the preparation of its proposals or for its attendance at any conferences or meetings related to this RFP. The Department is not liable for any costs incurred by any offeror prior to the full execution of a contract as provided in the Letter of Notice to Proceed. "Full execution" shall mean all Commonwealth and federal approvals required by law have been obtained.

I-12. Clarification of RFP

The Department recognizes the importance of providing clarification to any points in the RFP that may not have been understood by potential offerors. In lieu of a preproposal conference, written questions will be accepted by the Department through the website for this RFP at www.ins.state.pa.us/abrfp/.

The Department will make a good faith effort to answer all questions directly related to this RFP. However, questions determined to be repetitive or soliciting information that is classified as confidential information as part of the proposal or contracting process, or those as to which the Department has no additional information beyond what is already included in this RFP will not be specifically addressed. Questions will only be accepted until the date indicated on the website

and in the cover letter. Official, written responses will be posted on the website no later than three days following the deadline for submission of questions. Offerors should monitor the website to obtain these answers.

I-13. Addenda to the RFP

The Department reserves the right to reissue a modified version of this RFP; to amend, at any time, any part of this RFP upon publication on the department's website at www.ins.state.pa.us/abrfp/; and to change any of the scheduled dates, including the proposal due date stated in the cover letter.

All addenda will become part of this RFP and will be incorporated into any contract entered into between the Department and the selected offerors.

I-14. Response Date

Proposals must be delivered to the Department's Division of Budget and Office Management, at the address specified in Section I-2, on or before the date and time specified in the cover letter in order to be considered for selection. Offerors mailing proposals should allow sufficient mail delivery time to ensure timely receipt of their proposals. It is incumbent upon each offeror to assure that the proposal is received by the deadline. Proposals received after the time and date specified in the cover letter will not be considered regardless of the reason for the late submission. If, due to inclement weather, natural disaster, or any other cause, the Department office location to which proposals are to be returned is closed on the proposal response date, the deadline for submission shall be automatically extended until the next Department business day on which the office is open, unless the Department otherwise notifies the offerors. The time of day for submission of proposals shall remain the same.

I-15. Proposals

To be considered, a proposal must consist of a complete response, using the format provided in Part II of this RFP and the RFP Response Template and Confirmation Certificate at Appendices D and E. Proposals are to be submitted in three (3) separate sections. The Technical Section must be submitted as an original (signed by an official of the company who can bind the company to the proposal) with twelve (12) copies to the Department's Division of Budget and Office Management. Each offeror is also required to submit an original plus two copies of the Cost section, and an original copy of the Disadvantaged Business Information portion of the proposal. The Technical, Cost and Disadvantaged Business sections of the offeror's response must be clearly labeled, and individually bound and sealed. In addition, each offeror must submit one copy of the technical proposal on CD-ROM in Word or Word-compatible format. An electronic version of the cost proposal is required, preferably using Microsoft Excel or an Excel-compatible program.

Each offeror will make no other distribution of proposals. Each proposal page should be numbered for ease of reference. **An official who is authorized to bind the offeror to its provisions must sign proposals.** For this RFP, the proposal must remain valid until a contract

is executed or for a period of one hundred twenty (120) days, whichever is sooner. Moreover, the contents of the proposal of the selected contractors, as well as written instructions or specifications that may be developed, will become contractual obligations if a contract is entered into.

Each offeror should review all of the service requirements specified in this RFP when developing a response. Each offeror submitting a proposal specifically waives any right to withdraw or modify it, except as hereinafter provided. Proposals may be withdrawn by written or telefax notice received at the Issuing Office's address for proposal delivery prior to the exact hour and date specified for proposal receipt. However, if the offeror chooses to attempt to provide such written notice by telefax transmission, the Department shall not be responsible or liable for errors in telefax transmission. A proposal may also be withdrawn in person by an offeror or an authorized representative, provided the representative's identity is made known and he/she signs a receipt for the proposal, but only if the withdrawal is made prior to the exact hour and date set for proposal receipt. A proposal may only be modified by the submission of a new sealed proposal or submission of a sealed modification that complies with the requirements of this RFP before the stated deadline.

I-16. RFP Documentation Electronic Library

All documents referenced in the RFP will be accessible through the Department's website. A compiled list of the available documents can be found in Appendix F.

I-17. Disadvantaged Business Information

The Commonwealth encourages participation by small disadvantaged businesses as prime contractors, joint ventures, and subcontractors/suppliers, and by socially disadvantaged businesses as prime contractors.

Small Disadvantaged Businesses are small businesses that are owned or controlled by a majority of persons, not limited to members of minority groups, who have been deprived of the opportunity to develop and maintain a competitive position in the economy because of social disadvantages. The term includes: (a) Department of General Services Bureau of Minority & Women Business Opportunities (BMWBO)-certified Minority Business Enterprises (MBEs) and Women Business Enterprises (WBEs) that qualify as small businesses, and (b) United States Small Business Administration (SBA)-certified Small Disadvantaged Businesses or 8(a) small disadvantaged business concerns.

Small businesses are businesses in the United States that are independently owned, are not dominant in their field of operation, employ no more than 100 persons, and earn less than \$20 million in gross annual revenues (\$25 million in gross annual revenues for those businesses in the information technology sales or service business).

Socially disadvantaged businesses are businesses in the United States that BMWBO determines are owned or controlled by a majority of persons, not limited to members or minority groups, who are subject to racial or ethnic prejudice or cultural bias, but which do not qualify as small businesses. In order for a business to qualify as "socially disadvantaged," the offeror must

include in its proposal clear and convincing evidence to establish that the business has personally suffered racial or ethnic prejudice or cultural bias stemming from the business person's color, ethnic origin, or gender.

Questions regarding the Disadvantaged Business Program can be directed to:

Department of General Services
Bureau of Minority & Women Business Opportunities
Room 502, North Office Building
Harrisburg, PA 17125
gs-bmwbo@state.pa.us
Phone: (717) 787-6708
Fax: (717) 772-0021

Program information and a database of BMWBO-certified minority- and women-owned businesses can be accessed at www.dgs.state.pa.us, DGS Keyword: BMWBO. The federal vendor database can be accessed at www.ccr.gov by clicking on Dynamic Small Business Search (certified companies are so indicated).

I-18. Information Concerning Small Businesses in Enterprise Zones

The Commonwealth of Pennsylvania encourages participation by small businesses whose primary headquarters facility is physically located in areas designated by the Commonwealth as Designated Enterprise Zones, as prime contractors, joint ventures, and subcontractors/suppliers.

Small businesses are businesses in the United States that are independently owned, are not dominant in their field of operation, employ no more than 100 persons, and earn less than \$20 million in gross annual revenues (\$25 million in gross annual revenues for those businesses in the information technology sales or service business).

There is no database or directory of small business located in Designated Enterprise Zones. Information on the location of Designated Enterprise Zones can be obtained by contacting:

Aldona M. Kartorie
Center for Community Building
PA Department of Community and Economic Development
4th Floor Keystone Building
400 North Street
Harrisburg, PA 17120-0225
Phone: (717) 720-7409
Fax: (717) 787-4088
Email: akartorie@state.pa.us

I-19. Realistic Proposals

Proposal amounts, effort of work, and resources must be sufficient to ensure that the selected offeror can perform the work required by this RFP. This will aid in the avoidance of contract disputes.

I-20. Alternate Proposals

The Department will accept only **one** proposal from each offeror. Each offeror is expected to submit a single proposal that describes their best technical solution and satisfies the comprehensive requirements of this RFP.

I-21. Economy of Preparation

Each proposal should be prepared simply and economically using the RFP Response Template and Confirmation Certification at Appendices D and E. Responses must be provided in the format and sequence directed in the RFP Response Template and include straightforward, concise descriptions of the offeror's ability to meet the requirements of this RFP. When responding to questions and requirements presented in this RFP, the offeror is warned against the use of unexplained or undefined technical jargon or acronyms. Offeror responses should be concise and understandable to an audience that is not necessarily familiar with current contracts in place. Proposals must not exceed two (2) three-inch (3") binders in length. The first binder should include the offeror's technical response; the second may contain items such as addenda to the technical response.

I-22. Oral Presentations

Each offeror who submits a proposal may be required to make an oral or written presentation or clarification of their proposal to the Department. Such presentations provide an opportunity for the offeror to clarify its proposal to gain a thorough and mutual understanding of contractor responsiveness to the solicitation requirements. The Issuing Office will schedule these presentations as necessary. **The offeror's proposed project manager must be present at any scheduled oral presentation.** The inability of an offeror to make an oral presentation within five (5) working days of written notification by the Department may result in disqualification. At the conclusion of the oral presentation, the offeror will be asked to confirm any clarification to its proposal, in writing, to be incorporated into the proposal and/or contract as deemed necessary by the Department.

I-23. Best and Final Offers

To obtain best and final offers from each offeror, the Department may do one or more of the following: (a) enter into negotiations; (b) schedule oral presentations; and (c) request revised proposals. The Criteria for Selection found in Section III-3 shall also be used to evaluate best and final offers. Dollar commitments to Disadvantaged Businesses and Enterprise Zone Small Businesses can only be reduced in the same percentage as the reduction in the total price offered through negotiations.

I-24. Prime Contractors' Responsibilities

Each selected offeror will be required to assume responsibility for all services or products offered in the proposal, whether or not they are provided or performed by the selected offeror. Furthermore, the offeror must be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the cost of any contract. Any services or products provided by a subcontractor must be identified in the offeror's proposal. The Department reserves the right to approve or reject, in writing, any subcontractor proposed by the prime contractors.

I-25. Subcontracts and Joint Proposal

A single proposal may be submitted jointly by multiple parties. However, in that case, one (1) party must be identified as the prime contractor and all other parties as subcontractors. The Department will conduct all business through the contractor only.

I-26. Availability of Work Product

During the period of this contract, all information obtained by the offeror relating to or through work on the project will be made available to the Department immediately upon demand. If requested, the offeror shall deliver to the Department background material prepared or obtained by the offeror incident to the performance of this agreement. Background material is defined as original work papers, notes, and drafts prepared by the offeror to support the data and conclusions in final reports, and includes completed questionnaires, material in electronic data processing form, computer programs, other printed materials, pamphlets, maps, drawings, and all data directly related to the services being rendered.

I-27. Disclosure of Proposal Contents

Proposals will be held in confidence and will not be revealed or discussed with competitors, unless disclosure is required to be made (a) under the provisions of any Commonwealth or United States statute or regulation; or (b) by rule or order of any court of competent jurisdiction. If a contract is executed, however, the successful proposal submitted in response to this RFP shall be subject to disclosure. All other material submitted becomes the property of the Commonwealth of Pennsylvania and may be returned only at the Commonwealth's option.

Proposals submitted to the Department may be reviewed and evaluated by any person other than competing offerors at the discretion of the Department. The Department has the right to use any or all ideas presented in any proposal. Selection or rejection of the proposal does not affect this right.

I-28. Debriefing Conference

Each offeror whose proposal is not selected will be notified of the name of the selected offerors and will be given an opportunity to be debriefed, upon request. The Issuing Office will schedule

the time and location of the debriefing. The offeror will not be compared with other offerors, other than the position of its proposal in relation to all other proposals for each criterion for selection. The contractor's exercise of the opportunity to be debriefed shall not constitute the filing of a protest under section I-37 hereof.

I-29. Public Relations and News Releases

News releases pertaining to this project shall not be made without advance written approval by the Department, and then only in conjunction with the Issuing Office.

The Department reserves the right to make presentations to any audience with or without the participation of the selected offerors.

I-30. Commonwealth Participation

Unless specifically noted in this section, each offeror must provide all services, including office spaces and reproduction facilities, to complete the identified work. Program administration, monitoring, and oversight will be the responsibility of the Department. Designated Department staff will coordinate the program, provide or arrange technical assistance, and monitor the contractors for compliance with contract requirements, program policies, and procedures.

This RFP describes the program work statement with which contractors must comply. This RFP also includes information on the policies and procedures that the Department will follow in carrying out its program management, administration, monitoring, and oversight responsibilities.

I-31. Contract Commencement and Duration

The contract shall be for a period of three (3) years. Commencement of the contract will be in accordance with the standard terms and conditions found in Appendix A.

I-32. Confidentiality

Each selected offeror will assure the Commonwealth that the access, use, and disposal of all data will be safeguarded in accordance with federal and Commonwealth laws and regulations. Due to the nature of the proposed work, each contractor must ensure compliance with laws and regulations that protect the privacy of an individual, such as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. §§300gg *et seq.*, and the HIPAA Privacy Rule at 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information) within the HIPAA regulations.

In accordance with HIPAA and the HIPAA Privacy Rule at 45 CFR Parts 160 and 164, each selected offeror will be considered a Business Associate of the Pennsylvania Insurance Department (Covered Entity) and will be required to sign a Business Associate Agreement (Appendix I). All Protected Health Information covered under the Business Associate Agreement, as defined in HIPAA and its regulations, will be returned to the Pennsylvania

Insurance Department, upon termination of contract, in accordance with the standard terms and conditions found in Appendix A.

The records created or maintained by the offeror and any of its subcontractors, in connection with the capture of data relating to adultBasic enrollees, including the information received from all sources, are confidential and shall be open to public inspection or disclosure only to the extent the Department may be authorized by federal and state law and regulation. The offeror must also establish procedures to assure that information is not released to inappropriate individuals or agencies.

Each person hired by the offeror must be informed of the confidentiality of the information described in the paragraph above and the remedies involved in breaching confidentiality. All personnel must be required to sign a statement that they understand the requirements of confidentiality prior to receiving authorization to access the CHIP and adultBasic Processing System (CAPS) or any of its related operations. The offeror, and any of its subcontractors, shall provide written notice to all employees of the confidential nature of insurance records and shall specify that unauthorized disclosure is strictly prohibited and grounds for dismissal and any other applicable remedy.

Should a breach of confidentiality occur as a result of an unauthorized disclosure by a person employed by the offeror, or by any of its subcontractors, the offeror shall hold harmless the Commonwealth of Pennsylvania and its Departments and personnel. The offeror must assume total financial liability associated with any breach of confidentiality.

