State of West Virginia

Public Employees Insurance Agency

Medicare Advantage-Prescription Drug (MAPD)
Request for Proposal
September 2011

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CHAPTER 1: INTRODUCTION

1.1 Program Background

The Public Employees Insurance Agency (PEIA) is responsible for administering health care benefits on behalf of approximately 38,000 Medicare retirees and dependents. The PEIA currently covers these Medicare primary members through a Medicare Advantage Plan for medical benefits and through a self-insured Employer Group Waiver Prescription Drug Plan.

1.2 Clarification of Procurement Offering

The State of West Virginia is seeking proposals to provide a Medicare Advantage and Prescription Drug (MAPD) program to its Medicare primary policyholders and eligible dependents. This request for proposal (RFP) will result in the State's retirees having sufficient access to Medicare providers across the country with the benefits as outlined in Appendix A or as amended during our annual benefit evaluations.

All MAPD proposals must be based on the benefits described in Appendix A for comparison. Final benefits effective July 1, 2012, may vary. It is understood that if CMS requires a certain benefit level that is superior to a benefit listed in Appendix A, then the CMS benefit should be applied. All benefits described in this Appendix A are subject to change. This RFP is written to request a preferred provider organization plan (PPO). For members not eligible for the PPO because they do not live in a PPO service area, an alternate plan design must be offered. Currently the alternative is a Passive LPPO.

PEIA is interested a single vendor which will be responsible for the Medicare Advantage PPO Plan and the Prescription Drug Plan (PDP). Subcontracting will be permitted as long as all subcontractors meet CMS standards. All subcontracts must be in place prior to bidding. The MAPD plan must certify to PEIA that all subcontracts have been signed, are currently in effect and are consistent with CMS standards. Pending contracts are not acceptable.

PEIA reserves the right to allow its members, who are currently enrolled in the existing PEIA managed care plans to be grandfathered into those managed care plans rather than being covered under the MAPD plan.

1.3 Participation Standards

1.3.1 Capitation

Chapter Three contains more information regarding capitation rates.

1.3.2 Contracts Issued

The PEIA will execute contracts with the successful respondent independent of the WV Purchasing Division.

1.3.3 Contract Term

PEIA's plan year runs from July 1 to June 30 of each year. PEIA's intent is to enter into an initial contract for twelve (12) or eighteen (18) months, whichever is deemed by both parties to be more advantageous, effective July 1, 2012. It is the intent of the PEIA to execute annual contract renewals rather than conduct a new procurement for the subsequent plan years. However, PEIA reserves the right to conduct new procurement in subsequent years.

The successful MAPD vendor must provide updated claim experience information and capitation requirements prior to a capitation rate renewal or contract renewal. Taking into consideration CMS' volatile payment rates, the MAPD plan must be able to supply PEIA with an annual, percentage range of increases for the capitation rates. Capitation rates may be renegotiated annually.

1.4 General Information for Applicants

The procurement officer for PEIA will be:

Thomas Miller, MA, LPC, ALPS
Privacy Officer
West Virginia Public Employees Insurance Agency
601 57th St, SE, Suite 2
Charleston, West Virginia 25304-2345
Telephone: 304/558-7850 E 52663
Fax: 304/558-2470
thomas.d.miller@wv.gov

1.5 Procurement Schedule

The schedule below presents key milestone dates for the procurement. Additional information regarding procurement activities can be found in Chapter Four.

Proposed RFP
Key Milestone Dates

Milestone	Date/Time
RFP Release	September 8, 2011
Bidder's Conference (PEIA Offices or conference call)	September 15, 2011 10:00 AM
Notice of Intent to Bid	September 19, 2011 COB 4:00 PM
Deadline for Submission of Written Questions	September 30, 2011 COB 4:00 PM
Response to written Questions	October 7, 2011
RFP Addendum (if necessary)	October 14, 2011
Proposal Submission Deadline	October 28, 2011 COB 4:00 PM
Proposal Evaluations and Recommendation to Director	December 1, 2011
Contract Negotiations	December 2011
Contract Effective Date	January 1, 2012
Educational Sessions	April/May 2012
MAPD Coverage Effective Date	July 1, 2012

CHAPTER 2: MAPD PARTICIPATION STANDARDS

2.1 General

This chapter describes the operational and financial standards with which The MAPD plan must comply in full. These standards reflect extensive efforts undertaken by the PEIA to align the requirements for The MAPD plan that serve the needs of the members of the PEIA.

2.2 Licensure/Certification/Accreditation

Participation in this procurement is limited to organizations that are properly certified by CMS to offer an MAPD on an at-risk, prepaid basis and alternatively, a self-funded proposal. Documentation of CMS accreditation must be submitted to PEIA.

PEIA requires the successful bidder to be capable of enrolling all PEIA Medicare primary retirees residing in the U.S.

The successful bidder must also meet all applicable State and Federal laws, rules, and licensure requirements.

West Virginia State law will require the successful bidder to be licensed to do business in the State of West Virginia prior to beginning work under the scope of this contract.

The successful bidder must be willing to complying with any and/or all applicable rules and regulations of the State of West Virginia with regard to becoming a vendor, purchasing, contracts, and/or contract awards. This will include registering as a vendor with the West Virginia State Purchasing Division. For reference, the following link is provided:

http://www.state.wv.us/admin/purchase/vrc/default.html

2.3 Health Plan Administration

In addition to CMS standards, the MAPD Plan must maintain sufficient administrative staff and organizational components to comply with all standards described in this RFP. This includes:

- Executive Management
- Medical Director's Office
- Accounting and Budgeting function
- Customer Service function
- Medical Claims processing function

- Availability of appeals processing located in Charleston, WV
- Management information systems
- Provider services functions
- Auditing function (claims, administrative, operational)

Preference will be given to plans with a strong presence in West Virginia. The MAPD plan must, at a minimum, have an Account Representative located in Charleston, WV.

2.4 Eligibility

The categories of PEIA policyholders eligible for enrollment in the MAPD are described below. The PEIA is responsible for determining an individual's eligibility for participation in its health care programs. The MAPD plan is considered a program controlled by the PEIA.

2.4.1 Covered Lives

The PEIA will make available paid claims data for fiscal year 2011 of the program to any applicant who requests it, attends the bidder's conference, and completes the limited data use agreement (Appendix F). The data can be obtained by completing the agreement and submitting it to Tom Miller at the address listed in section 1.4 no later than the day of the mandatory bidder's conference. The data will not be released until the day of the mandatory bidder's conference.

2.4.2 Enrollment of Dependents

If there are two, or more, Medicare primary PEIA members in one family, each member will be enrolled as a policyholder. Dual eligible and ESRD individuals shall be enrolled consistent with CMS requirements.

2.4.3 Member Termination

Generally, PEIA may terminate a member due to non-payment of premiums or upon the member's request, consistent with CMS rules. Proposing vendor should consider the possibility of delegating responsibility for non-payment of premium notification to PEIA.

2.5 Member Marketing and Enrollment Materials

Plan must comply with all applicable State, CMS and agency-specific laws, rules, policies or requirements regarding marketing. This includes, but is not limited to:

- Benefit Booklets
- Evidence of coverage
- Identification Cards
- Rights and responsibilities of enrollees

- Information regarding appeals

Marketing and promotional materials, with the exception of correspondence specific to an individual enrollee, must be submitted to PEIA for review and written approval prior to distribution. Failure to obtain PEIA approval prior to mailing will result in a financial penalty. Materials must be pre-approved, in writing, by PEIA. Plans must allow PEIA at least ten (10) days for review and comment after draft materials are submitted. Any material problems or errors identified at any time in materials must be corrected by the MAPD plan as soon as the problems are identified. The MAPD plan will be responsible for all costs associated with printing and distribution.

2.6 Covered Services

The MAPD plan must promptly provide or arrange to provide all medically necessary services included in the covered benefit package and assume financial responsibility for the provision of the services. The definition of medical necessity shall be consistent with that of CMS, Local Coverage Determinations (LCDs), and National Coverage Determinations (NCDs).

2.6.1 Member Liability

The MAPD plan cannot hold an enrollee liable for the following:

- The debts of the health plan if it should become insolvent;
- Payment for services (except for allowable cost sharing amounts) provided by the MAPD plan if the MAPD plan has not received payment from the PEIA or CMS, or if the provider, under contract or other arrangement with the MAPD plan, fails to receive payment from the MAPD plan; or
- Payments to providers that furnish covered services under a contract or other arrangement with the MAPD plan that are in excess of the amount that normally would be paid by the enrollee if the service had been received directly from the MAPD plan.

The MAPD plan is permitted to charge copayments and other cost sharing in amounts approved by the PEIA consistent with proposed benefit grid, included herein.

2.6.2 Preventive Services

The MAPD plan must provide clinical preventive services, consistent with CMS standards, as appropriate for age, sex and other risk factors and as recommended by the U.S. Preventive Services Task Force. Preventive services may include, but are not limited to:

- General physical examinations
- Hypertension screening
- Cholesterol screening
- Screening for high blood sugar
- Immunizations, adult
- Colorectal cancer screening
- Prostate cancer screening
- Mammography and/or other breast cancer screening
- Pap tests
- Sigmoidoscopy
- Abdominal aortic aneurysm screening
- Osteoporosis screening
- Peripheral Artery Disease screening
- Dementia screening
- Thyroid Disease screening
- Carotid Artery Stenosis screening
- Other procedures known to either prevent disease or to detect disease in its early stage.

The MAPD plan must periodically remind and encourage enrollees to use those clinical preventive services which are available. Emphasis should be placed on the age-appropriateness of screenings and the recommended intervals for different clinical preventive services. All preventive services must also be significantly linked to a corresponding disease management program, when applicable.

In addition to the required services, the MAPD plan is encouraged to provide supplemental preventive health and wellness services to their members.
If preventative services are available, the MAPD must clearly describe which tools are used in the performance of health risk assessments, identify any vendors used in providing these services, and provide sample materials used in educating the beneficiaries.