I-33. Computer Virus Protection

Each offeror must ensure that all data transmitted to the Department is free of computer viruses. In addition to other remedies that may be available to the Department, the Department may impose additional damages for computer virus transmittals. In the event that an offeror-transmitted data file is found to have a computer virus, the offeror will be assessed damages equal to the costs to correct and/or repair files as determined by the Department and committed to writing by the Department.

I-34. Changes

The Department may, at any time and only by written instruction, make changes in the Work Statement, Part IV, provided such changes are within the general scope of the Work Statement, Part IV, and provided further that the total cost of the negotiated contract is not exceeded. Due to possible changes in federal or state requirements, e.g., statute or regulation, the Department reserves the right to make changes in the requirements of the project caused by such changes at any time during the proposed life of the contract. Any changes the Department requires will be submitted in writing to each offeror.

Any changes outside the scope of this contract shall be accomplished through the use of normal Commonwealth procedures and will result in either a new contract or an amendment to this

contract, and fully executed by all parties, including all Commonwealth signatures as required by law. No work may begin until the date specified in the Letter of Notice to Proceed.

I-35. Contractor's Representations and Authorizations

Each offeror by submitting its proposal understands, represents, and acknowledges that:

- A. All information provided by, and representations made by, the offeror in the proposal are material and important and will be relied upon by the Issuing Office in awarding the contract(s). Any misstatement shall be treated as fraudulent concealment from the Issuing Office of the true facts relating to the submission of this proposal. A misrepresentation shall be punishable under 18 Pa. C.S. §4904.
- B. The price(s) and amount of this proposal have been arrived at independently and without consultation, communication, or agreement with any other contractor or potential contractor.
- C. Neither the price(s) nor the amount of the proposal, and neither the approximate price(s) nor the approximate amount of this proposal, have been disclosed to any other firm or person who is a contractor or potential contractor, and they will not be disclosed on or before the proposal submission deadline specified in the cover letter to this RFP.
- D. No attempt has been made or will be made to induce any firm or person to refrain from submitting a proposal on this contract, or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal or other form of complementary proposal.
- E. The proposal is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive proposal.
- F. To the best knowledge of the person signing the proposal for the offeror, the offeror, its affiliates, subsidiaries, officers, directors, and employees are not currently under investigation by any governmental agency and have not in the last four (4) years been convicted or found liable for any act prohibited by State or Federal law in any jurisdiction, involving conspiracy or collusion with respect to bidding or proposing on any public contract, except as disclosed by the offeror in its proposal.
- G. To the best of the knowledge of the person signing the proposal for the offeror and except as otherwise disclosed by the contractor in its proposal, the offeror has no outstanding, delinquent obligations to the Commonwealth including, but not limited to, any state tax liability not being contested on appeal or other obligation of the offeror that is owed to the Commonwealth.

- H. The offeror is not currently under suspension or debarment by the Commonwealth, or any other state, or the federal government, and if the offeror cannot certify, then it shall submit along with the proposal a written explanation of why such certification cannot be made.
- I. The offeror has not, under separate contract with the Issuing Office, made any recommendations to the Issuing Office concerning the need for the services described in the proposal or the specifications for the services described in the proposal.
- J. Each offeror, by submitting its proposal, authorizes all Commonwealth agencies to release to the Commonwealth information related to liabilities to the Commonwealth including, but not limited to, taxes, unemployment compensation, and workers' compensation liabilities.
- K. Until the selected offeror receives a fully executed and approved written contract from the Issuing Office there is no legal and valid contract, in law or in equity, and the offeror should not begin to perform.

I-36. Application Software Rights

The Department will have all ownership rights to software or modifications thereof, and associated documentation designed, developed, or installed by the Commonwealth or its information technology contractors. To the extent that any selected offeror uses any of its property (including, without limitation, any hardware or software of the selected offeror, or any proprietary or confidential information of the selected offeror), or any trade secrets of the selected offeror in performing services hereunder, such property shall remain the property of the selected offeror.

I-37. RFP Protest Procedure

The following information outlines the processes and requirements for filing an RFP protest:

- A. **Who May File the Protest.** Any actual or prospective contractors who are aggrieved in connection with the solicitation or award of the contract may file a protest, in writing, with the Issuing Office.
- B. **Time and Place for Filing.**
 - (1) A protest by a party not submitting a proposal must be filed within seven (7) days after the protesting party knew or should have known of the facts giving rise to the protest, no later than the proposal submission deadline specified in the cover letter to the RFP. Contractors who submit a proposal may file a protest within seven (7) days after the protesting contractor knew or should have known of the facts giving rise to the protest, but in no event may a protest be filed later than seven (7) days

after the date of the notice of selection. The date of filing is the date of receipt of the protest.

(2) A protest must be in writing and filed with the Issuing Office.

- C. Contents of Protest.** A protest shall state all grounds upon which the protesting party asserts the RFP or selection was improper. The protesting party may submit with the protest any documents or information it deems relevant.
- D. Notice of Protest.** The Issuing Office shall notify the successful contractors of the protest if selection has been made. If the protest is received before selection and substantial issues are raised by the protest, all contractors who appear to have a substantial and reasonable prospect of selection shall be notified and may file their agreement/disagreement with the Issuing Office within five (5) days after receipt of notice of protest.
- E. Stay of Procurement.** The head of the purchasing agency or designee will immediately decide upon receipt of a timely protest whether or not the award of a contract shall be delayed or, if the protest is timely received after the award, whether the performance of the contract should be suspended. The Issuing Office shall not proceed further with the solicitations or with the award of the contract and shall suspend performance under the contract, if awarded, unless the head of the purchasing agency or designee makes a written determination that the protest is clearly without merit or that award of the contract without delay is necessary to protect the substantial interests of the Commonwealth.
- F. Response and Reply.** Within fifteen (15) days of receipt of the protest, the Issuing Officer may submit to the head of the purchasing agency or designee and to the protesting party a response to the protest. The protesting party may file a reply to the response within ten (10) days of the date of the response.
- G. Procedures.** The head of the purchasing agency or designee shall review the protest and any response or reply. The Issuing Office may decide the merits of the protest on the written, submitted documentation; request and review any additional documents or information he/she deems necessary to render a determination; or, in his/her sole discretion, conduct a hearing.
- H. Determination.** The head of the purchasing agency or designee shall promptly, but in no event later than sixty (60) days from the filing of the protest, issue a written determination. The determination shall:
- (1) State the reason for the decision.
 - (2) Inform the protesting contractor of its right to file an action in Commonwealth Court within fifteen (15) days of the mailing date of the decision.

The Issuing Office shall send a copy of the determination to the protesting party and any other person determined by the Issuing Office to be affected by the decision.

I-38. Contract Awards

The RFP Evaluation Committee will submit its findings to the Insurance Commissioner. The Commissioner shall have the sole right to select the contractor or contractors to provide services. The Department will send written notice of intended contract awards to selected offerors. The letter will include instructions concerning the negotiation process, if required, for issuing a contract.

The Department reserves the right to negotiate any rate offered by an offeror. The Department shall have the sole right to make the final rate offer during contract negotiations. If the offeror does not accept the Department's final rate offer, the Department may, at its sole discretion, reject the proposal.

The Department reserves the right to select additional contractors in the event that a selected contractor is terminated or in the event that a contractor is the subject of a merger, acquisition, or other similar transaction.

I-39. Unsuccessful Negotiations

If, in the opinion of the Department, contract and/or rate negotiations with the selected offeror cannot be concluded within thirty (30) days following the selected offeror's receipt of a standard contract, the Department may, at its discretion, immediately discontinue negotiations with the selected offeror.

PART II INFORMATION REQUIRED FROM THE OFFEROR

II-1. General Requirements

To be considered, the proposal must comport with all requirements set forth in this Part II of this RFP. Proposals must be submitted in the format described below. Any other information thought to be relevant, but not applicable to the enumerated categories, should be provided as an appendix to the proposal.

Each proposal shall consist of three (3) separately sealed submittals. The submittals are as follows: (a) Technical Submittal; (b) Disadvantaged Business Submittal; and (c) Cost Submittal. Each submittal must be clearly identified and include type of submittal, offeror's name, RFP name, and RFP number.

The Department reserves the right to request additional information from the offeror, if in the opinion of the evaluation committee such information is necessary to determine the qualifications of the offeror.

The Department may make such investigations as it deems necessary to determine the ability of any offeror to perform the work, and each offeror shall furnish to the Department all such information and data for this purpose as requested by the Department. The Department reserves the right to reject any proposal if the evidence submitted by, or investigation of, such offeror fails to satisfy the Department that such offeror is properly qualified to carry out the obligations of the agreement and to complete the work specified.

II-2. Technical Submittal

This section includes instructions for preparing the technical proposal. Failure to comply with these instructions in full may result in disqualification.

The technical proposal should provide evidence of the offeror's ability to meet the work statement described in Part IV of this RFP. The format for the technical proposal is provided in the RFP Response Template in Appendix D and is outlined below.

An accompanying document, Confirmation Certificate, Appendix E, contains a checklist of mandatory requirements for this RFP that must be acknowledged. Please annotate the appropriate column on the checklist.

If publications (such as brochures, pamphlets, etc.) are supplied to augment a response to a requirement, the response should include reference to the document number and page number. This will provide a quick reference for the evaluators. Proposals not providing this reference will be considered to have no reference material included in the additional documents.

Tab 1. Statement of the Problem

State in succinct terms your understanding of the problem presented or the service required by this RFP.

Tab 2. Executive Summary

The Executive Summary must be written in succinct terms and provide an overview of the proposing organization and the proposal, with the offeror’s key strengths highlighted.

The offeror must demonstrate experience and familiarity with the medical, educational, social, and economic needs of the target population. The offeror must describe its ability to further the Department’s goals for this project, including plans to control costs while improving the quality of care and improving the health outcomes of enrollees.

Tab 3. Prior Experience

The corporate background and experience section must describe the history and relevant experience of the offeror and its subcontractors.

Each offeror that is an HMO must provide to the Department verification of the counties in which it has been authorized to operate pursuant to the certificate of authority issued by the Department of Health and the Department to provide health care services. Should an offeror that is an HMO desire to provide health care services in any county for which they have not received authorization from the Department and the Department of Health, that offeror shall be required to submit to the Department verification which confirms that authorization has been requested of the Department and the Department of Health to provide health care services in that county. This information is also due by the proposal submission date. An offeror identified as a selected contractor must have approved operating authority in the counties the offeror proposes to serve by the date on which its contract is signed with the Department or by the start of the Readiness Reviews, whichever is sooner.

Tab 4. Personnel

Submit a current or proposed organizational chart.

This section should include a description of the offeror’s overall organizational structure and its proposed organizational structure for the operation of the program. The offeror should demonstrate that all of the required functions listed in the work statement in Part IV of this RFP are contained within the offeror’s organization.

In the key administrative positions section of the proposal, the offeror should identify the name and position of the person authorized to negotiate a contract with the Department. Reference checks may be conducted of the Offeror’s administrator and the program

manager. The offeror must provide the name, address, telephone number, and contact person that can provide references for the positions requested.

The offeror shall attach resumes of the Offeror's administrator and the program manager as an appendix. Attach a job description, as an appendix, that includes minimum education and training requirements of each staff position identified in the proposal for the proposed organizational structure for the program. Specify where these personnel will be physically located during the time they are engaged to work. Each contractor is required to keep the Department informed at all times of the management individual whose duties include each of the responsibilities outlined in Part IV-5.A. Submission of a proposal is acceptance of these conditions.

Tab 5. Work Plan

The offeror must describe in narrative form their technical plan for accomplishing the work. **Please use the RFP Response Template as a guide in preparation of your proposal.** The RFP Response Template is intended to guide you in describing your organization's ability to perform the functions described in this RFP and to solicit alternative approaches that still meet the intent of the controlling statutes. Each of the questions refers back to a specific requirement in either Part II or Part IV of the RFP. The offerors are cautioned not to provide more documentation than necessary to demonstrate their ability to meet the work statement described in Part IV.

II-3. Disadvantaged Business Information

To receive credit for being a Small Disadvantaged Business or a Socially Disadvantaged Business, entering into a joint venture agreement with a Small Disadvantaged Business or subcontracting with a Small Disadvantaged Business (including purchasing supplies and/or services through a purchase agreement), a company must include proof of Disadvantaged Business qualification in the Disadvantaged Business submittal of the proposal:

- A. Small Disadvantaged Businesses qualifying as a result of MBE/WBE certification from BMWBO must provide a photocopy of their BMWBO certificate.
- B. Disadvantaged Businesses qualifying as a result of certification from the U.S. Small Business Administration as an 8(a) or Small Disadvantaged Business must submit proof of Small Business Administration Certification. The owners of such businesses must also submit proof of United States citizenship.
- C. All companies claiming Small Disadvantaged Business status, whether as a result of BMWBO certification or Small Business Administration certification as an 8(a) or Small Disadvantaged Business, must attest to the fact that the business has 100 or fewer employees.
- D. All companies claiming Small Disadvantaged Business status, whether as a result of BMWBO certification or Small Business Administration certification as an

8(a) or Small Disadvantaged Business, must submit proof that their gross annual revenues are less than \$20,000,000 (\$25,000,000 for those businesses in the information technology sales or service business). This can be accomplished by including a recent tax or audited financial statement.

All companies claiming status as a Socially Disadvantaged Business must include in the Disadvantaged Business submittal of the proposal clear and convincing evidence to establish that the business has personally suffered racial or ethnic prejudice or cultural bias stemming from the business person's color, ethnic origin, or gender. The submitted evidence of prejudice or bias must:

- Be rooted in treatment which the business person has experienced in American society, not in other countries.
- Show prejudice or bias that is chronic and substantial, not fleeting or insignificant.
- Indicate that the businessperson's experience with the racial or ethnic prejudice or cultural bias has negatively impacted on his or her entry into and/or advancement in the business world.

BMWBO shall determine whether the offeror has established that a business is socially disadvantaged by clear and convincing evidence.

In addition to these verifications, this portion of the proposal should include the following information:

- The name and telephone number of your project (contact) person for the Small Disadvantaged Business(es) or Socially Disadvantaged Business.
- The company name, address, and telephone number of the prime contact person for each **specific** Small Disadvantaged Business or Socially Disadvantaged Business included in the proposal. The offeror must specify the Small Disadvantaged Business(es) or Socially Disadvantaged Business to which it is making commitments. The offeror will not receive credit by stating it will find a Small Disadvantaged Business or Socially Disadvantaged Business after the contract is awarded or by listing several companies and stating it will select one later.
- The specific work, goods, or services the Small Disadvantaged Business(es) or Socially Disadvantaged Business will perform or provide.
- The location where the Small Disadvantaged Business(es) or Socially Disadvantaged Business will perform these services.

- The timeframe for the Small Disadvantaged Business(es) or Socially Disadvantaged Business to provide or deliver the goods or services.
- The amount of capital, if any, the Small Disadvantaged Business(es) or Socially Disadvantaged Business will be expected to provide.
- The form and amount of compensation each Small Disadvantaged Business or Socially Disadvantaged Business will receive. Provide the estimated dollar value of the contract to each Small Disadvantaged Business or Socially Disadvantaged Business.
- The percent of the total value of services or products purchased/subcontracted under the proposal that will be provided by the Small Disadvantaged Business(es) or Socially Disadvantaged Business.
- In the case of a joint venture agreement, a copy of the agreement, signed by all parties, must be included in the Disadvantaged Business portion of the proposal. If subcontracting, a signed subcontract or letter of intent must be included in the Disadvantaged Business portion of the proposal.
- Include in the Disadvantaged Business Submittal any and all information concerning the contractor's proposed utilization of small businesses located in *Designated Enterprise Zones* as required by Section II-4, Enterprise Zone Small Business Utilization Response.

The Disadvantaged Business submittal of the proposal must be clearly identified as Disadvantaged Business information and sealed in an envelope separately from the remainder of the proposal. Only one copy of the Disadvantaged Business section is needed. **Each offeror must submit a Disadvantaged Business Participation packet even if you indicate that it is not applicable.**

The dollar value of the commitment to each Small Disadvantaged Business or Socially Disadvantaged Business must be sealed in the same envelope with the Disadvantaged Business submittal of the proposal. **The selected offeror's Disadvantaged Business commitment amount, name of the Disadvantaged Business, and services to be provided, including timeframe for performing services, will be included as a contractual obligation when the contract is executed.**

II-4. Enterprise Zone Small Business Utilization Response

To receive credit for being an Enterprise Zone Small Business or entering into a joint venture agreement with an Enterprise Zone Small Business or subcontracting with an Enterprise Zone Small Business, a company must include the following information in the Disadvantaged Business submittal of the proposal:

- Proof of the location of the business' headquarters (such as a lease or deed or Department of State corporate registration).
- Confirmation of the enterprise zone in which it is located (obtained from the local enterprise zone office).
- Proof of United States citizenship of the owners of the business.
- Certification that the business employs 100 or fewer employees.
- Proof that the business's gross annual revenues are less than \$20,000,000 (\$25,000,000 for those businesses in the information technology sales or service business). This can be accomplished by including a recent tax or audited financial statement.

In addition to these verifications, this portion of the submittal should include the following information:

- The company name, address, and name and telephone number of the primary contact person for each Enterprise Zone Small Business included in the proposal. The offeror must specify the Enterprise Zone Small Business to which it is making commitments. The offeror will not receive credit by stating that it will find an Enterprise Zone Small Business after the contract is awarded or by listing several companies and stating it will select one later.
- The specific work, goods, or services the Enterprise Zone Small Business will perform or provide.
- The location where the Enterprise Zone Small Business will perform these services.
- The timeframe for the Enterprise Zone Small Business to provide or deliver the goods or services.
- The amount of capital, if any, the Enterprise Zone Small Business will be expected to provide.
- The form and amount of compensation each Enterprise Zone Small Business will receive. In the Disadvantaged Business portion of the proposal, provide the estimated dollar value of the contract to each Enterprise Zone Small Business.
- The percent of the total value of services or products purchased/subcontracted under the proposal that will be provided by the Enterprise Zone Small Business.
- In the case of a joint venture agreement, a copy of the agreement, signed by all parties, must be included in the Disadvantaged Business Submittal of the

proposal. If subcontracting, a signed subcontract or letter of intent must be included in the Disadvantaged Business Submittal of the proposal.

The dollar value of the commitment to each Enterprise Zone Small Business must be sealed in the same envelope with the Disadvantaged Business Submittal of the proposal. The selected contractor's Enterprise Zone Small Business commitment amount, name of Enterprise Zone Small Business, and services to be provided, including timeframe for performing services, will be included as a contractual obligation when the contract is executed.

II-5. Cost Proposal.

This section includes instructions for preparing the cost proposal. The offeror is cautioned to carefully review this section and follow all the instructions. Failure to comply with these instructions in full may result in an offeror's disqualification. The information in this section is required to support the reasonableness of your quotation and is for internal Department use only.

Care should be exercised that no other part of the proposal has references to the cost portion of the proposal, not even indirectly. Each proposal should include the cost proposal sealed separately from the remainder of the proposal. The cost proposal shall be kept confidential between the Commonwealth and the offeror.

The contract for the program is for a period of three (3) years. For **current contractors**, rates are subject to review and adjustment, where appropriate, on an annual basis. The initial set of rates will remain valid for the period covering the initiation of the new contract through June 30, 2006. For **new contractors**, the same rates shall apply for the first two (2) years of the program (through June 30, 2007) to allow for utilization experience. However, rates for the third year are subject to review and adjustment where appropriate. Subsequent rates for all contractors will remain valid for the state fiscal year (July 1 through June 30).

The rate is designed to provide the offeror with a prospectively determined monthly amount sufficient to meet the Benefit Plan statement described in Part IV. The offeror must demonstrate that its proposed rates are actuarially sound. In general, this means that offerors awarded contracts should be able to keep average utilization at or near their projected levels and contract for unit costs that average out at or near the amounts shown on the Rate Calculation Sheets (RCS) described below. See Appendix H for a copy of the RCS form. The basis of all financial projections must be linked to the rate proposal.

The Commonwealth is interested in working towards a solution to rising health care costs and the increasing number of uninsured Pennsylvanians, and towards improving access to quality health care. As noted in Part IV, the Department's goal is to contain costs to the level of annual medical inflation or seven and one-half percent (7.5%), whichever is lower. To address these issues, each offeror must provide a cost proposal for each of the following four (4) Benefit Packages. Current Contractors' rates must be based on the actual adult Basic Coverage Program experience of the \$30-Pay Enrollees. New contractors' rates may be based on commercial

products, and adjustments made to the data must be clearly indicated on the RCS form and discussed in the Actuarial Memorandum.

Package 1 – This is the basic current package that includes all the benefits described below under the Instructions For Completing the Rate Calculation Sheet (RCS). There is a copayment of five dollars (\$5) for primary care physician visits, ten dollars (\$10) for specialist visits, and twenty-five dollars (\$25) for emergency room (ER) visits. Please note that there is no copayment for wellness programs, annual gynecological exams, obstetrical care, and routine mammograms, and the ER copayment is waived if the insured is admitted.

Package 2 – This is the same as Package 1 with the following changes for cost sharing:

- Deductible of one hundred dollars (\$100) per calendar year on inpatient hospital services.
- Deductible of fifty dollars (\$50) per admission on outpatient hospital and SPU services.
- Copayment of fifty (\$50) for emergency room. Copayment is waived if admitted.
- Copayment of ten dollars (\$10) for primary care physician visits and fifteen dollars (\$15) for specialist visits.
- Copayment of five dollars (\$5) per visit for diagnostic services.
- Copayment of five dollars (\$5) per visit for rehabilitation therapy and a limit of fifteen (15) visits per calendar year.
- Copayment of five dollars (\$5) per prescription on diabetic supplies and injections.

Package 3 – Price and describe packages of benefits that can be provided for a Medical PMPM of:

- \$150.
- \$200.
- \$280.

Please note that the goal of this exercise is to reduce costs, not utilization. The Department has concerns that very high cost sharing represents a barrier to health care. Please document the pricing.

Package 4 – Price the following benefits:

- Inpatient Hospital with a limit of thirty (30) days per calendar year.
- Inpatient Hospital with a limit of twenty (20) days per calendar year.
- DME – medical supplies, prosthetics, and orthotics. Please provide details of covered services.
- Prescription drugs – with copayment of five dollars (\$5)/ten dollars (\$10) for generic and brand respectively.

The Department will determine which Package(s) of Benefits will be used after having reviewed the cost proposals provided by all the offerors. Successful offerors will be notified of this determination. Pricing information from Package 4 may be used to substitute benefits in the first three (3) packages. The Package selected by the Department will remain in place for the three (3)-year enrollment period covered by this RFP.

An original and two (2) copies of the Cost Proposal must be provided. Each Cost Proposal must include the hardcopy RCS forms described below. In addition, each Cost Proposal must be sent on a CD ROM/diskette as a file that provides the data submitted on the hardcopy RCS forms. The Department's software preference is Microsoft Excel. The CD ROM/diskette should be enclosed with the sealed hardcopies. In the event of a discrepancy between the hardcopy forms and the electronic file, the Department will evaluate the hardcopy forms. For Package 3, the same RCS form must be used. The benefits listed on the RCS form that are not included in the package must be colored yellow to indicate clearly that these are being excluded, in addition to leaving the projected utilization, unit cost, and PMPM blank. Benefits not included on the RCS form may be added in the section at the bottom of the RCS form.

A. Rating Information By Contracted Service Area

Each Cost Proposal must consist of a Rate Calculation Sheet (RCS) for each Contracted Service Area that the offeror is proposing to cover for the program.

INSTRUCTIONS FOR COMPLETING THE RATE CALCULATION SHEET (RCS)

(1) Utilization Estimates

(a) General

Offerors should begin development of their cost proposals by estimating utilization for each service category described below and presenting these estimates along with their underlying assumptions. The current adultBasic Program contractors must base these estimates on the actual adultBasic Program experience of the \$30-Pay enrollees. Any variations from it must be explained. The offerors not currently under contract in the adultBasic Program must base these estimates on actuarially sound estimates. The service categories represent

the major areas of utilization for program enrollees. Instructions follow regarding the method of calculating the various utilization frequencies.

The purpose for requiring this information is to assist the Department in understanding the offeror's rationale for its cost proposals.

In making utilization estimates, offerors should not include estimates for services not included in the Benefit Package.

(b) Service Categories

The annual utilization frequencies must be estimated for the following service categories:

- **Hospital Services**: These are subcategorized as follows:
 - Hospital Inpatient: The anticipated utilization should be expressed as the average number of hospital inpatient days expected per one thousand (1,000) enrollees. This subcategory should be further broken down as follows:
 - In-Area
 - Maternity
 - Normal
 - C-Section
 - Non-Maternity
 - Out-of-Area
 - Short Procedure Unit (SPU): The anticipated utilization should be expressed as the average number of SPU encounters expected per one thousand (1,000) enrollees.
 - Hospital Outpatient: The anticipated utilization should be expressed as the average number of hospital outpatient encounters expected per one thousand (1,000) enrollees.
 - Emergency Room: The anticipated utilization should be expressed as the average number of emergency room visits expected per one thousand (1,000) enrollees.

- Miscellaneous: The anticipated utilization should be expressed as the average number of all other covered hospital services rendered but not listed in the above subcategories, expected per one thousand (1,000) enrollees.
- **Physician Services**: These are subcategorized as follows:
 - Primary Care Provider (PCP) Visits: The anticipated utilization should be expressed as the average number of visits expected per one thousand (1,000) enrollees. This category should be further broken down as follows:
 - Medical
 - Preventive
 - Specialist Visits: The anticipated utilization should be expressed as the average number of specialist visits expected per one thousand (1,000) enrollees.
 - Surgery: The anticipated utilization should be expressed as the average number of surgeries expected per one thousand (1,000) enrollees. This subcategory should be further broken down as follows:
 - Inpatient – Physician’s services performed in the hospital.
 - Outpatient – Physician’s services for office surgery.
 - Anesthesia – Anesthesiologist services for surgery.
 - Assistant – Physician’s assistant/nurse for surgery.
 - Emergency Room: The anticipated utilization should be expressed as the average number of emergency room encounters expected per one thousand (1,000) enrollees.
 - Obstetrics: The anticipated utilization should be expressed as the average number of cases expected per one thousand (1,000) enrollees. This category should be broken down as follows:
 - Normal
 - C-Section

- Miscellaneous: The anticipated utilization should be expressed as the average number of all other covered provider services rendered but not listed in the above subcategories.
- **Diagnostic Tests**: These are subcategorized as follows:
 - Laboratory/Pathology: The anticipated utilization should be expressed as the average number of services expected per one thousand (1,000) enrollees.
 - X-rays: The anticipated utilization should be expressed as the average number of x-ray services expected per one thousand (1,000) enrollees.
 - Medical: The anticipated utilization should be expressed as the average number of services expected per one thousand (1,000) enrollees.
 - Routine Mammograms: The anticipated utilization should be expressed as the average number of services expected per one thousand (1,000) enrollees.
- **Other**:
 - Rehabilitation Therapy: The anticipated utilization should be expressed as the average number expected of covered therapy visits performed per one thousand (1,000) enrollees. This subcategory should be further broken down as follows:
 - Hospital
 - Non-Hospital
 - Covered Ambulance Services: The anticipated utilization should be expressed as the average number of services expected per one thousand (1,000) enrollees.
 - Diabetic Supplies and Injections: The anticipated utilization should be expressed as the average number of scripts expected per one thousand (1,000) enrollees.
 - Routine Gynecological Care: The anticipated utilization should be expressed as the average number of visits expected per one thousand (1,000) enrollees.

- **Miscellaneous**: The anticipated utilization should be expressed as the average number of all other covered services rendered but not listed in any of the above categories or subcategories, expected per one thousand (1,000) enrollees. If this service category is used, the offeror must itemize these services and provide sufficient data to allow examination and verification by the Department.

(2) Cost Estimates

(a) General

Offerors should estimate costs, on a per-unit basis, for each service category described below and present these estimates along with their underlying assumptions. Once developed, the unit cost estimates will provide the information necessary for developing an offeror's Medical Rate. The purpose for requiring this information is to assist the Department in understanding the offeror's rationale for its rate proposals.

The cost estimates should be based on the actual rate method as contracted with the providers in the offeror's network, including hospitals and PCPs. Adjustments should be made to account for the effect of expected inflation within the proposal year.