2.6.3 Coordinated Care and Disease Management

In addition to the Preventive Services, Coordinated Care and Disease Management Programs are also a priority of PEIA. The MAPD plan must provide various case management and disease management programs consistent with CMS standards and PEIA priorities. PEIA has identified the following areas as priorities:

- Diabetes;
- Tobacco cessation;
- Nutrition/exercise counseling, with targeted outreach for members with heart disease and diabetes, or any other condition that could improve using this type of counseling

- Weight Management
- Chronic Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Polypharmacy
- Chronic Kidney Disease
- Osteoporosis

The MAPD plan must identify all Disease Management programs offered. In addition, the MAPD Plan must provide details regarding the methodology used in the delivery of each of its programs, professional credentials of all individuals involved in the program (RN, RD, MD, etc.), program intensity, duration, and frequency of MAPD plan intervention with participants. Further, the MAPD plan must provide the programs' format for written care plans, describe how it will report program results to PEIA, identify any vendors used in providing these services, and provide sample materials used in educating the beneficiaries. The MAPD plan must also allow beneficiaries to participate, or continue participation, in PEIA Face to Face Disease Management program. In addition, the MAPD plan must also be willing to coordinate with the PEIA programs and refer beneficiaries to PEIA programs, when appropriate.

2.7 Provider Network (Where Applicable, Preferred Provider Organization Plan Networks)

The MAPD plan must establish and maintain provider networks with a sufficient number of providers and in geographically accessible locations for the populations they serve consistent with the CMS standards. The MAPD plan networks must contain all of the provider types necessary to furnish the prepaid benefit package, including: hospitals, physicians (primary care and specialist), behavioral health providers, allied health professionals, pharmacies, DME providers, etc. PEIA encourages the MAPD plan to use in-state providers when appropriate.

The MAPD plan must assure that persons and entities providing care and services on their behalf in the capacity of physician, dentist, physician assistant, registered nurse, other medical professional or paraprofessional, or other such persons or entities, satisfy all applicable licensing, certification, or qualification requirements under various state laws and that the functions and responsibilities of such persons and entities in providing benefit package services do not exceed those permissible under various state laws.

The MAPD plan shall encourage and foster cultural competency among their providers. Culturally appropriate care is care given by a provider who can relate to the enrollee and provide care with sensitivity, understanding and respect for enrollee's culture and background.

If the plan is considering or intends to make any changes within the contract year that would have a negative effect on a member with regard to access to providers, such change must be clearly disclosed in advance to the Director of PEIA for consideration.

The MAPD plan must clearly identify all network providers geographically.

2.7.1 Physicians

All network physicians must meet the minimum CMS requirements for the number of board-certified physicians within their network.

2.7.2 Primary Care Physicians

The insured's Primary Care Physician (PCP) can be a general practice doctor, family practice doctor, internist, pediatrician, geriatrician, or, for women in the plan, an OB/GYN.

The MAPD plan must actively encourage the beneficiaries to utilize one PCP with the intent to connect insureds with a physician who can oversee and coordinate all of their care.

2.7.3 Member-to-Provider Ratios

Member-to-Provider ratios must comply with applicable CMS certification criteria.

2.7.4 Regarding Network Changes (Where Applicable)

In the event that the MAPD Plan has a significant change in its network and must report this change to CMS, it must concurrently report the event to PEIA.

2.8 Complaint, Grievance and Appeals Resolution

The MAPD plan must develop internal procedures to address organization determinations, complaints, grievances, and appeals consistent with applicable State and Federal Laws and CMS standards.

Also, the MAPD Plan must describe the employer/plan sponsor's role in its appeals process.

2.9 Medical Management and Quality Improvement

PEIA will have the right to conduct on-site reviews to assess plan performance. PEIA also may, at its discretion, accept the findings of CMS or a national review organization (in lieu of a separate review) in any areas where a national review organization has found the plan to be in full compliance with its accreditation standards.

2.9.1 Medical Records Standards

The MAPD plan must have policies and procedures in place consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards for privacy and security of protected health information and any other applicable state or Federal law related to the privacy or security of information.

The successful bidder must sign a Business Associate Agreement with PEIA and enforce any and/or all terms and conditions of said Business Associate Agreement with any and/or all subcontractors who may provide any direct and/or indirect services as part of this contract award. Direct and/or indirect services would include, but not necessarily be limited to: information technology services, customer service, claims handling/processing, member communications, member consultation/counseling, and/or other services.

The MAPD plan must be fully compliant with the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 and the Interim Breach Notification Rule(s) as enacted by the 2009 American Reinvestment and Reauthorization Act (ARRA) of 2009. The MAPD plan must be willing to guarantee the privacy, security, and integrity of any and/or all PEIA member data. File transfers must occur via secure tested ftp type sites using recognized security standards such as NIST and/or ISO 27001.

2.9.2 Utilization Review Procedures

The MAPD plan must have in place utilization review policies and procedures, consistent with CMS requirements, which include protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims meeting pre-defined criteria. Plans also must develop procedures for identifying and correcting patterns of over- and under-utilization on the part of their enrollees.

2.9.3 Case Management and Care Coordination

The MAPD plan must have systems in place to ensure care coordination, consistent with CMS standards, including at a minimum:

- Management and integration of health care through Primary Care Physician or other means;

- Systems to assure referrals for medically necessary specialty, secondary and tertiary care;

- A system by which enrollees may obtain a covered service or services that the health plan does not provide or for which the plan does not arrange because it would violate a religious or moral teaching of the religious institution or organization by which the health plan is owned, controlled, sponsored or affiliated; and

The MAPD plan must provide coordination services to assist enrollees in arranging, coordinating and monitoring all medical and support services. The health plan must also designate an individual or entity to monitor and supervise enrollees with ongoing medical conditions, including coordination of hospital admission/discharge planning, post-discharge care and continued services.

2.9.3.1 Special Provisions for Members with Complex or Chronic Conditions

PEIA policyholders with complex and chronic conditions will enroll in the MAPD. Therefore, plans must have chronic care improvement plans in place consistent with the CMS standards.

2.9.4 Quality Indicator Measures and Clinical Studies

The MAPD plan shall disclose to PEIA and its members the plan's rating according to the CMS Stars Program. The disclosure shall include the MAPD plan's scoring on all fifty-three (53) quality measures.

In addition to the CMS requirements for quality, PEIA will establish performance standards consistent with those described in Appendix C.

2.9.4.1 Clinical and Non-Clinical Quality Improvement Projects

All clinical and non-clinical quality improvement programs must be conducted consistent with the CMS requirements for QI projects.

2.9.4.2 Medical Director

The MAPD plan must designate a Medical Director with responsibility for the development, implementation, and review of the internal quality assurance plan. The Medical Director's position need not be full time but must include sufficient hours to ensure that all Medical Director responsibilities are carried out in a timely and appropriate manner. The MAPD plan also may use assistant or associate Medical Directors to help perform the functions of this office.

The Medical Director must be licensed to practice medicine in their respective state without restriction(s) and/or sanction(s) and must be board-certified in his or her area of specialty. The specific responsibilities of the Medical Director must include, but need not be limited to the following:

- Oversight of, or substantial participation in, the health plan's QA/QI Committee;
- Oversight of the development and revision of clinical standards and protocols;
- Oversight of the plan's prior authorization/referral process for non-primary care services;
- Reviewing potential quality of care problems and overseeing development and implementation of corrective action plans;
- Serving as a liaison between the plan and its providers; and
- Being available to the health plan's medical staff on a daily basis for consultation on referrals, denials, and complaints and appeals.

2.9.5 Confidentiality

All enrollee information, medical records, data and data elements collected, maintained or used in the administration of this contract shall be protected by the health plan from unauthorized disclosure. The MAPD plan must provide safeguards that restrict the use or disclosure of information concerning enrollees to purposes directly connected with the administration of this contract. The MAPD Plan selected will be considered part of an Organized Health Care Arrangement as defined in 45 CFR §160.103. As a result of this arrangement, "Protected Health Information" about the enrolled PEIA members can be disclosed by MAPD Plan to PEIA for "treatment," "payment," or "healthcare operations." These terms are defined in 45 CFR §164.501. The MAPD plan provider shall be required to sign a Business Associate Agreement with PEIA. The MAPD plan is encouraged to submit its plan for compliance with the proposed rules posted on May 30, 2011 by the United States Department of Health and Human Services that would require full accounting of any and/or all disclosures including those for treatment, payment, and/or healthcare operations.

2.9.6 Records Retention

The MAPD plan must maintain books and records relating to their West Virginia PEIA managed care program services and expenditures, including reports to PEIA and source information used in preparation of these reports. These reports include but are not limited to financial statements, records relating to quality of care and

medical records. In addition, The MAPD plan must agree to permit inspection of their records.

All financial and programmatic records, supporting documents, statistical records and other records of enrollees, which are required to be maintained by the terms of the contract, shall be retained for the entire period required by State and Federal law. If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the required retention period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the regular five years period, whichever is later. The health plan must agree to retain the source records for its data reports for a minimum of five years and must have written policies and procedures for storing this information in a safe and secure manner.

2.9.7 External Monitoring and Evaluation

The PEIA and authorized representatives of the State, including, but not limited to, the State Auditor and other State and/or any applicable federal agencies providing funds, shall have the right, during the MAPD plan's normal operating hours, and at any other time a MAPD plan function or activity is being conducted, and within the provisions set forth under the requirements of HIPAA, to monitor and evaluate, through inspection or other means, the MAPD plan's performance and that of its network providers. During the contract period, access will be provided at all reasonable times. During the five-year post-contract period, delivery of and access to records will be at no cost to the PEIA.

This includes, but is not limited to, assessments of the quality, appropriateness, and timeliness of services provided to PEIA enrollees, as well as focused clinical studies of acute and chronic health conditions determined to be of high priority to the PEIA, and audits of financial records. This also includes the performance of periodic medical audits and collection of management data to be conducted at least once per year. A thirty (30) day notice will be given prior to onsite visit.

2.10 Operational and Financial Data Reporting

The MAPD plan must provide the PEIA with uniform utilization, quality assurance, claims, grievance and other data on a regular basis as required by PEIA and/or CMS requirements.

2.11 Ownership of Data

To the extent that it is not in conflict with any provision of HIPAA, any data, member specific or otherwise, or any reports collected or prepared by The MAPD plan, in the course of performing their duties and obligations under this program, will be deemed to be owned by PEIA at all times. This provision is made in consideration of The MAPD plan's use of public funds in collecting and preparing

such data, information, and reports. In addition, all proposals submitted in response to this RFP become the property of the PEIA and will not be returned.

2.12 Detailed Claims Data Submission

The MAPD plan must submit member level detailed claims payment data to the PEIA data warehouse consultant on a monthly basis. These data must be submitted in an electronic format stipulated by PEIA. The MAPD plan will be required to provide adequate information to allow for appropriate data mapping into PEIA's data warehouse. See Appendix H for the required file layout.

2.13 Disclosure of Ownership and/or Control

The MAPD plan must report ownership and control and any other related information to PEIA.

2.14 Solvency Requirements

The MAPD plan must maintain a fiscally sound operation as demonstrated by the following:

- Licensed and in good standing with respective insurance regulatory authority.
- Maintaining adequate liquidity to meet all obligations as they become due for services performed under the provider agreement;
- Maintaining a positive net worth in every annual reporting period as evidenced by total assets being greater than total liabilities based on the health plan's audited financial statement. If the health plan fails to maintain a positive net worth, the plan must submit a financial corrective action plan outlining how a positive net worth will be achieved by the next annual reporting period; and
- Maintaining a net operating surplus in every annual reporting period based on the annual audited financial statement. If the health plan fails to earn a net operating surplus, it must submit a financial corrective action plan outlining how it will achieve a net operating surplus within available financial resources by the end of the next annual reporting period.
- The MAPD Plan must submit the last three years of audited financial statements.
- The MAPD plan must also submit the names of the three (3) largest contracts as well as the three (3) largest terminated contracts. This information should be provided using the forms in Appendix B.

If insolvency insurance protection is carried as a rider to an existing reinsurance policy, the conditions of the coverage must not exclude the MAPD plan's PEIA line of business.

The MAPD plan must notify PEIA within sixty (60) days if any changes are made to their insolvency protection arrangement.

2.15 MAPD Association with PEIA

2.15.1 Capitation Payments

The MAPD plan may propose capitated and/or Administrative Services Organization (ASO) Arrangements for all services listed in the benefit package. PEIA will maintain records of all its respective enrollees and issue payment to the health plan for enrollees on a monthly basis for ASO services and will fund medical and prescription drug payments on a weekly basis for ASO services. Payment will be issued based upon verified PEIA eligibility data. In the event of subsequent corrections to the number of enrollees, adjustments will be made in the month such errors are discovered, without interest. In no case will retroactive adjustments be made exceeding sixty (60) days. Capitation payments made 61 or more days beyond the beginning of any month shall have appropriate interest penalties applied.

2.15.2 Member Contribution to Premiums

2.15.2.1 Employees

If Medicare primary employees share in the premium cost of the program, regular deductions from salaries or wages will be made by PEIA. The PEIA will issue payment to the MAPD plan.

2.15.2.2 Retired Employees

If retired employees share in the premium cost of the program, regular deductions from pension will be made or direct billing to the retiree will occur. The PEIA will issue payment to the MAPD plan.

For further reference, see Sections 2.16 and 3.1.2 of this RFP.

2.15.2.3 Prohibition Against Billing Members

The MAPD plan and its sub-contractors or its contracted providers or providers that accept assignment (i.e. PFFS) shall not charge a PEIA enrollee for any covered service (subject to the appropriate authorization requirements) except for any cost identified as the enrollee's responsibility in the cost sharing schedule.

2.15.3 Third Party Liability

Pursuit of third party payment for services is the responsibility of the MAPD plan, and MAPD health plan. The MAPD plan should utilize and require their subcontractors to utilize or pursue, whenever available, covered medical and hospital services or payments for PEIA enrollees available from other public or private sources. This responsibility includes accident and trauma cases that occur when a PEIA member is enrolled in the health plan. The MAPD plan will retain all funds collected as part of this activity.

For ASO services, third party liability recoveries will belong to PEIA.

Third party liability reporting is required and must be submitted to PEIA on an annual basis.

2.15.4 Prohibition of Balance Billing

The Omnibus Health Care Act enacted by the West Virginia Legislature in April 1989 applies to the PEIA and its primary members. This Law requires that any West Virginia health care provider who treats a PEIA insured must accept assignment of benefits and cannot balance bill the insured for any portion of charges over and above the PEIA fee allowance or for any discount amount applied to a provider's charge or payment, this is known as the "prohibition of balance billing."

Any provisions regarding balance billing and assignment acceptance from CMS shall also be enforced by the MAPD plan.

2.16 MAPD Benefits

The MAPD must submit their proposals based on the benefits outlined in Appendix A with no variance. It is understood that if CMS requires a certain benefit level that is superior to a benefit listed in Appendix A, then the CMS benefit should be applied. All benefits described in this Appendix A are subject to change.

The MAPD plan is encouraged to submit a second MAPD option that incorporates a cost competitive premium that is balanced with reasonable out-of-pocket requirements that equate to an approximate 25% reduction in premiums from the base plan. Such a plan may have a separate tier system for prescription approval, higher co-pays, higher deductibles, greater out-of-pocket maximums, and/or utilize other plan structures that allow PEIA retirees to opt for the second plan should they choose. This second option plan, if chosen by a PEIA retiree, would be a one (1) year lock in and PEIA retirees would not be able to opt out of this plan mid-year. Please note that the Reduced Plan Benefit Option also includes a Benefit Assistance plan.

The formulary of the proposals must be in compliance with CMS MAPD plan formulary standards. Plans must provide a proposal that is equivalent to the PEIA PPB plan formulary (Appendix E). Plans may also propose their own formulary. The PEIA reserves the right to offer prescription drug coverage to Medicare primary retirees in the event it is determined to be financially advantageous to do so. The MAPD plan must submit proposals that include the Medicare Advantage as well as the Prescription Drug Plan options. MA only options will not be considered.

PEIA expects that the current PEIA formulary be priced as well as the vendor's recommended formulary. Also provide:

1. A comparison of the PEIA formulary and the proposed formulary (disruption analysis)
2. Total members affected if the vendor's formulary is implemented.
3. The top 20 drugs and member counts if the vendor's formulary is implemented.
4. What is the expected savings if the vendor's formulary is implemented?

Further, the MAPD plan must allow for the grandfathering of existing Medicare Retirees' prescription drug coverage, at PEIA's discretion. For example, if a beneficiary is taking a prescription drug that is covered under the existing PEIA formulary and PEIA chooses an MAPD plan whose formulary does not include this particular drug, the MAPD plan must allow for coverage and/or a transition period for a drug that is included on the MAPD plan formulary. The MAPD Plan must clearly describe its plan to address this issue.

The PEIA also offers premium assistance programs to its retiree members who are at or below 250% of the Federal Poverty Level. These programs may impact some of the benefits offered in Appendix A.

CHAPTER 3: CAPITATION

3.1 PEIA Capitation Rates

3.1.1 General

Applicants must submit rate proposals, as described in Chapter Four, against which the PEIA contribution will be applied.

3.1.2 Determination of Member Contribution

PEIA members enrolled in the MAPD plan are required to pay a monthly premium that is presently adjusted to the years of service of the policyholder, the date the individual retired and current financial condition, when applicable.

CHAPTER 4: PROPOSAL SUBMISSION REQUIREMENTS

4.1 Procurement Process Overview

4.1.1 Delivery

Proposals may be delivered in person or by certified mail to:

Thomas Miller, MA, LPC, ALPS
Privacy Officer
West Virginia Public Employees Insurance Agency
601 57th Street, SE
Suite 2
Charleston, West Virginia 25304-2345
thomas.d.miller@wv.gov

Applicants are responsible for ensuring the timely delivery of their proposals to PEIA office.

4.1.2 RFP Amendments

The PEIA reserves the right to amend this RFP at any time prior to the proposal due date by issuing written amendments.

4.1.3 Bidder's Conference

The bidder's conference will be held at the PEIA at the address shown in Section 4.1.1 above. The purpose will be to allow the PEIA to respond to questions concerning the RFP, both technical and capitation.

Attendance at the bidder's conference is not mandatory. For your convenience, a conference number will be established.
Applicants are permitted to submit written questions for the conference prior to it. Questions may be mailed, faxed, or hand delivered to the address shown above in Section 4.1.1 and must be submitted in both hard copy and CD (IBM compatible, Microsoft Word 2010 or earlier). All questions must be cross-referenced to the Section number of the RFP to which they relate.

The PEIA will distribute written answers to both the pre-submitted questions and questions received after the bidder's conference to all vendors. The PEIA will also take questions at the conference itself, although the answers provided will not be binding until distributed in writing at a later date.

4.1.4 Contact with PEIA Representatives

Applicants are prohibited from communicating with any PEIA representatives regarding this procurement, except for the contact listed in Chapter One. This provision is not intended to restrict existing contractors from communicating with PEIA staff regarding ongoing operational matters.

4.1.5 Cost of Preparing Proposals

Applicants are solely responsible for the costs incurred in preparing and submitting their proposals.

4.1.6 Acceptance of Proposals

Each applicant may submit only one proposal. Applicants may withdraw and resubmit their proposals up to the submission deadline.

Proposals submissions are limited to seventy-five (75) pages not counting attachments. Attachments should only be used to support content of the RFP submission and should not be used to provide substantive responses to RFP requirements. Attachments should be clearly labeled as to what part of the RFP response they reference and/or support.

The PEIA will accept for evaluation all proposals that are complete and timely submitted. PEIA reserves the right to:

- Reject any proposals found to be incomplete or substantially non-responsive to the requirements described herein;
- Waive minor irregularities in proposals, provided such action is in the best interest of the PEIA. Where such waivers are granted, they will in no way modify the requirements of the RFP or the obligations of The MAPD plan awarded contracts through it;
- Conduct Site Visits;
- Conduct Finalist Presentations;
- Enter into BAFO negotiations with one (1) or more vendors of PEIA's choice;
- Award a contract(s), with or without negotiations, based on the terms, conditions, and premises of this RFP and the proposals of selected applicants;
- Request clarification or correction of proposals; and/or

- Reject any or all proposals received, or cancel part or all of this procurement, according to the best interest of the PEIA and its members.

4.1.7 Disposition of Proposals

Successful proposals will be incorporated into resulting contracts and will be a matter of public record. All materials submitted by bidders become the property of the PEIA, which may dispose of them as it sees fit. The PEIA shall have the right to use all concepts described in proposals, whether or not such proposals are accepted.