Each offeror that is a current adultBasic Program contractor must base the cost estimates for the "fee-for-service" benefits on its actual adultBasic Program experience of the \$30-Pay enrollees. Any variations from it must be explained. Each offeror not currently under contract in the adultBasic Program must base these estimates on actuarially sound estimates.

For capitated services, the actual amount as contracted with the provider should be used. If the provider is capitated with an incentive/withhold program, the amount should represent the gross capitation paid with supporting documentation showing the amount and structure of the incentive/withhold plan, including but not limited to the theoretical maximum and minimum incentives/withholds.

(b) Services Categories

The cost estimates must be estimated for the following service categories:

- **Hospital Services**: These are subcategorized as follows:
 - **Hospital Inpatient**: The anticipated unit cost should be the average expected daily payment or per diem payment that the offeror has negotiated with its hospitals. This subcategory should be further broken down as follows:

- In Area
 - Maternity
 - Normal
 - C-Section
 - Non-Maternity
- Out of Area
- Short Procedure Unit (SPU): The anticipated unit cost should be the average cost per encounter or a special contracted rate the offeror has negotiated with its providers.
- Hospital Outpatient: The anticipated unit cost should be the average cost per encounter or a special contracted rate under a capitation agreement that the offeror has negotiated with its providers. If there is a facility charge plus supplies and equipment billed by the outpatient facility, include those charges here.
- Emergency Room: The anticipated unit cost should be the average cost per emergency room visit or a special contracted rate under a capitation agreement that the offeror has negotiated with its providers. If an inpatient stay began in the emergency room, leave those emergency room costs in the emergency room cost category and record inpatient costs in the hospital category.
- Miscellaneous: The anticipated unit cost should be the average cost per service or a special contracted rate under a capitation agreement that the offeror has negotiated with its providers for all covered services rendered but not listed in the above hospital subcategories. If this service category is used, the offeror must itemize these services and provide sufficient data to allow examination and verification by the Department.
- **Physician Services**: These are subcategorized as follows:
 - Primary Care Provider (PC) Visits: The anticipated unit cost should be the average cost per physician visit or a special contracted rate under a capitation agreement that the offeror has negotiated. This subcategory should be further broken down as follows:
 - Medical

- Preventive
- Specialist Visits: The anticipated unit cost should be the average cost per visit or a special contracted rate under a capitation agreement that the offeror has negotiated with a specialist physician or practitioner.
- Surgery: The anticipated unit cost should be the average cost per surgery performed by the physician or a special contracted rate the offeror has negotiated under a capitation agreement. This subcategory should be further broken down as follows:
 - Inpatient – Physician’s services performed in the hospital
 - Outpatient – Physician’s services for office.
 - Anesthesia – Anesthesiologist services for surgery.
 - Assistant – Physician’s assistant/nurse for surgery.
- Emergency Room: The anticipated unit cost should be the average cost per encounter or a special contract rate the offeror has negotiated under a capitation agreement, for physician’s services provided in an emergency room, which are not included in hospital payments.
- Obstetrics: The anticipated unit cost should be the average cost per case or a special contract rate the offeror has negotiated under a capitation agreement. This subcategory should further be broken down as follows:
 - Normal
 - C-Section
- Miscellaneous: The anticipated unit cost should be the average cost per service or a special contract rate the offeror has negotiated under a capitation agreement for all other covered services rendered, but not listed in the above subcategories. If this service subcategory is used, the offeror must itemize these services and provide sufficient data to allow examination and verification by the Department.
- Diagnostic Tests: These are subcategorized as follows:
 - Laboratory/Pathology: The anticipated unit cost should be the average cost per service or a special contract rate the offeror has negotiated under a capitation agreement.

- X-rays: The anticipated unit cost should be the average cost per x-ray service or a special contract rate the offeror has negotiated under a capitation agreement.
- Medical: The anticipated unit cost should be the average cost per service or a special contract rate the offeror has negotiated under a capitation agreement.
- Routine Mammograms: The anticipated unit cost should be the average cost per service or a special contract rate the offeror has negotiated under a capitation agreement.
- **Other**:
 - Rehabilitation Therapy: The anticipated unit cost should be the average cost per service or a special contract rate the offeror has negotiated under a capitation agreement for therapy services. This subcategory should be further broken down as follows:
 - Hospital
 - Non-Hospital
 - Covered Ambulance Service: The anticipated unit cost should be the average cost per service or a special contract rate the offeror has negotiated under a capitation agreement.
 - Diabetic Supplies and Injections: The anticipated unit cost should be the average cost per script or a special contract rate the offeror has negotiated under a capitation agreement.
 - Routine Gynecological Care: The anticipated unit cost should be the average cost per service or a special contract rate the offeror has negotiated under a capitation agreement.
- **Miscellaneous**: The anticipated unit cost should be the average cost per service or a special contract rate the offeror has negotiated under a capitation agreement for all other covered services rendered, but not listed in any of the above categories or subcategories. If this service category is used, the offeror must itemize these services and provide sufficient data to allow examination and verification by the Department.

(3) PMPM and Medical Rate

The PMPM amount for fee-for-service benefits must be calculated by multiplying the utilization per one thousand (1000) by cost per unit and dividing by twelve

thousand (12,000) for each service category or subcategory for which utilization and costs have been estimated as shown above. For services that have capitation agreements, the PMPM amount is the actual capitated amount. The Medical Rate is obtained by adding the PMPM amounts for each service.

(4) Administrative Expenses

The Administrative Expenses (AE) are the direct (marginal) costs of the adultBasic Program up to ten percent (10%) of the Total Rate described below. The offeror must identify the AE through appropriate cost accounting and ensure that the “marginal” AE are fully described and justified. The AE must be broken down into the following components:

- Expenses associated with eligibility determination and the enrollment of program enrollees;
- Claims adjustment;
- Salary of employees when working only on the adultBasic Program;
- Enrollee services;
- Utilization Management;
- Quality Assurance;
- Health data systems/computer reporting;
- Technical support and other support services – list must be provided;
- Legal;
- Others not listed above – list must be provided.

(5) Risk and Contingency

A Risk and Contingency (RC) component of up to two percent (2%) of the Total Rate with justification therefor may be included for the Department’s consideration.

(6) Total Rate

$$\text{Total Rate} = \text{Medical Rate} / (1 - \text{AE}\% - \text{RC}\%)$$

$$\text{AE Amount} = \text{Total Rate} \times \text{AE}\%$$

RC Amount = Total Rate x RC%

(7) RCS Form

For each Contracted Service area, the offeror should use the information developed above to complete a separate RCS form for each Cost Proposal. The RCS form is included in Appendix H of this RFP.

Instructions for completing the RCS form:

- (a) Enter the Cost Proposal Package Number, the Contracted Service Area, and the Experience Period at the top of the form.
- (b) Enter the experience data in column (A) to (F) for each service category or subcategory for which utilization and costs have been developed above. Note for the “Miscellaneous” line item, a single entry for all the included services will suffice. The information required in each column is as follows:

Column A – Number of days/services

Column B – Incurred Claims

Column C – Number of enrollee months

Column D – Utilization/1000

Column E – Unit Cost

Column F – Actual PMPM

- (c) Enter the adjustment factors, including trend factors, used to develop the Projected PMPM from the experience data in columns G to K. (Explanation for the basis of these adjustments should be included in the Actuarial Memorandum.)
- (d) Enter the annual utilization rate for each service category or subcategory as developed above in Column L. Note for the “Miscellaneous” line item: A single utilization rate for all the included services will suffice.
- (e) Enter the cost per unit for each service category or subcategory as developed above, expressed in dollars and cents in Column M. Note for the “Miscellaneous” line item: A single unit cost for all the included services will suffice.

- (f) Enter the PMPM amount based on the entries for units per one thousand (1,000) and cost per unit in Column N. Note for the “Miscellaneous” line item: A single PMPM rate for all the included services will suffice.
- (g) Enter the Medical Rate by adding PMPM amounts for each service.
- (h) Enter the Administrative Expense amount, the Risk and Contingency amount, and the Total Rate developed above. The sum of the Medical Rate, AE amount, and the RC amount must be equal to the Total Rate.
- (i) Enter the services included under the “Miscellaneous” category in Lines 7, 15, and 24 respectively.
- (j) Repeat steps 1 through 9 for each Contracted Service Area.

(8) Other Information Required with the Cost Proposal

- **Contact Person:** The name and telephone number of the person(s), who may be contacted by the Department, should there be any questions on the rate development must be provided.
- **Actuarial Memorandum:** Each cost proposal must also include a narrative that gives an explanation of the rate justification and all underlying assumptions used for each benefit in the development of the proposed rates described above. **The adjustment factors must be shown in columns G to K of the RCS form and the justification of these adjustment factors must be included in the Actuarial Memorandum.** If completion factors have been used in the development of incurred claims, these must be discussed for each service category or subcategory in this memorandum.
- **Counties:** A list of the counties that will be covered under each Contracted Service Area must be included.
- **Capitated Services:** All the services being capitated (in whole or in part) must be clearly indicated. The signature and fee schedule page must be included for each capitated service. For PCP agreements, only the fee schedules, the distribution by age/gender used in the derivation of the rate, and a worksheet showing the calculation of the requested PMPM amount must be included.
- **Maternity Benefits:** A description of the services covered under Hospital Services (Maternity – Normal & C-section) and Physicians Services (Obstetrics – Normal & C-Section) must be included. Explain how the services provided for complications of pregnancy are reported on the RCS worksheet.

- **Historical Experience Data:** The current contractors must submit the actual experience data (as of the date used for the current year’s experience data above), for each calendar year since the inception of the program for each Contracted Service Area. This data must be provided in the format shown in Appendix I and must include the enrollee-months, PMPM, Total Paid claims, Total Incurred claims, and Completion Factors for the major benefit categories – Inpatient Hospital, Outpatient Hospital, Physicians’ Services, Diagnostic Tests, and Other.
- **Prescription Drug Discount Program:** If the offeror has a prescription drug discount plan currently available in Pennsylvania, the offeror shall provide such a plan at no cost to enrollees as an additional benefit of this program. The offeror must provide a description of the plan and how it is administered.
- **Additional Benefits for Enrollees:** If the offeror intends to include any additional benefits to the enrollees in this program in addition to the Benefit Package, but without additional cost to the enrollees, a detailed description of the benefits must be submitted.
- **Optional Benefits for Enrollees:** If the offeror intends to include any other services or other benefits to the enrollees in this program on an optional basis, a detailed description of the services or other benefits and the additional cost to the enrollees on a PMPM basis must be submitted to the Department for prior approval.

Incurred Claims: A discussion of the method (completion factor method, loss ratio method) used to calculate the incurred but unpaid claim liability must be provided with each application.

- (a) Consistency of the paid claim experience used to estimate incurred but unpaid claim liabilities with the paid claims reported in the financial statements.
- (b) The definition of incurred date used in the analysis of paid claim experience to estimate the incurred but unpaid claims for the following services:
 - Per Diem hospital cost for a stay from the middle of one month to the middle of the next month.
 - Ancillary charges for the above hospital stay.
 - Primary Care Provider (“PCP”) office visit.

- (c) Adjustments made for changes in plan provisions between the prior experience periods used to estimate the incurred and unpaid claims and the contract period.
- (d) Adjustments made for changes in claim processing rates between the prior experience periods used to estimate the incurred and unpaid claims and the contract period.
- (e) Adjustment for changes in inflation and utilization trends between the prior experience periods used to estimate the incurred and unpaid claims and the contract period.
- (f) Adjustments made for changes in provider networks and contracts between the prior experience periods used to estimate the incurred and unpaid claims and the contract period.
- (g) Any adjustments made during the contract year that affect payments made to the provider networks must be disclosed and explained.

B. RATE ADJUSTMENT FOR SUBSEQUENT YEARS:

- (1) The Department may, at its discretion, adjust rates for the second and third years of the RFP for any **current** Adult Basic Program contractor and for the third year of the RFP for any **new** contractor, which adjustments, if any, will be subject to actuarial review.
- (2) Each contractor must submit the most recent experience data for a one (1)-year period in the required RCS format as described in Section A above. An RCS form must be submitted for the program for each Contracted Service Area.
- (3) In the event no adjustments are made, the rates applicable to the previous year will apply.
- (4) Rate negotiations will commence at least thirty (30) days prior to the start of the contract year. If no agreement is reached at the start of the contract year, rates applicable to the previous year continue to apply until any new rates are finalized.
- (5) For monitoring purposes, each contractor must submit its total experience data for the program at the end of each program year in the required RCS format, for each Contracted Service Area, **even when no rate adjustment is requested**.
- (6) Each contractor must submit its actual experience data for each calendar year since the inception of the program, as of the date used for the data in item 2 above. These data must be provided in the format shown in Appendix I and must include the enrollee-months, PMPM, Total Paid claims, Total Incurred claims,

and Completion Factors for the major benefit categories – Inpatient Hospital, Outpatient Hospital, Physicians’ Services, Diagnostic Tests, and Other.

PART III CRITERIA FOR SELECTION

III-1. Mandatory Responsiveness Requirements

To be eligible for selection, a proposal must be (a) received as specified in the cover letter; (b) properly signed by an individual with legal authority to bind the offeror; and (c) formatted such that all cost data is kept separate from and not included in the Technical Submittal.

III-2. Evaluation Committee

Proposals will be reviewed and evaluated by a committee of qualified personnel selected by the Department. This committee will review those proposals that meet all of the qualifying factors specified in Parts II and IV. The committee will submit its findings to the Insurance Commissioner who shall have the sole right to select the contractors to provide services. Award will only be made to contractors determined to be responsible in accordance with Commonwealth Management Directive 215.9, Contractor Responsibility Program (Appendix F).

III-3. Criteria for Selection

The following areas of consideration will be used in making the selection. The Department reserves the right to refuse to further consider a proposal that is not fully responsive to the requirements listed in Part IV of this RFP and the **RFP Response Template** at Appendix D. The Department also reserves the right to reject any offeror's proposal for failing to meet any of the criteria specified below:

A. Cost

The Department will review the rate submittals of each offeror after a thorough review of the technical proposal. In the event that more than one qualified technical proposal is received for a service area, e.g., county, collection of counties, the highest score for this area will be awarded to the offeror who submitted the proposal providing the best value to the Commonwealth to service that area.