The MAPD plan must clearly identify which data and/or materials are considered proprietary. If the PEIA receives a FOIA request for data, labeled by the MAPD plan as proprietary, the PEIA will notify the MAPD plan, in writing, of the request to allow the MAPD plan time to obtain the appropriate court order to prevent the release of the information. Otherwise, the PEIA will be compelled by state law to release such information

4.1.8 Proposal Composition and Copies

Health plan proposals will consist of two (2) parts:

1. General Technical including a description of MAPD Plan and Benefits
2. Capitation Proposal

Applicants must submit one original, six (6) bound copies (three-ring binders are acceptable), one (1) unbound copy of their proposals and (1) electronic copy in a disk format. The original proposal should be identified as such on the cover. The originals must be signed by a person having the authority to bind the vendor to their proposal(s). *All signatures in the original must be made in blue ink.*

Proposals must be segmented into General Technical MAPD Plan and Capitation sections. Each section should be separately tabbed and clearly labeled. Every page of applicant proposals, except for section dividers, must be numbered, starting at "1" and continuing sequentially throughout the entire RFP. This requirement applies to exhibits and tables, as well as narrative. Applicants may number their proposals by hand.

Proposals submissions are limited to seventy-five (75) pages not counting attachments. Attachments should only be used to support content of the RFP submission and should not be used to provide substantive responses to RFP requirements. Attachments should be clearly labeled as to what part of the RFP response they reference and/or support.

4.2 General Technical Proposal

4.2.1 Format

Applicants must organize the General Technical section of their proposals as follows:

- Transmittal Form (B-1)
- Compliance with Participation Standards
- Other Technical Submission Forms (Forms B-2 to B-5)

4.2.2 Transmittal Form

The Transmittal Form should be placed at the very beginning of the General Technical section. It must be signed by an individual duly authorized to make commitments on the applicant's behalf. **Reminder**: *All original signatures must be signed in blue ink.*

4.2.3 Confidentiality of Proprietary Data

The MAPD plan must clearly identify which data and/or materials are considered proprietary. If the PEIA receives a FOIA request for data, labeled by the MAPD plan as proprietary, the PEIA will notify the MAPD plan, in writing, of the request to allow the MAPD plan time to obtain the appropriate court order to prevent the release of the information. Otherwise, the PEIA will be compelled by state law to release such information.

4.3 Financial Proposal

In this section, applicants must provide information regarding their financial status, as well as capitation rates for PEIA. Capitation rates must be reported in the format provided in Capitation Proposal Form.

4.3.1 Health Plan Financial Information

Applicants must provide the information listed below for the organization holding a license to operate as a health plan in West Virginia. If the licensed plan is owned by a parent corporation, all financial information must be provided for the parent as well. Also, the applicant must include a letter from the parent corporation indicating its willingness to furnish whatever financial support is necessary to assure the solvency of the plan's operations in West Virginia.

The applicant should provide as much detail and supporting documentation as it feels is warranted for the items listed below to support that it is a fiscally viable entity for purposes of this procurement:

1. Audited financial statements for the three most recent corporate fiscal years, and interim statements for the two most recent quarters for which statements are available. The statements must include a balance sheet, income statement, and a statement of cash flows. Audited statements must be complete with opinions, notes, and management letters. This should include a SAS 70 Type II report. If no audited statements are available, explain why and submit unaudited financial statements and other supporting financial data.

2. Projected balance sheets, income statements, and monthly cash budget for the period beginning January 1, 2009 to present.

4.3.2 Financial Rate Proposal and Benefit Package

4.3.2.1 Rate Submission

Applicants must submit capitation rates for the PEIA Medicare Primary Single Policyholder Plan. The MAPD plan must assume a 1% risk factor and submit a plan to validate risk factors in an effort to maximize capitation. The MAPD plan also must disclose the actual CMS risk factors on a quarterly basis, or as requested by PEIA. The Capitation Proposal Form (Appendix G) must be used to submit the capitation rate proposal.

Applicants may also submit an ASO rate for the PEIA Medicare Primary Single Policyholder Plan. Use Appendix G, Option 3 to submit your ASO rates.

4.3.2.2 Benefit Package

The PEIA is requiring applicants to develop a premium and submit benefits based on the benefit grid as outlined in Appendix A. It is understood that if CMS requires a certain benefit level that is superior to a benefit listed in Appendix A, then the CMS benefit should be applied. All benefits described in this Appendix A are subject to change.

4.4 Proposal Evaluation

4.4.1 General

The PEIA will establish an evaluation committee to review proposals received in response to this RFP. Technical proposals will be evaluated on including, but not limited to, the following criteria:

- Geo Access – Adequate services available for all Medicare beneficiaries

- Location of Operations – preference is given to bidders demonstrating a strong presence in West Virginia.
- Prospective vendor's CMS STAR rating and/or their rating in accordance with the 2012 Medicare Advantage Quality Bonus Payment Demonstration program
- Implementation Plan – Demonstrated ability to effectively and efficiently take over coverage of Medicare eligible members.
- Percentage of total beneficiaries – If awarded the contract, what percentage of the PEIA covered lives will make up your total covered lives?
- Description of pharmacy benefits structure and formulary.
- Oral presentations and site visits – This may have an impact on the initial scoring in the other technical areas if a conflict arises.

4.4.2 Evaluation Criteria

The purpose of this section is to explain the criteria that will be used in evaluating the proposals. PEIA requires a single vendor for MA and PDP services. Each proposing entity will be evaluated using these criteria. As stated earlier, each proposing entity will submit the following items to be evaluated:

1. Response to Participation Standards (Technical Proposal)
2. Signature Page (See Appendix B)
3. Cost Proposal (to be submitted sealed under separate cover)
4. Signature Page (to be submitted under separate cover with the cost proposal)

The technical section of the proposals will be evaluated by a team of individuals determined by the PEIA Director. Consensus scoring will determine the final score for each proposal. This means that each member of the evaluation team must agree on the score for each and every item before the score is assigned.

The Cost Proposal must be submitted under separate cover and will be evaluated separately using the form in Appendix G. Vendors wishing to request preference for residency status must complete the Vendor Preference Certificate in Appendix D.

A point evaluation system has been designed. A total score of 100 points is possible for the technical and cost proposals combined. The technical proposal will represent 60 points (60%) of the total evaluation score while the cost proposal will represent 40 points (40%). Finalist presentations and site visits may be used to validate the information presented in the proposal. As such, information obtained during oral presentations and/or site visits may be used to adjust the technical scores.

Proposing entities will be selected for the finalist presentation if they obtain a minimum acceptable score for the service(s) they propose. The minimum

acceptable score for each technical proposal will be set at 85% (60 points X 85% = **51 points**) of the total technical score.

4.4.3 Best Interest of the PEIA

Notwithstanding the evaluation process outlined herein, PEIA reserves the right to make award decisions based upon the best interest of the PEIA and its members.

4.4.4 Miscellaneous Provisions

The following provisions will be incorporated into any agreement entered into between PEIA and the successful bidder. The successful bidder will be asked to sign a form accepting the provisions described below.

4.4.4.1 Arbitration

Any references to arbitration contained in the agreement are hereby deleted. Claims against PEIA or the State of West Virginia arising out of the agreement shall be presented to the West Virginia Court of Claims.

4.4.4.2 Hold Harmless

Any clause requiring the Agency to indemnify or hold harmless any party is hereby deleted in its entirety. The successful bidder must indemnify and hold harmless the State of West Virginia and PEIA for its acts or omissions arising out of the contract.

4.4.4.3 Governing Law

The procurement of this contract and the resulting agreement shall be governed by the laws of the State of West Virginia. This provision replaces any references to any other State's governing law.

4.4.4.4 Taxes

Provisions in the agreement requiring the Agency to pay taxes are deleted. As a State entity, the Agency is exempt from Federal, State, and local taxes and will not pay taxes for any Vendor including individuals, nor will the Agency file any tax returns or reports on behalf of Vendor or any other party.

4.4.4.5 Payment

Any references to prepayment are deleted. Payment will be in arrears.

4.4.4.6 Interest

Should the agreement include a provision for interest on late payments, the Agency agrees to pay the maximum legal rate under West Virginia law. All other references to interest or late charges are deleted.

4.4.4.7 Recoupment

Any language in the agreement waiving the Agency's right to set-off, counterclaim, recoupment, or other defense is hereby deleted.

4.4.4.8 Fiscal Year Funding

Service performed under the agreement may be continued in succeeding fiscal years for the term of the agreement, contingent upon funds being appropriated by the Legislature or otherwise being available for this service. In the event funds are not appropriated or otherwise available for this service, the agreement shall terminate without penalty on June 30. After that date, the agreement becomes of no effect and is null and void. However, the Agency agrees to use its best efforts to have the amounts contemplated under the agreement included in its budget. Non-appropriation or non-funding shall not be considered an event of default.

4.4.4.9 Statute of Limitation

Any clauses limiting the time in which the Agency may bring suit against the Vendor, lesser, individual, or any other party are deleted.

4.4.4.10 Similar Services

Any provisions limiting the Agency's right to obtain similar services or equipment in the event of default or non-funding during the term of the agreement are hereby deleted.

4.4.4.11 Attorney Fees

The Agency recognizes an obligation to pay attorney's fees or costs only when assessed by a court of competent jurisdiction. Any other provision is invalid and considered null and void.

4.4.4.12 Assignment

Notwithstanding any clause to the contrary, the Agency reserves the right to assign the agreement to another State of West Virginia agency, board or commission upon thirty (30) days written notice to the Vendor and Vendor shall obtain the written consent of Agency prior to assigning the agreement.

4.4.4.13 Limitation of Liability

The Agency, as a State entity, cannot agree to assume the potential liability of a Vendor. Accordingly, any provision limiting the Vendor's liability for direct damages or limiting the Vendor's liability under a warranty to a certain dollar amount or to the amount of the agreement is hereby deleted. In addition, any limitation is null and void to the extent that it precludes any action for injury to persons or for damages to personal property.

4.4.4.14 Right to Terminate

Agency shall have the right to terminate the agreement upon Ninety (90) written notice to Vendor.

4.4.4.15 Termination Charges

Any provision requiring the Agency to pay a fixed amount or liquidated damages upon termination of the agreement is hereby deleted. The Agency may only agree to reimburse a Vendor for actual costs incurred or losses sustained during the current fiscal year due to wrongful termination by the Agency prior to the end of any current agreement term. Upon termination of this agreement, or any extension thereto, the MAPD Plan has the duty to continue to provide any reports required by the agreement or any law or regulation. In addition, the MAPD plan is required to pay all claims incurred from the effective date of the agreement through the termination date, regardless of when the claims are received.

4.4.4.16 Renewal

Any reference to automatic renewal is hereby deleted. The agreement may be renewed only upon mutual written agreement of the parties.

4.4.4.17 Insurance

Any provision requiring the Agency to insure equipment or property of any kind and name the Vendor as beneficiary or as an additional insured is hereby deleted.

4.4.4.18 Right to Notice

Any provision for repossession of equipment without notice is hereby deleted. However, the Agency does recognize a right of repossession with notice.

4.4.4.19 Acceleration

Any reference to acceleration of payments in the event of default or non-funding is hereby deleted.

4.4.4.20 Amendments

All amendments, modifications, alterations or changes to the agreement shall be in writing and signed by both parties.

APPENDICES

APPENDIX A – Benefit Grid for PEIA MAPD (Benefits described below are subject to change)

Benefit	Standard Plan In-Network and Out-of-Network No Changes to this Plan Allowed	Reduced Benefit Plan In-Network and Out-of-Network **25% Benefit Reduction Proposal**	Standard Plan with Benefit Assistance In-Network and Out-of-Network No Changes to this Plan Allowed	Reduced Benefit Plan with Benefit Assistance In-Network and Out-of-Network **25% Benefit Reduction Proposal**
1 - Premium and Other Important Information	Premium varies $25 Annual Deductible Maximum Out-of-pocket: $750 for each member. All co-pays and coinsurance count towards the MOOP.		Premium varies $25 Annual Deductible Maximum Out-of-pocket: $300 for each member. All co-pays and coinsurance count towards the MOOP.	
2 - Doctor and Hospital Choice	You may go to any doctor, specialist, or hospital that accepts Medicare.		You may go to any doctor, specialist, or hospital that accepts Medicare.	
3 - Inpatient Hospital Care	$100 per admission copayment;		$100 per admission copayment;	
4 - Inpatient Mental Health Care	$100 per admission copayment ; There is a 190-day lifetime limit for inpatient services in a psychiatric hospital (the 190-day limit does not apply to mental health services in a psychiatric unit of a general hospital)		$100 per admission copayment ; There is a 190-day lifetime limit for inpatient services in a psychiatric hospital (the 190-day limit does not apply to mental health services in a psychiatric unit of a general hospital)	
5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	100% coverage for day 1 - 100; limited to 100 days per plan year		100% coverage for day 1 - 100; limited to 100 days per plan year	

6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	100% coverage		100% coverage	
7 - Hospice	100% coverage		100% coverage	
8 - Doctor Office Visits	$10 copay for Primary Care Physician office visit $20 copay for specialist office visit		$2 copay for Primary Care Physician office visit $5 copay for specialist office visit	
9 - Chiropractic Services	100% coverage; $20 copay applies to the office visit. Subject to 20 visit max for services other than manual manipulation of the spine to correct subluxation.		100% coverage; $5 copay applies to the office visit. Subject to 20 visit max for services other than manual manipulation of the spine to correct subluxation.	
10 - Podiatry Services	$20 copay office visit only; $50 copay for surgical procedures Other services 100% coverage . Nail debridement is covered for diabetic patient.		$2 copay office visit only; $50 copay for surgical procedures Other services 100% coverage. Nail debridement is covered for diabetic patients.	
11 - Outpatient Mental Health Care	100% coverage;		100% coverage;	
12 - Outpatient Substance Abuse Care	100% coverage		100% coverage	
13 - Outpatient Services/Surgery	$50 copay		$50 copay	
13 a) Office surgery	$50 copayment; copayment does not apply to diabetic foot care for diabetics		$50 copayment; copayment does not apply to diabetic foot care for diabetics	
14 - Ambulance Services (medically necessary ambulance services)	100% coverage		100% coverage	

15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	$25 co pay $50 co pay (non-emergency)		$25 co pay $50 co pay (non-emergency)	
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	$10 copayment for each primary care office visit $20 copay for each specialist office visit		$2 copayment for each primary care office visit $5 copay for each specialist office visit	
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	100% coverage ; Includes vision therapy, chiropractor, speech therapy, Physical Therapy, Occupational Therapy, acupuncture.		100% coverage ; Includes vision therapy, chiropractor, speech therapy, Physical Therapy, Occupational Therapy, acupuncture.	
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	100% coverage		100% coverage	
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	100% coverage		100% coverage	
20 - Diabetes Self-Monitoring Supplies (includes coverage for test strips, lancets, and self-management training)	Covered Under Prescription Drug Plan; glucose monitors are only covered under the medical or plan, if not available at no charge. They are provided to the member at no charge through Bayer.		Covered Under Prescription Drug Plan; glucose monitors are only covered under the medical or plan, if not available at no charge. They are provided to the member at no charge through Bayer.	
21 - Diagnostic Tests, X-Rays, and Lab Services	100% coverage		100% coverage	
22 - Bone Mass Measurement (for people who are at risk)	100% coverage for individuals at risk of losing bone mass or at risk of osteoporosis; covered once per year or more frequently if medically necessary.		100% coverage for individuals at risk of losing bone mass or at risk of osteoporosis; covered once per year or more frequently if medically necessary.	
23 - Colorectal Screening Exams (age 50 and older)	Covered at 100% if members meets criteria		Covered at 100% if members meets criteria	

24 - Immunizations (Flu vaccine, Hepatitis B vaccine - for people who are at risk, Pneumonia vaccine)	There is no co-payment for these vaccines.		There is no co-payment for these vaccines.	
25 - Mammograms (Annual Screening) (for women age 40 and older)	Covered at 100%		Covered at 100%	
26 - Pap Smears and Pelvic Exams	Pap smear is covered at 100%; pelvic and office visit are subject to the $10 copay; this benefit is covered annually		Pap smear is covered at 100%; pelvic and office visit are subject to the $2 copay; this benefit is covered annually	
27 - Prostate Cancer Screening Exams (for men age 50 and older)	There is no co-payment for approved lab services; the $10 copay applies to the office visit		There is no co-payment for approved lab services; the $2 copay applies to the office visit	
28 – Other Preventative Care Services (all Medicare covered preventative testing and screening are covered)	Covered at 100%		Covered at 100%	
29 - Prescription Drugs	$75 individual deductible. $5/$15/$50. If a generic is available the Brand name drug cost is $5 plus the difference between the generic and brand drug. Maintenance Medication is in 90-day supplies for 2 copays. Out of Pocket maximum is $1,750 individual.		$75 individual deductible. $3/$10/$50. If a generic is available the Brand name drug cost is $3 plus the difference between the generic & brand drug. Maintenance Medication is in 90-day supplies for 2 copays. Out of Pocket maximum is $250 individual.	
30 - Dental Services	$50 copayment; Impacted teeth and accident-related only; accident related must be within 6 month of accident for least expensive professionally acceptable alternative treatment		$50 copayment; Impacted teeth and accident-related only; accident related must be within 6 month of accident for least expensive professionally acceptable alternative treatment	
31 - Hearing Services	You pay 100% for routine hearing exams & hearing aids. Medicare-approved diagnostic hearing exams covered at 100%.		You pay 100% for routine hearing exams & hearing aids. Medicare-approved diagnostic hearing exams covered at 100%.	

32 - Vision Services	Routine vision services are not covered. You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. If at risk, you are covered for annual glaucoma screenings.		Routine vision services are not covered. You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. If at risk, you are covered for annual glaucoma screenings.	
33 - Physical Exams	$10 Copay for PCP office visits; coverage is for one annual routine physical exam		$2 Copay for PCP office visits; coverage is for one annual routine physical exam	
33 - Transportation (Routine)	Not Covered		Not Covered	
35 - Acupuncture	100% of medically appropriate services		100% of medically appropriate services	
36 - Optional Supplemental Benefits	Vision and dental offered through Flexible Benefits. PEIA offers this coverage on a voluntary basis. Member pays 100% of costs.		Vision and dental offered through Flexible Benefits. PEIA offers this coverage on a voluntary basis. Member pays 100% of costs.	
37 - Transportation / Lodging / Meals Benefit is per transplant (For Transplant Services Only)	Up to $5,000 per transplant for travel, meals and lodging for patient and family member *or* friend.		Up to $5,000 per transplant for travel, meals and lodging for patient and family member *or* friend.	

See Section 2.16 of this RFP regarding the second plan option (Reduced Plan Options)

APPENDIX B – Transmittal Forms

B-1 Transmittal Form

I hereby attest to the following on behalf of _____:

- We have read, understand, and are able and willing to comply with all standards and participation requirements described in the RFP for the programs in which we are applying to participate, as well as in the corresponding contracts;
- All of the information contained in this proposal is accurate and truthful to the best of our knowledge;
- If proposing to participate in the PEIA program, our capitation rates have been approved by the CMS (or respective state's insurance regulatory authority, if applicable) and were developed independently, without collusion, conflict of interest, consultation, communication, or agreement for the purpose of restricting competition, as to any matter relating to such rates with any other applicant, prospective applicant or competitor. Our capitation rates further have not been knowingly disclosed prior to award, either directly or indirectly, to any other applicant or competitor;
- This proposal will be held firm until at least June 30, 2013; and
- Neither we, nor any of our representatives have paid, agreed to pay, or will pay directly or indirectly to any person, firm, or corporation any money or valuable consideration for assistance in procuring or attempting to procure the agreement(s) referred to herein.

_____	_____
Signature	Name (Print)
_____	_____
Title	Date

Applicant point of contact regarding proposal:

Name: _____

Title: _____

Tel: _____

Fax: _____

B-2 – Top Three Clients Form

Instructions to Applicants: Complete the chart, listing your top 3 clients/groups starting with the largest number of covered lives (other than PEIA). Include current phone number and address for contact persons. Points will be deducted for failure to provide contact information.

	Client/Group	Number of Enrollees	Initial Offer Date	Contact Name	Address	Telephone Number
1						
2						
3						

B-3 – Terminated Contracts Form

Instructions to Applicants: Complete the chart below, listing the 3 largest all groups with 25 or more enrollees that have terminated their contracts with your plan since December 31, 2008. Include current phone number and address for of cooperative contact persons. Points will be deducted for failure to provide contact information.