B. Financial Condition

The Department will review the annual statement and the CPA audit report for each offeror that are periodically submitted as part of the Department's oversight responsibilities. The Department will review the statements for an indication that the offeror is financially sound and has the financial resources required to engage in a project of this magnitude.

C. Contractor Qualifications

The Department will review the ability of each offeror to meet the terms of the RFP, especially the quality, relevance, and scope of services rendered by the organization. The offeror's management information system and its capability will be considered.

D. Personnel Qualifications

The Department will assess each offeror's description of professional personnel who will be assigned to work on the program. Qualifications of professional personnel will be measured by experience and education, with particular reference to experience in services similar to that described in the RFP. Particular emphasis will be placed on the qualifications of the key personnel.

E. Understanding of the Services to be Provided

The Department will assess each offeror's understanding of the nature and scope of the work to be performed and services to be provided as outlined in Part IV of this RFP.

F. Soundness of Approach

The Department will assess the soundness of the approach taken by each offeror in its response with emphasis on:

- (1) The methods described for providing access to care.
- (2) The methods of measuring the quality of care and improved health outcomes.
- (3) The proposed approaches to cost control and alternative benefit packages.
- (4) The methods to encourage minority provider participation in a meaningful and significant manner.
- (5) The methods for managing a timely claims processing system.
- (6) The methods for assuring quality customer service.

The technical approach must be responsive to all written specifications and requirements contained in the RFP and follow the format described in Part II and Appendix D.

G. Disadvantaged Business Participation

The following options will be considered as part of the final criteria for selection:

Priority Rank 1. Proposals submitted by Small Disadvantaged Businesses.

Priority Rank 2. Proposals submitted from a joint venture with a Small Disadvantaged Business as a joint venture partner.

Priority Rank 3. Proposals submitted with subcontracting commitments to Small Disadvantaged Businesses.

Priority Rank 4. Proposals submitted by Socially Disadvantaged Businesses.

Each proposal will be rated for its approach to enhancing the utilization of Disadvantaged Businesses. Each approach will be evaluated with Priority Rank 1 receiving the highest score and the succeeding options receiving scores in accordance with the above-listed priority ranking.

To the extent that a proposal is submitted by a Small Disadvantaged Business or a Socially Disadvantaged Business, the Small Disadvantaged Business or Socially Disadvantaged Business cannot enter into subcontract arrangements for more than 40 percent of the total estimated dollar amount of the contract. If a Small Disadvantaged Business or a Socially Disadvantaged Business subcontracts more than 40 percent of the total estimated dollar amount of the contract to other contractors, the Disadvantaged Business Participation scoring shall be proportionally lower for that proposal.

H. Enterprise Zone Small Business Participation

The following options will be considered as part of the final criteria for selection:

Priority Rank 1. Proposals submitted by an Enterprise Zone Small Business will receive the highest score.

Priority Rank 2. Proposals submitted by a joint venture with an Enterprise Zone Small Business as a joint venture partner will receive the next highest score for this criterion.

Priority Rank 3. Proposals submitted with a subcontracting commitment to an Enterprise Zone Small Business will receive the lowest score for this criterion.

Priority Rank 4. Proposals with no Enterprise Zone Small Business Utilization shall receive no points under this criterion.

To the extent that a proposal is submitted as a prime contractor by an Enterprise Zone Small Business, the Enterprise Zone Small Business cannot enter into contract or subcontract arrangements for more than 40 percent of the total estimated dollar amount of the contract.

III-4. Ranking

The Evaluation Committee will evaluate each technical proposal against the requirements. The Evaluation Committee will review the cost proposals of all offerors who have demonstrated that they have the ability to meet the technical requirements of the RFP. Discussions and negotiations will be conducted with responsible offerors to obtain best and final offers. If two or more offerors are bidding on the same coverage areas, the Department reserves the right to select the proposal of the offeror that provides the “best value,” e.g., with the best balance of approaches, benefits, and cost. The Department shall have the sole right to select the number of contractors in accordance with the ranking of the proposals and requirements in this RFP, Department policies, and applicable laws.

If there are not enough acceptable proposals to adequately serve the program population, the Department reserves the right to reject all proposals and pursue another procurement.

III-5. Special Terms and Conditions

The Department reserves the right to specify special terms and conditions for each individual offeror as part of making awards. If an award includes any special terms and conditions, the award will not be considered official until the offeror complies with these terms and conditions in full.

III-6. Rejection of Proposal

Any proposal may be rejected in its entirety for failure to meet any criteria for selection.

PART IV WORK PLAN

IV-1. Overview

As provided for in Act 2001-77, the Department intends to provide basic health care insurance to eligible adults through contracts with selected contractors. The goal of the program is to provide quality, basic health care insurance in a cost-effective manner to the maximum number of potentially eligible adults who are at least nineteen (19) years of age but less than sixty-five (65) years of age.

The Department intends to achieve this goal by contracting with contractors that will enroll eligible adults and that will provide health insurance coverage and other services as described in the RFP in return for payment made on a per-enrollee-per-month basis.

IV-2. Objectives

The Department intends to fund reasonable proposals that demonstrate cost effectiveness and provide sufficient detail that the offeror is capable of meeting the requirements specified with this RFP. Any offeror who is a Health Plan Corporation will be required to propose to provide service in the total geographic area for which a Certificate of Authority has been issued. Any offeror that is not a Health Plan Corporation is strongly encouraged, but are not required, to propose to provide service in every county for which a Certificate of Authority has been awarded. Each contractor will be paid a negotiated monthly amount for the provision of in-plan services to eligible adults. The program is and will continue to be offered statewide.

In addition to the defined health care insurance coverage outlined in this RFP, the Department is providing offerors the flexibility to recommend alternative benefits or services. Each offeror is encouraged to propose modifications to the standard packages that would reduce or contain costs without adversely affecting services or associated health outcomes received by consumers. The Department's goal is to control costs at or below the medical inflation rate(s) with a maximum of seven and one-half (7.5) percent annual inflation over the term of the contract, in order to maximize use of available funding and the number of persons served.

IV-3. Nature and Scope of Project

A. Contractor Responsibilities/Tasks

Each successful offeror will be required to complete tasks including, but not limited to, the following:

- Comply with all conditions set forward in the Act, 35 P.S. §§5701.1301 – 5701.1304.

- If an MCO, comply with all conditions set forth in Article XXI of Act 1998-68 (relating to Quality Health Care Accountability and Protection), 40 P.S. §§991.2101 – 991.2193. (Note: Applies to MCOs only.)
- Provide customer service.
- Determine initial and renewal eligibility for coverage, and enroll those eligible for coverage
- Collect the monthly payment from enrolled adults and from waitlisted adults who are purchasing at full cost.
- Provide the contractually agreed upon benefit package.
- Contract with qualified providers to provide primary and preventive health care.
- Perform quality assurance tasks (including, but not limited to, monitoring quality of care and health outcomes).
- Implement Wellness and Disease Management Programs.
- Conduct enrollee health education.
- Recommend and implement measures to contain costs.
- Use the Department’s CAPS Internet application for application entry, renewal, eligibility determination, and reporting, and assist in related development and testing.
- Provide the Department with enrollee-level electronic data files regarding access, claims costs, and utilization of medical services.
- Perform such other duties as the Department may reasonably require.
- Comply with all applicable state and federal laws and regulations.

B. Major Disasters Or Epidemics

In the event of a major disaster or epidemic as declared by the Governor of the Commonwealth, each contractor shall cause providers to render all services provided for in this RFP and the contract as are practical within the limits of providers’ facilities and staff which are then available. No contractor shall have any obligation or liability for any provider’s failure to provide services or for any delay in the provision of services when such a failure or delay is the direct or

proximate result of the depletion of staff or facilities by the major disaster or epidemic.

C. Performance Standards

Performance standards for the program are included throughout this RFP. Each contractor will comply with standards, which may change from time to time. Each contractor will receive written advance notice in the event of a change in standards.

IV-4. Tasks

Each selected offeror is required to perform the following tasks and scope of services. Please utilize the RFP Response Template at Appendix D to describe how you will meet the requirements of this section. Complete the Confirmation Certificate at Appendix E to confirm your compliance with the required elements of this RFP.

A. Customer Service

The Department is committed to meeting the needs of customers by providing the information and assistance that they need in applying for coverage and receiving health care services.

Customer service is comprised of the following components and requirements:

(1) Outreach

Each contractor is required to conduct outreach activities to identify and inform potentially eligible adults of the availability of the program for purposes of enrollment into the program. Each contractor shall develop and submit to the Department for approval an Outreach Plan within two (2) months of the effective date of the contract. The Outreach Plan must describe the strategies of the contractor to inform potential enrollees about the adultBasic program and to encourage enrollment.

A portion of the individuals served by the program will be minority populations and other underserved populations. Outreach activities must be sensitive to the culturally and ethnically diverse persons served.

(2) Enrollee Helpline

Each contractor is required to maintain a toll-free help line available to all applicants and enrollees for the purpose of providing information and for problem resolution related to eligibility and enrollment issues. At its option, each contractor may use the toll-free help line as a means of offering applicants and enrollees the opportunity to apply for or renew

coverage over the telephone. The helpline must be available during customary business hours (Monday through Friday) and provisions for leaving messages must be available during non-operational hours. Bilingual, multilingual, TDD, and TTY services must be provided for applicants. Calls must be logged to track and report telephone service performance areas (such as call volume, response time, live answer rate, length of time in queue, length of time on hold, and abandonment rate).

(3) Written Materials

Each contractor is responsible for the issuance of written materials to applicants and enrollees. Written materials include: Application forms, brochures, enrollee handbooks, notices regarding eligibility determinations, health education materials, and the like. The Department will provide direction for the content of certain types of notices and letters. Each contractor must use the adultBasic logo and program identification on all materials and correspondence sent to applicants and enrollees. All printed material should be understandable at the sixth (6th) grade level and available in English and Spanish.

(a) Application and Renewal Forms

Each contractor must use the standard application format provided by the Department in producing application and renewal materials. The standard application format serves as a multiple service form for Medicaid, the Children's Health Insurance Program (CHIP), and adultBasic. (Sample provided at Appendix G.)

(b) Brochures

Each contractor may augment brochures prepared by the Department with outreach and informational materials of their own design. Such materials must include the adultBasic service mark.

(c) Enrollee Handbooks

Each Contractor must provide to each new enrollee an Enrollee Handbook that provides all the information necessary to explain benefit coverage and services. Each contractors who is an MCO must include the information required by Section 2136(f) of Act 1998-68, "Information for Enrollees," 40 P.S. §991.2136(f). Each contractor operating alternative delivery systems will be expected to adapt its Enrollee Handbooks to accommodate those requirements. The Department reserves the right to review and comment on the Enrollee Handbook prior to printing and distribution. Any subsequent updates to the Enrollee Handbook

must be submitted to the Department for review and comment prior to printing and distribution. Each contractor must update Enrollee Handbooks at least annually, if applicable revisions have occurred.

(d) Notices of Eligibility Determinations

Contractors must provide notice regarding eligibility determinations in accordance with instructions contained throughout the adultBasic Procedures Manual.

(4) Eligibility, Enrollment, and Renewal Procedures

Each contractor is required to determine initial and renewal eligibility, enroll and renew enrollees on an annual basis in accordance with statutory requirements and directives issued by the Department. (See adultBasic Procedures Manual at Appendix F.) Each contractor will be required to use the CHIP and adultBasic Processing System (CAPS) for processing applications and renewals, and to update enrollee information.

Each contractor must provide sufficient personnel, staff time, and technology in order to meet the demands of eligibility and enrollment procedures in a timely manner as prescribed by the Department.

Each contractor is required to obtain standardized information, as prescribed by the Department, on the contractors' application forms (See Appendix G). In accordance with Transmittal Number 2002-2 to the adultBasic Procedures Manual, each contractor may add data elements that are not related to the determination of eligibility, if the addition of the data element is related to a contractor practice for enrollment (e.g., selection of primary care practitioner). The application form will serve as an application for the program, for CHIP, and for the Medicaid Program. The application form will facilitate enrollment in the appropriate health care coverage program for which the person is eligible.

Each contractor must have protocols in place that identify persons who may be eligible for Medicaid categories of coverage for which Federal funds are available (e.g., pregnant women, persons with temporary or permanent disabilities, patients that may require transplants). Protocols must include actions at time of application and renewal as well as periodic reviews of utilization data throughout the enrollment cycle.

In no instance should an eligible adult be denied enrollment or coverage on the basis of a pre-existing condition.

(5) Collection of Premiums

Each contractor is solely responsible for the collection of a monthly payment from eligible and enrolled adults. The current amount of the monthly payment is thirty dollars (\$30.00). As prescribed by the Act, the Department shall adjust the monthly payment amount based on the annual change in the consumer price index or other index as allowed. Each enrollee must be notified by his or her contractor of any change in the monthly payment amount at least thirty (30) days in advance of any change in the amount.

Each contractor shall notify the applicant that he or she is eligible and invoice the applicant for his or her share of the monthly premium. The notification shall state the date the premium must be paid, the amount to be paid, the address to which payment should be sent, as well as the fact that there is no grace period for payment.

Each contractor is also responsible for collecting the premium from those individuals on the waitlist that choose to purchase coverage pending enrollment. The amount of the premium will be at the “monthly per member premium” cost negotiated by the Department.

(6) Selection of Primary Care Provider (PCP)

(a) Contractors who are HMOs

Enrollees who are enrolled in an HMO must have and be given the opportunity to select a PCP. If the applicant has not selected a PCP at the time of application, the contractor shall provide the enrollee with the opportunity to select a PCP within ten (10) calendar days of the date that eligibility has been determined. No person may be denied coverage or terminated if he or she fails to select a PCP. If no selection is made within the specified time frame, the contractor shall assign a PCP and the person will be so notified.

Each contractor may establish and maintain a referral process to effectively manage the care of its enrollees, but that process may not restrict access to medically necessary services. Enrollees shall be permitted to use providers of their choice to the extent that those providers are (except in emergencies) in the contractor’s provider network (if any).

(b) Contractors who are PPOs and Other Delivery Systems

Enrollees who are not enrolled in an HMO need not select or be assigned a PCP. However, each contractor is required to encourage and promote the concept of a medical home and assist enrollees, where feasible, in selecting a primary care physician.