	Client/Group	Number of Enrollees	Initial Offer Date	Contact Name	Address	Telephone Number
1						
2						

3						

B-4 – Plan Management Form

Instructions to Applicants: Identify the Account Team that will be devoted to PEIA. Also indicate whether the position is salaried or contracted. Include up-to-date resume for each individual (or a job description for vacant positions) behind this form.

Position	**Name**	**Date of Hire**	**% FTE PEIA**	***Check the Appropriate Box***	
				Salaried	**Contracted**
CEO/Executive Director					
CFO					
Medical Director					
QA/QI Director					
UM Director					
Member Services Director					
Provider Services Director					
Complaints/Grievances Director					
Claims Director					

Pharmacy Director					
MIS Director					
Privacy Officer					
Other: _____					

B-5 – Staffing Form

Instructions to Applicants: Indicate the number of non-clerical, non-secretarial FTEs employed or contracted in each of these areas. Also indicate the number of additional FTEs anticipated for hire/contracting if awarded a contract in all regions bid.

Function	**Current FTE Count**	**Additional to Hire**	**Total**	**% of Total to be Devoted to PEIA**
Accounting and Budgeting				
Medical Director's Office				
QA/QI				
Medical Management				
Member Services				

Pharmacy Program				
Provider Services				
Complaints/Grievances				
Claims				
MIS				
Privacy				

APPENDIX C – Performance Standards and Penalties

Medical Claims Quality

Financial Error Claim is one either incorrectly settled with respect to dollar amount or incorrectly settled, in whole or in part, with respect to a wrong payee. No claim shall be declared a financial error claim if incorrect (actual) settlement amount differs from corrected (audited) settlement amount by less than one dollar.

Financially Correct Claim is a claim which is not a financial error claim.

Financial Accuracy Amount is 100% for any settled claim, which is not a financial error claim. If a financial error claim is one involving a wrong payee, then the financial accuracy amount is the amount of claim settlement directed to the wrong payee.

Quality performance measurements with respect to financial error claims .and related financial accuracy amounts shall be based on MAPD Plan's quarterly internal audit and shall be reported quarterly to PEIA. MAPD Plan will audit a statistically valid random sample of all settled claims for each quarterly audit period. Performance measurements reported to the PEIA shall be based on the entirety of that sample. Sample size and performance measurements shall be reported to the PEIA quarterly.

Two quarterly performance measurements shall be calculated each quarter as follows (N denotes the audit sample size):

Q1 - Financially Correct Claim Percent =

100 * (1- (Number of Financial Error Claims/N))

Financially Correct Claim Percent (Q1) is rounded to two decimals in order to determine the performance standard and penalty amount, if applicable.

Q2 - Financial Accuracy Amount Percent =

100 * (1- (Sum of Financial Accuracy Amounts/Sum of Audit Claim Settlement Amounts))

Financial Accuracy Amount (Q2) is rounded to two decimals in order to determine the performance standard and penalty amount, if applicable.

Timeliness

Claim turnaround time is defined as the number of working days after the date the claim is received until the date the claim is finalized. Finalized claims include those which are read for release of payments, denied, applied to deductible, closed, or referred to PEIA for handling.

For example, a claim received on Tuesday and finalized on the next day, Wednesday, has a turnaround time of one day. Similarly, that same claim finalized, instead, on the Tuesday one week hence, would have a turnaround time of five days.

Claim turnaround time should be calculated by reference to the "Turnaround Days" and "Number of Claims – Cumulative %" columns in a report which will be produced each quarter. For purposes of this performance standard and corresponding measurement, this report will exclude all claims, which are either adjustments or claims which were delayed in processing at the request of the PEIA as a result of PEIA actions or in accordance with the Plan.

The following timeliness performance measurement shall be calculated each quarter:

Percent of Claims Finalized in Twelve (12) Working Days (T1) =Turnaround time (T1) will be rounded to two decimals in order to determine performance standard and penalty amount, if applicable.

Telephone Responsiveness

Telephone responsiveness shall be calculated each quarter under the following three (3) performance measurements:

Abandonment Percentage

Telephone responsiveness for both provider and member customer service inquires shall be measured by the Summary Abandonment Rate Percentage Report, which will be produced each quarter. The abandonment rate percentage is denoted as A1. The abandonment rate percentage (A1) is rounded to two decimals in order to determine the performance standard and penalty amount, if applicable.

Average Speed of Answer

Telephone responsiveness for both provider and member customer service inquires shall also be measured by a report using the MAPD Plan's call center software. S1 will denote the average speed of answer and will be rounded to two decimals in order to determine the performance standard and penalty amount, if applicable.

Blockage Percentage

Telephone responsiveness for the entire toll free line shall also be measured by a report using the MAPD Plan's call center software, which will be produced each quarter. The blockage percentage is denoted as B1. The blockage percentage will be rounded to two decimals in order to determine the performance standard and penalty amount, if applicable.

Penalty Calculations

- The MAPD Plan shall be subject to penalties for the following performance measurements:
- Financially Correct Claims Percentage (Q1)
- Financial Accuracy Percent (Q2)
- Percent of Claims Finalized in 12 Working Days (T1)
- Telephone Calls Abandonment Percentage (A1)
- Average Speed of Answer in Seconds (S1)
- Blockage Percentage (B1)

The penalty amount is determined by multiplying the average number of members during the quarter by the respective rates described below. Said performance penalties apply only for claims received during the contract. Required performance standards and penalties applied when performance standards are not met are:

Performance Standard		Rating	Penalty	Rating	Penalty
Q1	98%	96%-98%	$0.35	less than 96%	$0.50
Q2	At least 99.5%	96%-98%	$0.35	less than 96%	$0.50
T1	At least 92%				$0.50
A1	5% or less				$0.25
S1	30 seconds or less				$0.25
B1	1% or less				$0.25

Consideration will be given the MAPD PLAN for the 1st quarter's performance standards with regard to the application of the financial penalties.

Pharmacy Claims Quality

Service Performance Guarantees	Standard	Measurement
1. Network Size	At least 93% of members will have 1 network pharmacy within 10 miles if any retail pharmacy is available in that distance. Bidder shall perform a GeoAccess analysis of members upon request of PEIA, and shall notify PEIA any time the number of network pharmacies in West Virginia decreases by 3%	Performance will be reported quarterly, if applicable. Penalties, if any, will be paid annually.

Service Performance Guarantees	Standard	Measurement
	or more	
2. Retail Point-of-Sale Claims Adjudication Accuracy	Bidder guarantees a financial accuracy rate of at least 98% for all Rx claims processed at point-of-sale.	Performance will be measured by an annual audit conducted by PEIA
3. Point-of-Sale Network System Downtime	Bidder guarantees that the claims processing system will be operating at least 99.5% of the time, based on 24 hours a day,, 7 days a week, 365 days a year, as measured annually on the Bidder's book-of-business.	Performance will be reported monthly. The guarantee will be measured and penalties, if any, will be paid annually.
4. Reporting Requirements	Bidder guarantees that all claims information will be available for electronic reporting within 10 business days after billing, and that Executive Reports and Performance Guarantee Reports will be available 45 days after the end of the calendar quarter	Performance will be measured monthly and reported quarterly. Penalties, if any, will be paid quarterly.
5. Desk Audits	Bidder will perform desk audits on at least 50% of network pharmacies each year.	Performance will be reported quarterly and measured annually. Penalties, if any will be paid annually.
6. On-Site Audits	Bidder will perform on-site audits of at least 10% of West Virginia pharmacies that are identified in desk audits as outliers, according to a mutually agreed-upon definition of outlier	Performance will be reported quarterly and measured annually. Penalties, if any will be paid annually.
7. Call Answering Time	Bidder guarantees that the average speed of answer (ASA) of member calls will not exceed 30 seconds, excluding calls abandoned before answering.	Performance will be measured monthly and reported quarterly. Penalties, if any, will be paid quarterly.
8. Call Abandonment Rate	Not more than 3% of member calls will be abandoned.	Performance will be measured monthly and reported quarterly. Penalties, if any, will be paid quarterly.
9. Call Answering Time to speak to Supervisor or Pharmacist	Bidder agrees that the average hold time to speak to supervisor or pharmacist, upon request, will not exceed 60 seconds.	Performance will be measured monthly and reported quarterly. Penalties, if any, will be paid quarterly.
10. Member Correspondence	Bidder shall respond to all correspondence from members and providers within an average of five (5) business days.	Performance will be measured monthly and reported quarterly. Penalties, if any, will be paid

Service Performance Guarantees	Standard	Measurement
		quarterly.
11. Mail Order	Bidder will guarantee that all mail service prescriptions will be shipped within an average of 2 business days for non-protocol prescriptions and 4 business days for protocol prescriptions	Performance will be measured monthly and reported quarterly. Penalties, if any, will be paid quarterly.
12. Successful Implementation	Bidder will guarantee that the implementation /transition will be successful based on criteria determined in advanced and agreed to by both parties and which will include: a.) 99% of members receiving welcome packet/ID cards prior to the effective data, b.) all systems are available and operational as of the effective date, c.) plan design and benefits set-up correctly, d.) member service representative are trained and delivering accurate information to members, e.) PEIA management staff is satisfied with implementation and account management team performance.	Performance will be measured and reported within 120 days from the effective date. Penalties, if any, will be paid within 180 days from the effective date.

APPENDIX D- Vendor Preference Certificate

Certification and application* is hereby made for Preference in accordance with West Virginia Code, §5A-3-37.

West Virginia Code, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the ***West Virginia Code***. This certificate for application is to be used to request such preference. PEIA will make the determination of the Resident Vendor Preference, if applicable.

A. Application is made for 2.5% preference for the reason checked:

____ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification;

or

____ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification;

or

____ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification.

B. Application is made for 2.5% preference for the reason checked:

____ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid;

or

____ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid.

Bidder understands if the Secretary of Tax & Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) rescind the contract or purchase order issued; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to PEIA and authorizes the Department of Tax & Revenue to disclose to the PEIA Director appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

*Check any combination of preference consideration(s) in either "A" or "B", request up to the maximum of 5% preference for both "A" and "B".

APPENDIX E – Preferred Drug List - replace with current PDL

The following is a list of the most commonly prescribed drugs. It represents an abbreviated version of the drug list (formulary) that is at the core of your prescription-drug benefit plan. The list is not all-inclusive and does not guarantee coverage. In addition to using this list, members are encouraged to ask their doctor to prescribe generic drugs whenever appropriate.

PLEASE NOTE: Not all the drugs listed are covered by all prescription-drug benefit programs; members are encouraged to check their benefit materials for the specific drugs covered and the copayments for their prescription-drug benefit

program. For specific questions about their coverage, members are to call the phone number printed on their ID card.

KEY:

- The symbol [INJ] next to a drug name indicates that the drug is available in injectable form only.
- The symbol [P] indicates that prior authorization may apply.
- The symbol [Q] indicates that quantities dispensed may be limited.
- The symbol [S] indicates that step therapy may apply.
- **For the member:** Generic medications contain the same active ingredients as their corresponding brand-name medications, although they may look different in color or shape. They have been FDA-approved under strict standards.
- **For the physician:** Please prescribe preferred products and allow generic substitutions when medically appropriate.
- Brand-name drugs are listed in CAPITAL letters.
- Generic drugs are listed in lower case, italicized letters.

A

ABILIFY, DISCMELT [Q]
acarbose
acetaminophen-codeine
ACTOPLUS MET, -XR [Q] [S]
ACTOS [Q] [S]
acyclovir
ADVAIR DISKUS, HFA [P] [Q]
ADVICOR [Q]
AGGRENOX
albuterol sulfate syrup, tab, tab sa
alendronate sodium [Q]
allopurinol
ALPHAGAN P 0.1% DROPS
amantadine
amiodarone hcl
AMITIZA
amitriptyline hcl
amlodipine besylate, -benazepril
amox tr-potassium clavulanate
amoxicillin
apraclonidine
APRISO
ARANESP [INJ] [P]
ARICEPT, ODT
(excluding 23mg) [S]
ARIXTRA [INJ]
ASMANEX [Q]
atenolol
AVANDAMET [Q] [S]
AVANDARYL [Q] [S]
AVANDIA [Q] [S]
AVELOX, ABC PACK
aviane
AZASITE
azathioprine [P]
azelastine [Q]
azithromycin [Q]

B

baclofen
balsalazide
BARACLUDE
benztropine mesylate
BETASERON [INJ] [P] [Q]
betaxolol hcl
bisoprolol fumarate-hctz
BONIVA tab [Q] [S]
brimonidine tartrate
budeprion sr, xl [Q]
buspirone hcl
butalbital-caff-apap-codeine
BYETTA [INJ] [P] [Q]

C

calcitriol
CANASA
carbamazepine, xr
carbidopa-levodopa
carvedilol
cefdinir
cefuroxime, axetil
CELEBREX [S]
cephalexin
chlorhexidine gluconate dental rinse
cholestyramine light
ciclopirox [P]
CIPRODEX
ciprofloxacin er, hcl
citalopram, hbr [Q]
clarithromycin, er
clindamycin hcl, phosphate
clonidine hcl
clonidine patch [Q]
clotrimazole-betamethasone
COMBIGAN [S]
COMBIVIR
COMTAN
COPAXONE [INJ] [P] [Q]
CREON DR
CRESTOR [Q] [S]
cyclosporine cap, soln [P]
CYMBALTA [Q] [S]

D

desipramine hcl
diclofenac sodium
didanosine
digoxin
diltiazem er, hcl
DIOVAN, -HCT [S]
dorzolamide, -timolol
doxazosin mesylate [Q]
doxepin hcl
doxycycline hyclate, monohydrate
dronabinol [P]
DUETACT [Q] [S]

E

EFFIENT
ELIDEL [S]
eliphos
EMEND [P] [Q]
ENABLEX [S]
enalapril maleate, -hctz
ENBREL [INJ] [P]
enulose
EPIVIR, -HBV
EPZICOM
erythromycin, ethylsuccinate
estradiol [Q]
estradiol-noreth
EURAX
EVISTA
EXELON PATCH [S]
EXFORGE, HCT [S]

F

famciclovir [Q]
famotidine
fenofibrate
fentanyl citrate [P] [Q]
fentanyl patch
fexofenadine hcl [Q]
finasteride
fluconazole [P] [Q]
flunisolide [Q]
fluocinolone acetonide
fluocinonide, emollient, -e
fluorometholone
fluoxetine hcl [Q]
fluticasone propionate [Q]
fluvoxamine maleate [Q]
FORADIL [Q]
FORTEO [INJ] [P] [Q]
fortical
FROVA [Q]
furosemide

G

gabapentin
gemfibrozil
GEODON [Q]
glimepiride
glipizide, er, xl, -metformin
GLUCAGEN [INJ]
glyburide, micronized, -metformin hcl

GRIFULVIN V

H

haloperidol, lactate
HUMIRA [INJ] [P] [Q]
hydralazine hcl
hydrochlorothiazide
hydrocodone-acetaminophen
hydroxyzine hcl, pamoate [P]

I

ibuprofen
imiquimod
isosorbide dinitrate, mononitrate

J

jantoven
JANUMET [Q]
JANUVIA [Q]

K

ketoconazole
ketorolac [Q]

L

lamotrigine
lansoprazole [Q]
LANTUS vials (excluding cartridges and solostar) [INJ]
LETAIRIS [P]
LEVEMIR vials (excluding cartridges) [INJ]
levetiracetam
levocarnitine
levothyroxine sodium
levoxyl
LEXIVA
LIDODERM [P]
LIPOFEN [S]
lisinopril, -hctz
lithium carbonate
losartan, -hctz [S]
lovastatin [Q]
LOVAZA
LOVENOX [INJ]
low-ogestrel
LUMIGAN
LYRICA [S]

M

MAXALT, MLT [Q]
meclizine hcl
medroxyprogesterone acetate [Q]
MEGACE ES
meloxicam [Q]
MENEST
MEPRON
metaxalone [P]
metformin hcl, er
methadone hcl
methotrexate [P]
methylprednisolone
metoclopramide hcl
metolazone
metoprolol succinate, tartrate
metronidazole
MICARDIS, -HCT [S]
mirtazapine
misoprostol
morphine sulfate [Q]
mupirocin
mycophenolate mofetil [P]
MYFORTIC [P]

N

NAMENDA
naproxen
nateglinide
necon
neomycin-polymyxin-dexameth
neomycin-polymyxin-hc
NEXIUM [Q] [S]
NIASPAN
nitrofurantoin, macrocrystal
nitroglycerin inj, patch
nortriptyline hcl
NOVOFINE, 32, AUTOCOVER
NOVOLIN [INJ]
NOVOLOG [INJ]
nystatin
nystatin-triamcinolone

O

ofloxacin
omeprazole [Q]
ondansetron hcl, odt [P] [Q]
ONGLYZA [Q]

OPANA ER [Q] [S]
OSMOPREP
OXSORALEN-ULTRA, LOTION
oxybutynin chloride, er [Q]
oxycodone, -apap, -ibuprofen
oxycodone er [Q]

P

pacerone tab 200 mg
paroxetine hcl [Q]
PEGASYS [INJ] [P] [Q]
penicillin v potassium
phenytoin sodium extended
pilocarpine hcl
PLAVIX
potassium chloride
pravastatin sodium [Q]
prednisolone acetate,
sodium phosphate
prednisone
PREMPHASE
PREMPRO
primidone
PRISTIQ [Q] [S]
PROAIR HFA [Q]
prochlorperazine maleate
PROCRIT [INJ] [P]
promethazine hcl [P]
PROVENTIL HFA [Q]

Q

quinapril hcl, -hctz
QVAR [Q]

R

ramipril
RANEXA
ranitidine hcl
RELENZA [Q]
RENVELA
reprexain
RESCRIPTOR
RESTASIS [Q]
REYATAZ
ribavirin
RIOMET
risperidone, odt [Q]
ropinirole hcl

S

SANCTURA XR [S]
SANTYL
SAPHRIS [Q]
SAVELLA [Q] [S]
selegiline hcl
SELZENTRY
SEROQUEL, XR [Q]
sertraline hcl [Q]
SIMCOR [Q]
simvastatin [Q]
SINGULAIR
SOLARAZE [P]
SPIRIVA [Q]
spironolactone, -hctz
STALEVO
STRATTERA [S]
sulfamethoxazole-trimethoprim
sumatriptan tab, inj [Q]
SUSTIVA
SYMBICORT [P] [Q]
SYMLIN, PEN [INJ] [P] [Q]

T

tamoxifen citrate
tamsulosin
TASMAR
TAZORAC [P]
TEKTURNA, -HCT [S]
terazosin hcl [Q]
terbinafine hcl [P]
TESTIM [P]
testosterone cypionate,
enanthate [INJ]
tetracycline hcl
thioridazine hcl
timolol, maleate
tizanidine hcl
torsemide
TRACLEER [P]
tramadol hcl,
-acetaminophen [Q]
trandolapril hcl, -verapamil
trazodone hcl
triamcinolone acetonide
triamterene-hctz
trihexyphenidyl hcl
trimethoprim

TRIZIVIR
TWYNSTA [S]

U

ULORIC [S]
UROXATRAL
ursodiol

V

VAGIFEM
valacyclovir [Q]
venlafaxine [Q]
verapamil er, hcl
veripred 20
VIDEX pediatric soln
VIGAMOX
VIRACEPT
VYTORIN [Q] [S]

W

warfarin sodium

X

XALATAN

Z

zaleplon [Q]
zamicet
ZETIA [S]
ZIAGEN
zidovudine
zolpidem tartrate [Q]
zonisamide [P]
ZYCLARA
ZYLET
ZYPREXA, ZYDIS [Q]

Examples of Nonformulary Medications With Selected Formulary Alternatives

The following is a list of some nonformulary brand-name medications with examples of selected alternatives that are on the formulary.

- Column 1 lists examples of nonformulary medications.
- Column 2 lists some alternatives that can be prescribed.