(7) Identification Cards

Each contractor is required to provide each enrollee with an identification card. The card must not specifically identify the holder as being in the adultBasic program. The Department reserves the right to review and approve identification cards prior to production and distribution.

(8) Eligibility Review Process

Each contractor must provide applicants and enrollees with a written notice of the opportunity for review of an adverse decision regarding ineligibility for adultBasic coverage. Information about this must be included in the letters of notification regarding eligibility decisions, enrollee handbooks, and application documents.

The contractors are required to follow procedures set forth in Chapter 25 of the adultBasic Procedures Manual.

(9) Waiting List

In accordance with Section 1303(d) of Act 2001-77 (relating to potential waiting list), the Department will maintain a centralized waiting list of eligible adults who have applied for the program but who are not enrolled due to insufficient appropriations. The waiting list will be maintained and managed through CAPS.

For applications received after the implementation of the waiting list, the contractors are required to enter all data into CAPS and complete a determination of eligibility. When applicants are placed on the waiting list, the contractor must send the appropriate notice to the applicants informing them of their status and providing the options as listed in the adultBasic Procedures Manual, including the option to purchase adultBasic at the cost negotiated by the Department.

B. Benefit Plan

(1) Benefit Package

Section 1303 (f) of the Act, 35 P.S. §5701.1303(f) requires that each contractor provide the following benefit package with the scope and duration determined by the Department:

- Preventive care
- Physician services
- Diagnosis and treatment of illness or injury, including all medically necessary covered services related to the diagnosis and treatment of sickness or injury and other conditions provided on an ambulatory basis, such as laboratory tests, x-rays, wound dressing and casting to immobilize fractures
- Inpatient hospitalization
- Outpatient hospital services
- Emergency accident and emergency medical care.

The Department has determined that the following core of specific services is within the scope of the statutory requirements:

- (a) **Primary and Preventive Care Services:** Includes sick office visits during office hours, and during non-office hours and routine physical examinations once per year for the detection and minimization of the effects and causes of disease or disability.
- (b) **Injections and Medications:** Includes all injections and medications provided at the time of the office visit or therapy and outpatient surgery performed in the office, a hospital or freestanding ambulatory service center, including immunizations and the immunizing agents, which, as determined by the Department of Health, conform with standards of the Advisory Committee on Immunization Practices of the Center for Disease Control, U.S. Department of Health and Human Services, and anesthesia services when performed in connection with covered services.
- (c) **Routine Gynecological Services:** Includes one routine annual gynecological examination, including a pelvic examination and

clinical breast examination and one routine Papanicolaou smear per year for all female enrollees. Each enrollee may utilize her primary care physician or she may choose any participating professional provider.

- (d) Obstetrical Services: Includes prenatal and postnatal care, and complications of pregnancy and childbirth. A referral is not required when the maternity care is provided by a network obstetrician, network nurse-midwife or a network PCP.
- (e) Newborn Care: Includes the provision of benefits for a newborn child of an enrollee for a period of thirty-one days (31) following birth. Includes routine nursery care, prematurity services, preventive health care services, as well as coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
- (f) Routine Mammograms: Includes an initial baseline mammographic screening for all female enrollees between thirty-five (35) and forty (40) years of age; an annual routine mammographic screening for all female enrollees forty (40) years of age or older; and a mammographic screening for all female enrollees regardless of age when such service is prescribed by the PCP or by a network obstetrician/gynecologist.
- (g) Diagnostic, Laboratory and X-ray Services: Includes all laboratory and x-ray services, EKGs and other diagnostic services related to the diagnosis and treatment of sickness and injury provided on an ambulatory or inpatient hospital basis.
- (h) Diabetic Treatment, Equipment, and Supplies: Includes blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar, orthotics, and outpatient self-management training and education, including information on proper diets.
- (i) Specialist Physician Services: Includes medical care in any generally accepted medical specialty or subspecialty. Contractors may require prior authorization for specialty services and must identify the service(s) and medical items to be prior authorized on the form provided in Appendix D. The Department must be notified in writing of any changes in services or medical items that require prior authorization.
- (j) Inpatient Hospitalization and Skilled Nursing Facility (In lieu of inpatient hospitalization): Includes semi-private room and board

accommodations; private accommodations when medically necessary; general nursing care, use of intensive or special care facilities when medically necessary; diagnostic and therapeutic radiological procedures; use of operating room and related facilities; drugs, medications, and biologicals; laboratory testing and services; pre- and post-operative care, special tests when medically necessary; therapy services, oxygen, anesthesia and anesthesia services, and any other services normally provided by the contractor relating to inpatient hospitalization and skilled nursing inpatient care.

- (k) **Reconstructive Surgery:** Includes surgical procedure for mastectomy, including prosthetic devices and reconstructive surgery incident to any mastectomy.
- (l) **Emergency Medical and Accident Services (including emergency transportation):** Includes at a minimum emergency services as defined herein. Contractors utilizing alternative delivery systems are required to adhere to the provision of this benefit. Emergency providers may initiate the necessary intervention to stabilize the condition of the patient without seeking or receiving prior authorization by the contractor.
- (m) **Disease Management:** Includes education, self-management tools, monitoring, support between office visits to a physician through any media--telephone, print, Internet or in person or a combination of these, and coordination of a physician's treatment plan. Specific to this RFP, the target diseases for management include high-risk pregnancy, diabetes, cardiac care, asthma and obesity
- (n) **Prescription Drugs:** Does not include prescription drugs other than those specifically mentioned above. However, if the contractor has a prescription drug discount plan currently available in Pennsylvania, the contractor shall provide such a plan at no cost to enrollees as an additional benefit of this program.

(2) Optional Benefits

The Department is interested in potential alternative benefits that augment the core of services described above and which, if provided, have the potential of increasing service and health outcomes for the consumer and controlling costs.

If an offeror is proposing to include such optional benefits or services in its benefit plan, the rationale for inclusion must be described. The rationale must include a cost-benefit analysis.

An offeror may offer any other services or benefits to enrollees on an optional, voluntary basis at additional cost to the enrollee as described in Part II-5.

(3) Special Initiatives

The Department is interested in working with contractors to develop potential solutions for reducing the number of persons in the Commonwealth who are without health care coverage or access to care. Each offeror must suggest projects that might be conducted on a limited-scope, pilot basis that would test the viability of such concepts. Examples of projects about which the Department has particular interest are:

- Partnerships with small employers (fewer than 50 employees) who do not presently offer coverage to employees
- Partnerships with community health centers (e.g., FQHC, rural health clinics, etc) that result in improved access to service

In offering such a concept, the offeror must state the hypothesis of the concept to be tested, indicate the potential for replication statewide, and the manner in which the effectiveness of the effort will be measured.

IV-5. Requirements

A. Executive Management

(1) Management Functions

Each contractor must have in place sufficient administrative staff and organizational components to comply with the work statement described in this Part IV of this RFP. Each contractor must include in its organizational structure the components outlined in the table at Appendix D and must provide the names, titles if applicable, and office locations of the individuals fulfilling each of the listed functions. The functions must be staffed by qualified persons in numbers appropriate to the contractor's size of enrollment.

Each contractor may combine functions or split the responsibility for a function across multiple departments, unless otherwise indicated, as long as it can demonstrate that the duties of the function are fulfilled.

Similarly, each contractor may contract with a third party (subcontractor) to perform one or more of these functions, subject to the subcontractor

conditions described in Part IV-5.B.1 and provisions regarding disadvantaged businesses at Part I-17.

(2) Administrative Functions

Each contractor must address each of the administrative functions listed on the RFP Response Template at Appendix D (VI-5 Requirements). These functions may be combined or split as long as the contractor can demonstrate through its proposal that the duties of these functions will conform to the work statement described herein. For functions A.2.a.1 through A.2.a.4, the function must be assigned to a Pennsylvania licensed physician (including osteopathic physicians), Certified Registered Nurse Practitioner (CRNP), registered nurse, or physician's assistant with the experience listed with the function.

Each contractor's personnel must have appropriate training, education, experience, and orientation to fulfill the requirements of their positions. Each contractor shall inform the Department promptly of all changes in management individual(s) whose duties include each of the responsibilities outlined in Part IV-5.A.

Prior Authorization Coordinator: Neither the staff nor the coordinator will be permitted to deny authorization without review by a physician or health care professional with experience or expertise generally comparable to the prescriber. Denials for individuals require contact between the reviewing professional and prescriber.

Current Utilization Review Manager: Neither the staff nor the manager will be permitted to deny care recommended by a treating physician without review by a physician with experience or expertise generally comparable to the treating physician. Denials require contact between the reviewing professional and prescriber.

B. Administration

(1) Subcontracts

Each contractor may enter into subcontracts to fulfill its obligations under this contract. All subcontractors utilized to perform part or all of the contractor's responsibilities shall provide the same level of services and procedural protections set forth in the contract with the contractor, this RFP, and the successful proposal.

No contractor shall enter into any subcontracts, or utilize the services of any subcontractor unless the subcontractor complies with Commonwealth Management Directives No. 215.9 (Contractor's Responsibility Program)

Appendix F, and Provisions Concerning the Americans with Disabilities Act Appendix F, the Health Insurance Portability & Accountability Act of 1996, 42 U.S.C. §§300gg *et seq.*, and the HIPAA Privacy Rule 45 CFR, Parts 160 and 164.

Each contractor shall make all subcontracts available to the Department within ten (10) business days upon request by the Department (templates are acceptable). Subcontracts entered into by a contractor shall not abrogate the contractor's obligations under its contract with the Department.

(2) Records Retention and Availability

Each contractor must agree to maintain books and records relating to the program services and expenditures, including reports to the Department and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, and medical claims. Such records may be maintained either in paper or electronic imaging format and must be legible and readily retrievable. Each contractor is required to maintain all source and actual records for a minimum of five (5) years from the expiration date of the contract period, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until all tasks are completed.

Medical Claims. Each contractor must agree to retain enrollee-level medical claims information and other evidence of medical utilization for review, audit, or evaluation by authorized Commonwealth personnel or their representatives. Documents, enrollee-level claims information, and other evidence shall be available for review, audit or evaluation by authorized Commonwealth personnel or their representatives during the contract period and for a minimum of five (5) years thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until all tasks are completed.

Financial Records. Each contractor shall maintain books, records, documents and other evidence pertaining to all revenues (including receipt of premium payments received from enrollees), expenditures, and other financial activity pursuant to this contract as well as to all required programmatic activity and data pursuant to this contract for a minimum of five (5) year thereafter, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until all tasks are completed..

Audit. Each contractor shall, at its own expense, make all records available for audit, review, or evaluation by the Commonwealth and its

designated representatives. Access shall be provided as directed by the Department. During the contract and record retention period, these records shall be available at each contractor's chosen location, subject to approval of the Commonwealth. Each contractor must fully cooperate with any and all reviews and/or audits by the Commonwealth and its designated representatives, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable.

(3) Fraud

Each contractor is required to establish written policies and procedures for the detection and prevention of fraud that may be committed by providers within their networks, by enrollees or by the contractor's employees. Each contractor will be required to provide copies of its fraud detection and prevention policies and procedures when requested to do so by the Department. Each contractor must designate appropriate staff to be responsible for the proactive detection, prevention, and elimination of instances or patterns of fraud or abuse involving services to enrollees. Each contractor must submit to the Department annual statistical and narrative reports which relate to its fraud detection and sanctioning activities where fraud has been confirmed per instructions articulated in the adultBasic Procedures Manual (Appendix F).

Fraud detection activities must be compatible with the requirements of appropriate law enforcement agencies responsible for fraud detection and prosecution. Each contractor shall have an affirmative responsibility to refer information or suspected fraudulent activities of subcontractors, providers, and enrollees to relevant law enforcement agencies and shall cooperate fully with the investigation and prosecution by appropriate law enforcement agencies.

Each contractor shall require as a written provision in all contracts and/or subcontracts that the contractors and/or subcontractors recognize that payments made to the contractors and/or subcontractors are derived from government funds. Accordingly, each contractor shall advise all contractors and/or subcontractors of the prohibitions against fraudulent activities relating to their involvement with the program. Each contractor shall also, as a written provision in all contracts with providers, advise all providers of the prohibitions against the submission of false or fraudulent statements and claims related to the program.

In the event of confirmation of successful prosecution of a contractor and/or subcontractor or provider related to involvement with the program, each contractor shall take action to suspend or terminate the contractor and/or subcontractor or provider. Each contractor shall notify the Department immediately of any action being taken against a contractor and/or subcontractor or provider because of successful prosecution for fraudulent activities. Failure to report such information to the Department shall constitute a default of the contract as described in paragraph 17 of Appendix A, Standard Contract Terms and Conditions.

In the event of successful prosecution of a contractor for fraudulent activities relating to the program, the Department shall consider the contractor in default of the contract as described in Paragraph 17 of Appendix A, Standard Contract Terms and Conditions. The contract may be terminated pursuant to Paragraph 19(c) of the Standard Contract Terms and Conditions.

(4) Patient Safety

Each contractor must have policies and procedures that describe its efforts and programs related to patient safety and the reduction of medical errors. The Department reserves the right to request such policies and procedures for review upon request.

C. Disease Management

The Department is interested in gathering information regarding the contractor's various disease management programs in addition to specific Disease Management Programs to be provided to adultBasic enrollees. Please respond to the questions in the RFP Response Template at Appendix D, Section IV-5.C. Please complete a separate chart for each of the various programs (e.g., asthma, diabetes, etc.).

D. Provider Networks

(1) Adequacy

Each contractor utilizing provider networks must establish and maintain adequate provider networks as determined by the Department of Health to serve all eligible persons who are or may be enrolled, to include, but not be limited to: hospitals, specialty clinics, trauma centers, specialists, primary care physicians, and transportation services in sufficient numbers to make available all services in a timely manner. Covered services must be provided out-of-network if such services are not available through in-network providers in accordance with Department of Health regulations as outlined in Section 2111 of Act 1998-68, 40 P.S. §991.2111 and 28 Pa.

Code §§9.679(D), 9.679(E). Each contractor must have adequate health care available in a timely and accessible manner through its network providers. Any contractor not utilizing provider networks shall implement procedures so that providers providing coverage to its enrollees meet these standards.

(2) Cultural Competence

Each contractor is encouraged to be culturally sensitive and to establish provider networks that represent the diversity of its enrollees and their neighborhoods. Offerors are to provide a list of languages spoken by offeror's physicians using the format provided in the RFP Response Template at Appendix D.

(3) PCP/ Medical Home Responsibility

The PCP/ Medical Home must serve as the enrollee's initial and most important point of contact regarding health care needs (except in emergencies or for direct access benefits). As such, PCP/Medical Home responsibilities must include at a minimum:

- Providing primary and preventive care and acting as the enrollee's advocate, providing, recommending, and arranging for care.
- Maintaining continuity of each enrollee's health care.
- Making referrals for specialty care and other medically necessary services, both in and out of plan.
- Maintaining a current medical record for the enrollee, including documentation of all services provided to the enrollee by the PCP/Medical Home, as well as any specialty or referral services.
- Providing office hours accessible to enrollees for a minimum of 20 hours per week and be available directly or through on-call arrangements with other qualified, plan-participating PCPs/Medical Homes, 24 hours-per-day, 7 days-per-week, for urgent and emergency care.
- Any additional standards imposed by 28 Pa. Code §9.678.

(4) CRNP as a PCP/Medical Home

As permitted under 28 Pa. Code §9.678(d), CRNPs practicing in an advanced practice category generally accepted as a primary care area may function as a PCP/ Medical Home, especially in rural or other underserved

areas, if the CRNP meets the plan's credentialing criteria, practices and applicable laws.

(5) Standing Referrals/Specialist as a PCP/Medical Home

An enrollee with a life-threatening, degenerative, or disabling disease or condition shall have access to a specialist as a PCP/Medical Home, consistent with the procedure developed by the contractors pursuant to Section 2111(6) of Act 1998-68, 40 P.S. §991.2111(6). An enrollee shall have the right to request and receive an evaluation, and if the plan's standards are met, the enrollee shall receive either a standing referral to a specialist with clinical expertise in treating the disease or the designation of a specialist to provide and coordinate the enrollee's primary and specialty care.

(6) PCP/ Medical Home Teams

If the primary care network of a contractor includes institutions with teaching programs, PCP/ Medical Home teams, comprised of residents and a supervising faculty physician, may serve as a PCP/Medical Home. In addition, each contractor is encouraged to establish PCP/Medical Home teams that include Certified Nurse Midwives, CRNPs, and/or physician assistants who, at the enrollee's discretion, may serve as the point of first contact for the enrollee. The contractor must organize its PCP/Medical Home teams so as to provide continuity of care to enrollees and must identify a "lead physician" within the team for each enrollee. The "lead physician" must be an attending physician and not a resident.

(7) Physician Specialists

No contractor is required to maintain specific enrollee-to-specialist provider ratios. However, each contractor must agree to provide adequate access to physician specialists for PCP/Medical Home referrals, to employ or contract specialists in sufficient numbers to provide specialty services in a timely and geographically accessible manner.

(8) Federally Qualified Health Centers (FQHCs) and Community Health Center (CHC) Look-alikes

Each contractor is strongly encouraged to include FQHCs and CHCs in provider networks or as a source of primary care. In addition, each contractor is encouraged to systematically refer adultBasic enrollees or enrollees on the wait-list, if applicable, to FQHCs and CHCs in its network for services either not covered by adultBasic or in the case of wait-list individuals, for services in general.

Pennsylvania Department of Health's Quality Assurance Facility Directory provides a list of these facilities and is located at the following URL:

<http://app2.health.state.pa.us/commonpoc/dohqalocatorcommon.asp>

(9) Credentialing and Re-credentialing

Each contractor has the authority to selectively contract with providers and to select only a certain number in a geographic area in order to offer a greater volume of enrollees to each provider, negotiate cost-effective rates of payment, and define standards of care. The emphasis will be on the delivery system/network submitted by each contractor, not upon those providers, who, for whatever reason, are not included in the contractor's network. Therefore, the final decision is rendered by the contractor. The provider cannot appeal the contractor's credentialing and network decision to the Department.

(10) Provider Terminations

Each contractor has the authority to terminate providers as specified in their provider contracts. The provider cannot appeal the contractor's decision to the Department.

(11) Network Changes

Each contractor must notify the Department of any changes to the composition of its provider network that materially affects the contractor's ability to make available services in a timely manner. Each contractor also must have procedures to address changes in its network that negatively affect the ability of enrollees to access services. Material changes in network composition that negatively affect enrollee access to services may be grounds for contract termination, suspension of new enrollment, or other sanctions.

Department of Health regulations require that a managed care plan must report any probable loss from the network of any general acute care hospital and any primary care provider, whether an individual practice or a group practice, with 2000 or more assigned enrollees. At such time as a contractor submits such report to the DOH, a copy of the report shall be sent to the Department.

(12) Medical Necessity

The Department has defined Medical Necessity in this RFP for the purpose of the program. However, each contractor may offer an

alternative definition so long as it substantially comports with the Department's definition and/or has been approved by DOH and will result in no harm to a program enrollee. Each contractor must provide, in its response to this RFP, the definition of medical necessity it will utilize.

E. Provider Services

Each contractor must provide Provider Service functions. Provider Service functions will be required to be operated at least during regular business hours (Monday through Friday). Arrangements must be made to deal with emergency provider issues on a twenty-four (24) hour, seven (7) days a week basis. These Provider Service functions include, but are not limited to, the following:

- Assisting providers with questions concerning enrollee eligibility status.
- Assisting providers with claims payment procedures.
- Handling provider complaints.
- Facilitation of medical record transfer among providers as necessary.
- Providing PCPs, at least on a monthly basis, with a list of enrollees who are under their care, including identification of new and deleted enrollees.
- Provision of comprehensive enrollee profiles to PCPs reflecting encounters and claims processed for each enrollee.
- Coordination with out-of-plan services.

F. Appointment Standards

Each contractor must establish standards in accordance with accepted medical practice. Each contractor utilizing provider networks shall require that its contracted providers comply with the established standards. Any contractor not utilizing provider networks must also require that these standards are met by providers providing coverage to their enrollees.

In addition, offerors must describe the standards that will be utilized for scheduling, using the format provided in the RFP Response Template at Appendix D, Section IV-5.F.

G. Quality Management and Improvement and Utilization Management Program Requirements (QMI/UM)

(1) Objectives

(a) Quality Management and Improvement (QMI)

Quality is when the care and services meet or exceed the expectations of the client or consumer. Although expected outcomes for each person may be different, each feels the amount of their relief was directly related to the amount of quality care rendered by the healthcare provider. In addition, the healthcare provider strives to reduce the occurrence of undesired outcomes given the current state of their professional knowledge. The Department is committed to requiring that individuals enrolled in the program receive quality health care services that are delivered in a cost effective manner and to continuously improving the quality of care through:

- (1) Proactive interventions designed to identify and address problems relating to access and quality of care.
- (2) Regular and routine analysis and reporting of collected data.
- (3) Development of interventions which are designed to continuously meet and improve upon established standards of care.
- (4) Ongoing evaluation and assessment of the overall clinical care provided.

(b) Utilization Management (UM)

Utilization management is the planning, organizing, directing and coordinating of health care resources to provide medically necessary, timely and quality health care in the most cost effective manner. The Department is committed to requiring that individuals eligible for and enrolled in the program receive medically necessary and appropriate care through a planned program of UM and review that:

- (1) Provides for medical case management systems that are accountable to enrollees and providers that manage care across the service continuum.

- (2) Assesses the medical necessity and appropriate level of care of services.
- (3) Identifies instances and patterns of both over-utilization and under-utilization and analyzes how UM activities affect the quality of care provided.
- (4) Provides for the regular and routine analysis and reporting of collected data.

(c) **Complaint and Grievance Procedures**

Each contractor must have written policies and procedures for processing complaints and grievances. The policies and procedures must satisfy the requirements of Act 1998-68, 40 P.S. §§991.2101 – 991.2193. The standard of review for complaints, grievances, and appeals shall be de novo.

Each contractor must link its complaint and grievance system to its Quality Management and Utilization Management Program (QM/UMP) for review, corrective action, resolution, follow-up, and provider recertification decisions. Each contractor must have a data system in place capable of processing, tracking, and trending all complaints and grievances.

(2) General Requirements

- (a) Each contractor utilizing provider networks must have written policies and procedures for the quality and accessibility of care being provided in its network and to monitor utilization by its providers and enrollees. Each contractor not utilizing provider networks shall implement procedures to provide that these standards are being met by providers providing services to its enrollees.
- (b) Each contractor that is an MCP as defined herein shall comply with the requirements set forth in Section 2191 of Act 1998-68, “Compliance with National Accrediting Standards,” 40 P.S. §991.2191. For purposes of this RFP, offerors should attach a copy of their latest NCQA certificate reflecting their accreditation status, if applicable. If no certification of accreditation status is available, provide an explanation of the circumstances that has prevented the offeror from obtaining certification. Each contractor will be required to submit copies of future external reviews as they occur utilizing the External Quality Review Organizations (EQRO) approved by DOH. Each contractor is subject to any other

standards imposed by the Department which may exceed the EQRO's requirements.

- (c) Each contractor must have systems in place which provide for continuity of care and for case management of services in accordance with 28 Pa. Code §9.684.
- (d) Each contractor must maintain and make available to the Department, upon request, studies, reports, protocols, standards, worksheets, minutes or other such documentation as may be appropriate, concerning its QMI/UMP activities and corrective actions.
- (e) Each contractor must have written policies and procedure for maintaining the confidentiality of data and for complying with applicable state and federal laws and regulations.

(3) Department Oversight

- (a) Each contractor must agree to cooperate fully with all medical audit reviews conducted by the Department which assess the contractor's quality of care and agree to assist in the identification and collection of any data or clinical records to be reviewed by the Department. Each contractor must make data, clinical records, and workspace available to the Department upon request and at a site selected by the Department.
- (b) Each contractor must submit a corrective action plan, as determined by the Department, and within time frames established by the Department, to resolve any performance quality of care deficiencies identified as a result of the Department's evaluation. Failure to timely submit a corrective action plan may result in termination of the contract or other sanctions.
- (c) Each contractor must obtain advance written approval from the Department before releasing or sharing with any of the other contractors, data, correspondence, and/or corrective actions from the Department regarding the contractor's internal QMI/UMP.

(4) External Independent Assessment

- (a) Each contractor must agree to cooperate fully with any authorized external evaluations and assessments of its performance under the terms of the contract. Independent assessments will include, but are not limited to, HEDIS/CAHPS reviews by NCQA or other EQROs approved by DOH pursuant to Act 1998-68, 40 P.S.

§§991. 2101 *et seq.*, and any independent evaluation required by state or federal statute or regulation.

- (b) Each contractor must agree to assist in the identification and collection of any data or clinical records and to cooperate fully with all external medical audit reviews which assess the contractor's quality of care. Each contractor must make data, clinical records, and workspace available to the independent review team and to the Department upon request and at a site selected by the Department.
- (c) Each contractor must submit a corrective action plan, as determined by the Department, and within time frames established by the Department, to resolve any performance or quality of care deficiencies identified by the independent assessor as a result of the independent evaluation and/or by the Department. Failure to timely submit a corrective action plan may result in termination of the contract or other sanctions.

(5) Reporting Requirements

Each contractor must be able to supply to the Department individual enrollee records. The Department may audit the standard and process that the contractor uses to code enrollees' procedures.

IV-6. Program Outcomes

To measure performance in the areas of access to care, outcomes, and satisfaction, each contractor must submit to the Department the required deliverables outlined in Part IV of this RFP. These deliverables must receive advance written approval by the Department prior to their implementation unless otherwise specified by the Department. Deliverables include, but are not limited to, operational policies and procedures; required materials; letters of agreement; provider agreements; reimbursement methodology and rates; coordination agreements; reports; tracking systems; required files; and referral systems.

IV-7. Financial and Reporting Requirements

A. Financial Standards

The Department regulates the financial stability of insurers licensed in Pennsylvania. Each contractor must agree to comply with all the Department standards in addition to specific program standards described in this RFP.

(1) Risk Protection for High Cost Cases

The Department seeks to minimize risks that valid claims submitted to contractors by providers for costs incurred by an enrollee above a certain monetary threshold might not be paid. Each contractor must have a risk protection arrangement in place until the contract expires. This risk protection arrangement must include reinsurance that covers, at a minimum, eighty percent (80%) of inpatient costs incurred by one (1) enrollee during one (1) year in excess of \$150,000. The Department may alter or waive the reinsurance requirement if the contractor proposes an alternative risk protection arrangement.

To pass the Readiness Review, each contractor must provide the Department with documentation of execution of an acceptable risk protection arrangement. No contractor may change or discontinue the reinsurance arrangement without advance written approval from the Department. Each contractor must notify the Department thirty (30) days prior to any change in the reinsurance arrangement. The Department reserves the right to review such risk protection arrangements and require changes based on the Department's assessment of the contractor's overall financial condition.

(2) Equity Requirements

In addition to each contractor's responsibility to meet requirements of the Department, each contractor is required to meet financial standards for its contract and maintain them throughout the life of the contract. The purpose of the standards is to determine each contractor's ability to meet its financial obligations under the contract.

Each contractor shall maintain SAP-basis equity equal to the following:

- \$1.5 million.

AND

- The dollar amount of total adjusted net worth or total adjusted capital and surplus that creates a RBC ratio equal to 2.25 or above.

To determine the RBC ratio, use the NAIC RBC Formula Application. Authorized Control Level RBC = RBC after Covariance x Adjusted Factor (.5). RBC Ratio = Adjusted Net Worth divided by Authorized Control Level RBC. Figures available to calculate this ratio are found on the five-year historical page of the Annual Statement.

For the purpose of this requirement, equity amounts as of the last day of each calendar quarter will be determined in accordance with statutory accounting principles as specified or accepted by the Department. The RBC ratio will be based on results of the formula as reported on each Annual Statement filed with the Department. Instructions for completing the Annual Statement and Quarterly Statements are found in Appendix N. Quarterly Statements will be due no later than forty-five (45) calendar days after March 31, June 30, and September 30 of each contract year.

If the financial position of a contractor is trending in a negative direction that threatens the solvency of the company and its ability to meet its obligations under the contract, the Department may take appropriate actions that include but are not limited to the following:

- Discuss fiscal plans with contractor management.
- Require the contractor to submit and implement a corrective action plan.
- Submit an RBC plan where required by statute.
- Suspend some or all enrollment of consumers into the contractor.
- Terminate the contract effective the last day of the calendar month after the Department notifies the contractor of termination.
- Take any action authorized under Article V of the Insurance Department Act, 40 P.S. §§221.1-221.63.

(3) Medical Cost Accruals

As part of its accounting and budgeting function, each contractor must establish an actuarially sound process for estimating and tracking IBNRs. All program-related reserves must be maintained on the financial statements of the contractor. Each contractor should reserve funds by major categories of services (e.g., hospital inpatient; hospital outpatient) to cover both IBNRs and RBUCs. As part of its reserving methodology, each contractor should conduct annual reviews to assess its reserving methodology and make adjustments as necessary.

(4) Claims Processing and MIS

Each contractor must have a claims processing system and MIS sufficient to support the provider payment and data reporting requirements specified in this RFP. Each contractor should be prepared to document its ability to expand claims processing or MIS capacity should either or both be exceeded through the enrollment of program enrollees.

(5) Financial Data Reporting

The Department's report formats and definitions for each contractor to use in providing financial data will be provided at a future date.

(6) Financial Performance

The Department has the right to monitor the financial performance of each contractor and its major subcontractors. Monitoring will include, but not be limited to, financial viability and appropriateness of medical and administrative expenditures.

B. Acceptance of Rate Payments, Using the CAPS Database

Each contractor will receive an amount as established in the contract in payment for all in-plan services. The Commonwealth shall make these payments to each contractor on a monthly basis. The Department will identify the enrollees whose enrollment is effective on the first day of a month and for whom payment shall be made.

Each contractor must agree to accept rate payments in this manner and must have written policies and procedures for receiving, processing and reconciling such payments.

C. Rate Adjustments

The Department may, at its discretion, adjust rates in as described in Part II-5, Cost Proposal and below:

(1) Current Contractors:

- (a) As requested by the Department, each contractor will submit the most recent experience data for a one-year period in the required RCS format as described in the Cost Proposal Section, Part II-5. An RCS form must be submitted for the program for each Contracted Service Area.

- (b) In the event no adjustments are made pursuant to this section and Part II-5.B., the rates applicable to the previous year will apply.
- (c) Rate negotiations will commence at least thirty (30) days prior to the start of each contract year. If no agreement is reached by the start of the contract year, rates applicable to the previous year continue to apply until any new rates are finalized.
- (d) For monitoring purposes, each contractor will submit the total experience data for the program at the end of the first program year and at the time of rating for the contract year, in the required RCS format as described in the Cost Proposal Section, Part II-5. An RCS form must be submitted for the program for each Contracted Service Area.

(2) New Contractors:

- (a) Each contractor shall submit its initial proposal following the directions presented in Part II.5.
- (b) Adjustments to rates, if any, will be deferred to the third year to allow for the collection and analysis of experience data. Any adjustments will be made as described in Part II-5.B.
- (c) As requested by the Department, the contractors will submit the most recent experience data for a one-year period in the required RCS format as described in the Cost Proposal Section, Part II-5. An RCS form must be submitted for the program for each Contracted Service Area.
- (d) In the event no adjustments are made pursuant to this part and Part II-5.B, the rates applicable to the previous year will apply.
- (e) Rate negotiations will commence at least thirty (30) days prior to the start of the third contract year. If no agreement is reached by the start of the third contract year, rates applicable to the previous year continue to apply until any new rates are finalized.
- (f) For monitoring purposes, each contractor must submit the total experience data for the program at the end of the first program year and at the time of rating for the third contract year, in the required RCS format as described in the Cost Proposal Section, Part II-5. An RCS form must be submitted for the program for each Contracted Service Area.

D. Performance Management and Reporting Requirements

(1) General Requirements

Each contractor will be required to submit quarterly and annual reports to enable the Department to assess the quality of the service being provided by each contractor through its provider networks. These reports may also be used to trend for potential problem areas for which the program may provide technical assistance and develop corrective action plans.

The Department is developing a data warehouse to capture enrollee medical claims information. Until such time as the data warehouse is operational, each contractor will be required to electronically submit aggregate quarterly and annual reports, in a format specified by the Department, to enable the Department to assess the quality of the service being provided by each contractor through its provider networks. These reports may also be used to trend for potential problem areas for which the program may provide technical assistance and develop corrective action plans.

Reporting requirements consist of the following:

(a) Quarterly Reports

- **Complaint and Grievance Report:** This report provides information about the complaints or grievances filed by enrollees in accordance with Act 68.
- **Inpatient Utilization by Type of Service:** This report details the number of hospital admissions, average payments, total payments, and average length of stay.
- **Outpatient payments by Service Type/Provider:** This report consists of information on dollars paid for primary care services, and other physician specialties.

(b) Annual Reports

- **Top Ten Inpatient Hospitalizations by Diagnostic Category**
- **Top Ten Outpatient Diagnostic Categories**
- **HEDIS/CAHPS Reviews**
- **DOH Managed Care Plans Annual Status Report**

- Fraud and Abuse

(c) Ad Hoc Reports

The Department may request each contractor to provide ad hoc reports to meet specific reporting needs. These requests may result from, inter alia, federal or state legislative data calls; requests from other state agencies; or public sector entities.

The Department will provide to each contractor directions as to the due dates and format for each such report. The above list of reports is subject to change as deemed appropriate by the Department.

(2) Data Processing and Communications Capabilities

(a) CHIP and adultBasic Processing System (CAPS)

The Department has made every effort to automate and streamline the processes associated with eligibility determination, enrollment, and renewals. In November 2002, the Department fully implemented a web-based centralized enrollment and data management system. The system was dubbed CAPS (CHIP and adultBasic Processing System). The system's broad purpose is to automate and standardize the process of eligibility determination and to improve data capturing and reporting capability. The system is designed for use by the Department and the insurance companies under contract to the Department to determine eligibility and to enroll individuals for coverage. CAPS interfaces with the corporate enrollment system of each insurer, as well as with the COMPASS and CIS systems of the Department of Public Welfare.

The CAPS – COMPASS interface enables the electronic transmission of CHIP and adultBasic applications from COMPASS to CAPS. The CAPS – CIS interface is a daily batch process that is performed to do matches with Medicaid participants (applicants cannot be enrolled in CHIP or adultBasic if actively enrolled in Medicaid).

Technical design for Wave I of the CAPS data warehouse initiative began in July 2003 and includes capture and analysis of information related to eligibility for coverage for CHIP and adultBasic. The second phase, presently in technical design and contemplated for implementation in fall 2004, will include capture of service utilization data. This data will be used to enhance

services management and provide program-enhancing management data.

(b) Use of CAPS

Each contractor is required to use CAPS for processing applications and renewals, and to update enrollee information as it is received in accordance with statutory requirements and directives issued by the Department (See Appendix F, Procedures Manual).

General Requirements

Each contractor is required to:

1. Comply with the provisions of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§300gg *et seq.*, and any related federal or state regulations.
2. Provide continuous maintenance/enhancement support for agreed upon interface file formats as defined in the file specifications and companion guides, which include but not limited to, the following:
 - Inbound to Contractors (CAPS to Contractor)
 - HIPAA Format
 - 834 Benefit Enrollment and Maintenance
 - 997 Functional Acknowledgment
 - 274 Health Care Provider Information (optional)
 - Proprietary Format
 - Letter Generation File (LGF)
 - Renewal Generation (optional)
 - Outbound from Contractors (Contractor to CAPS)
 - HIPAA Format
 - 837 Health Care Claim: Intuitional
 - 837 Health Care Claim: Professional
 - 837 Health Care Claim: Dental
 - NCPDP 5.1

- 834 Benefit Enrollment and Maintenance
 - Proprietary Format
 - Provider File
 - Contractor Individual ID (optional)
3. Monitor and resolve functional and data issues pertaining to files generated by the Contractor's system and transmitted to CAPS for processing
 4. Continue to utilize existing File Transfer Protocol (FTP) or HTTPS technology for file transmission between the Contractor and CAPS systems. Each contractor shall be cognizant of the need to move toward the Department's standard of HTTPS when possible.
 5. Provide support, as needed, to verify disaster recovery testing activities and troubleshoot network connectivity issues.
 6. Incorporate technology data exchange standards and technology upgrades as required by the Department.

Application

Each contractor is required to obtain standardized information, as prescribed by the Department, on the contractor's application forms (See Appendix G). In accordance with Transmittal Number 2002-2 to the adultBasic Procedures Manual, each contractor may add data elements that are not related to the determination of eligibility, if the addition of the data element is related to a contractor practice for enrollment (e.g., selection of primary care practitioner). The application form will serve as an application for the program, for CHIP, and for the Medicaid Program. The application form will facilitate enrollment in the appropriate health care coverage program for which the person is eligible.

(c) Modifications to CAPS

As stated previously, prior to implementation of changes to the CAPS system, all modifications are required to be thoroughly tested. The CAPS contractor, currently Deloitte Consulting LLP, will participate in testing the modifications in the development and integration environments prior to requesting the contractors to participate in User Acceptance Testing (UAT). Each contractor

should have dedicated personnel to test and subsequently provide training and coordination of new systems or processes with individual end users. The objectives of UAT include for each contractor to:

- Provide adequate staffing levels that can best contribute to system testing
- Create a number of defined test cases to validate business processes
- Compare actual test results against expected results
- Participate in touch point meetings to evaluate the process and facilitate issue resolution
- Verify performance on critical business functions
- Assess and sign off on Go/No-Go readiness
- Provide that all users receive basic training related to enhancements

Participate in User Acceptance Testing (UAT) prior to implementation of new systems or processes relative to the CAPS, COMPASS, and Data Warehouse systems. Dedicated personnel will test and subsequently provide training and coordination of new systems or processes with individual end users.

(d) PC Requirements

The minimum and recommended user PC requirements for accessing CAPS:

Equipment	Minimum	Recommended
Processor	100 MHz	233 MHz
MB RAM	64	128
Video	15" monitor, 800x600	17" monitor with 4 meg Video True Color, 1024x768 resolution
Operating System	Window 95, NT 4	Windows 98, NT 4,2000, XP
Access the Internet	56K	56K
Browser Options: Internet Explorer	5.5 with 128 bit encryption	5.5 with 128 bit encryption

Each contractor must have the capacity to communicate via ANSI X12 Standard Format EDI transactions. Each contractor must support development and testing of required Proprietary EDI transactions.

Each contractor must have the capacity to transmit large amounts of data to the Department or any of its designated agents via public lines, by a secure method or dedicated communication lines. Each contractor must supply data in the Department-specified electronic file format. This may include enrollee-level claims processing and service data. Therefore, each contractor must have the ability to collect, un-duplicate, query, report, transmit and store all such information for each enrollee served.

Each contractor must be able to assist the Department in quantifying enrollee satisfaction. This may include assisting the Department or its representative in identifying enrollees to participate in surveys, focus groups, or in-depth interviews to determine a measurement of enrollee's satisfaction with contractor-provided services.

Each contractor must supply data in a Department specified format that will permit the Department to measure the quality of service provided to enrollees. These measurement standards will be supplied by the Department and may change periodically to address areas of concern and to address adequacy of care to enrollees.

(e) Data Warehouse Requirements

Each contractor is required to electronically transmit enrollee claims and or encounter level data to the Department. The Department has developed unique file formats to communicate the necessary information to satisfy ad hoc reporting and requirements for the CAPS Data Warehouse.

The Form 837 Health Care Claim transactions are mandated by HIPAA Transactions and Code Sets regulations when electronically communicating claim information. The 837 Implementation Guide developed by the Washington Publishing Company was used as the foundation for developing the 837 Professional, 837 Institutional, and 837 Dental Companion Guides. The NCPDP 5.1 File is the mechanism for electronically transmitting all drug information from the adultBasic contractors to the Department.

IV-8. Contract Requirements – Disadvantaged Business Participation and Enterprise Zone Small Business Participation

Each contract containing Disadvantaged Business participation must also include a provision requiring the contractor to meet and maintain those commitments made to Disadvantaged Businesses and/or Enterprise Zone Small Businesses at the time of proposal submittal or contract negotiation, unless a change in the commitment is approved by the BMWBO. Each contract containing Disadvantaged Business participation and/or Enterprise Zone Small Business participation must include a provision requiring Small Disadvantaged Business subcontractors, Enterprise Zone Small Business subcontractors, and Small Disadvantaged Businesses or Enterprise Zone Small Businesses in a joint venture to perform at least 50 percent of the subcontract or Small Disadvantaged Business/Enterprise Zone Small Business portion of the joint venture.

Commitments to Disadvantaged Businesses and/or Enterprise Zone Small Businesses made at the time of proposal submittal or contract negotiation must be maintained throughout the term of the contract. Any proposed change must be submitted to BMWBO which will make a recommendation as to a course of action to the contracting officer.

If a contract is assigned to another contractor, the new contractor must maintain the Disadvantaged Businesses participation and/or Enterprise Zone Small Business participation of the original contract.

Each contractor shall complete the Prime Contractor's Quarterly Utilization Report (or similar type document containing the same information) and submit it to the contracting officer of the Department and BMWBO within 10 workdays at the end of each quarter the contract is in force. If there was no activity, the form must also be completed, stating "No activity in this quarter." This information will be used to determine the actual dollar amount paid to Small Disadvantaged Business and/or Enterprise Zone Small Business subcontractors and suppliers, and Small Disadvantaged Businesses and/or Enterprise Zone Small Businesses involved in Joint Ventures. Also, it is a record of fulfillment of the commitment your firm made and for which it received Disadvantaged Business and Enterprise Zone Small Business points.

NOTE: EQUAL EMPLOYMENT OPPORTUNITY AND CONTRACT COMPLIANCE STATEMENTS REFERRING TO COMPANY EQUAL EMPLOYMENT OPPORTUNITY POLICIES OR PAST CONTRACT COMPLIANCE PRACTICES DO NOT CONSTITUTE PROOF OF DISADVANTAGED BUSINESS STATUS OR ENTITLE A PROPOSER TO RECEIVE CREDIT FOR DISADVANTAGED BUSINESS UTILIZATION.