Nonformulary	Formulary Alternative
ACCOLATE	SINGULAIR
ACIPHEX	*lansoprazole* [Q], *omeprazole* [Q], NEXIUM [Q] [S]
ACTONEL – WITH CALCIUM	*alendronate tablet* [Q], BONIVA TAB [Q] [S]
ALTOPREV	*lovastatin* [Q], *pravastatin* [Q], *simvastatin* [Q], CRESTOR [Q] [S], VYTORIN [Q] [S]
AMBIEN CR	*zaleplon* [Q], *zolpidem* [Q]
ANTARA	*fenofibrate*, LIPOFEN [S]
APIDRA	NOVOLOG
ATACAND	*losartan* [S], DIOVAN [S], MICARDIS [S]
ATACAND HCT	*losartan/hctz* [S], DIOVAN HCT [S], MICARDIS HCT [S]
AVALIDE	*losartan/hctz* [S], DIOVAN HCT [S], MICARDIS HCT [S]

AVAPRO	*losartan* [S], DIOVAN [S], MICARDIS [S]
AVODART	*finasteride*
AZOPT	*dorzolamide*, ALPHAGAN P 0.1% DROPS, COMBIGAN [S]
BENICAR	*losartan* [S], DIOVAN [S], MICARDIS [S]
BENICAR HCT	*losartan/hctz* [S], DIOVAN HCT [S], MICARDIS HCT [S]
CARDURA XL	*doxazosin* [Q], UROXATRAL
DETROL, -LA	*oxybutynin er* [Q], ENABLEX [S], SANCTURA XR [S]
DEXILANT	*lansoprazole* [Q], *omeprazole* [Q], NEXIUM [Q] [S]
EFFEXOR XR	*venlafaxine er* [Q], CYMBALTA [Q] [S]
FACTIVE	*ciprofloxacin*, *ofloxacin*, AVELOX
FENOGLIDE	*fenofibrate*, LIPOFEN [S]
FIBRICOR	*fenofibrate*, LIPOFEN [S]
HUMALOG	NOVOLOG
HUMILIN	NOVOLIN
LANTUS cartridge – SOLOSTAR	LANTUS VIALS, LEVEMIR VIALS
LEVAQUIN	*ciprofloxacin/er*, *ofloxacin*, AVELOX
LEVEMIR FLEXPEN	LEVEMIR VIALS, LANTUS VIALS
LEXAPRO	*fluoxetine* [Q], *citalopram* [Q], *paroxetine/er* [Q], *sertraline* [Q]
LIPITOR	*lovastatin* [Q], *pravastatin* [Q], *simvastatin* [Q], CRESTOR [Q] [S], VYTORIN [Q] [S]
LUNESTA	*zaleplon* [Q], *zolpidem* [Q]
LUVOX CR	*fluvoxamine* [Q], *fluoxetine* [Q], *paroxetine/er* [Q], *sertraline* [Q]
MAXAIR AUTOINHALER	PROAIR HFA [Q], PROVENTIL HFA [Q]
PROTONIX	*lansoprazole* [Q], *omeprazole* [Q], NEXIUM [Q] [S]
RAPAFLO	*tamsulosin*, UROXATRAL
TEVETEN	*losartan* [S], DIOVAN [S], MICARDIS [S]
TEVETEN HCT	*losartan/hctz* [S], DIOVAN HCT [S], MICARDIS HCT [S]
TOVIAZ	*oxybutynin er* [Q], ENABLEX [S], SANCTURA XR [S]
TRAVATAN Z	LUMIGAN, XALATAN
TRICOR	*fenofibrate*, LIPOFEN [S]

TRIGLIDE	*fenofibrate*, LIPOFEN [S]
TRILIPIX	*fenofibrate*, LIPOFEN [S]
VENTOLIN HFA	PROAIR HFA [Q], PROVENTIL HFA [Q]
VESICARE	*oxybutynin er* [Q], ENABLEX [S], SANCTURA XR [S]
XOPENEX HFA	PROAIR HFA [Q], PROVENTIL HFA [Q]
ZEGERID	*lansoprazole* [Q], *omeprazole* [Q], NEXIUM [Q] [S]

APPENDIX F – Limited Data Use Agreement

A limited data set is a set of records containing protected health information (PHI), from which direct identifiers have been removed, but in which certain potentially identifying information remains. The use or disclosure of a limited data set is limited to research, public health, and health care operations purposes only.

Name of data recipient:

Description of data: De-identified PEIA Paid Claims Data for its retiree population.

Purpose of use: PEIA will be disclosing a limited data set to health plans that will be submitting bids in response to this RFP as part of its health care operations. The data will be used by bidding health plans to prepare the cost estimate portion of its proposal.

By signing this agreement the recipient agrees:

- Not to further use or disclose any of the information, outside the purpose listed above, without prior written permission from PEIA or as otherwise required by law;
- That any further information requested by Recipient, or its Affiliates, regarding these reports must be made in writing to PEIA.
- Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the data use agreement;
- Report to PEIA any use or disclosure of the information not provided for by its data use agreement, of which it becomes aware;
- Ensure that any agent, including any affiliates, to whom it provides the limited data set agrees to the same restrictions and conditions that apply to the limited data set recipient with respect to such information; and
- Not to identify the information or to contact the individuals to whom the information pertains, if applicable.
- Properly and completely dispose of all data provided by PEIA upon completion of the project described above in "Purpose of use."

PEIA may terminate the agreement if it notifies the recipient of a pattern of activity or practice that constitutes a material breach or violation of the data use agreement, or law, unless the recipient cures the breach or ends the violation within a reasonable time, as determined by PEIA. PEIA will take reasonable steps to cure the breach or end the violation and if such steps are unsuccessful PEIA will discontinue disclosure and report the violation to the appropriate authorities.

_____ _____

Signature of Recipient Representative Date

_____ _____

Signature of PEIA Representative Date

APPENDIX G – Financial Cost Proposal Form

PEIA will consider any further risk sharing arrangements offered by the bidder which will allow it a positive financial benefit in the event of successful underwriting

experience. The bidder must provide a detailed explanation of any such arrangement that it wishes to propose.

Option 1 - Medical Plan with PEIA Prescription Drug Formulary

	Medical Plan	Drug Plan	Combined Medical and Drug Plan
Medical Claims			
Drug Claims			
Administration Cost			
Profit Allowance			
Total Annual Per			
Medicare Contract			
Monthly Capitation Bid Total			
Less CMS Capitation			
PEIA Capitation Per Contract			

Option 2 - Medical Plan with Vendor's Prescription Drug Formulary

	Medical Plan	Drug Plan	Combined Medical and Drug Plan
Medical Claims			
Drug Claims			
Administration Cost			
Profit Allowance			
Total Annual Per			
Medicare Contract			
Monthly Capitation Bid Total			
Less CMS Capitation			
PEIA Capitation Per Contract			

Option 3 - ASO Arrangement for Medical Plan with PEIA's Prescription Drug Formulary

	Medical Plan	Drug Plan	Combined Medical and Drug Plan

Medical Claims			
Drug Claims			
Administration Cost			
Profit Allowance			
Total Annual Per			
Medicare Contract			
Monthly Capitation Bid Total			
Less CMS Capitation			
PEIA Capitation Per Contract			

Option 4 - ASO Arrangement for Medical Plan with Vendor's Prescription Drug Formulary

	Medical Plan	Drug Plan	Combined Medical and Drug Plan
Medical Claims			
Drug Claims			
Administration Cost			
Profit Allowance			
Total Annual Per			
Medicare Contract			
Monthly Capitation Bid Total			
Less CMS Capitation			
PEIA Capitation Per Contract			

Appendix H – Data Warehouse Electronic File Exchange Layout

Column	Data Type	Length	Comments
PTID	VARCHAR2	17	Internal pt id. Comprised of insured SSN plus pt DOB

ASG	CHAR	2	Age and gender cell
CLM_MATCH_STAT	CHAR	1	Claim matching status to eligibility
CMPNY	CHAR	6	HealthSmart accounting structure
PLAN	CHAR	4	HealthSmart accounting structure
CLM_NBR	CHAR	8	Claim number
LINE_NBR	CHAR	4	Service line item number
CLM_MSTR_NBR	CHAR	8	Linked claim ID
IP_OP	CHAR	1	Inpatient / Outpatient flag
PLACE	CHAR	1	HealthSmart place of service
HIAA_PLACE	CHAR	2	CMS place of service
ASSGN_CODE	CHAR	1	Assignment code
EXPNS_CODE	CHAR	6	HealthSmart expense code
PROC	CHAR	5	Procedure / UB92 revenue code
PROC_MOD_1	CHAR	2	Procedure modifier
CPT_DESCP	CHAR	30	Procedure / UB92 service description
PDX	CHAR	5	Primary diagnosis
DX2	CHAR	5	Diagnosis 2
DX3	CHAR	5	Diagnosis 3
DX4	CHAR	5	Diagnosis 4
DX5	CHAR	5	Diagnosis 5
PDX_DESCP	CHAR	30	Primary diagnosis description
EOB_CODE_1	CHAR	2	EOB Code 1
EOB_TYPE_1	CHAR	3	EOB Code 1 Type
EOB_CODE_2	CHAR	2	EOB Code 2
EOB_TYPE_2	CHAR	3	EOB Code 2 Type
CAUSE	CHAR	1	HealthSmart claim cause code
DUPL_STAT	CHAR	1	Duplicate status
REV_CODE	CHAR	3	UB92 Bill type
INELG_TYPE_1	CHAR	4	HealthSmart ineligible charge code 1
INELG_TYPE_2	CHAR	4	HealthSmart ineligible charge code 2
INELG_TYPE_3	CHAR	4	HealthSmart ineligible charge code 3
INELG_TYPE_4	CHAR	4	HealthSmart ineligible charge code 4
INELG_TYPE_5	CHAR	4	HealthSmart ineligible charge code 5
IPROC1	VARCHAR2	8	ICD9 procedure code 1
IPROC2	VARCHAR2	8	ICD9 procedure code 2
DRG	CHAR	4	DRG assigned by HealthSmart
DRG_2	CHAR	4	DRG assigned during UR process (NO LONGER VALID)
PROC_TYPE	CHAR	3	Procedure type
DSCNT_EXCEP	CHAR	1	Exception flag for % discount
FEE_EXCEP	CHAR	1	Exception flag for fee schedule
PROV_PPO_ID	CHAR	4	Provider PPO ID
DSCNT_PCT	NUMBER	22	Discount % taken
EXAMR_NBR_1	NUMBER	22	Claim examiner ID
EXAMR_NAME_1	CHAR	30	Claim examiner name
EXAMR_NBR_2	NUMBER	22	Claim examiner ID (reviewer)
EXAMR_NAME_2	CHAR	30	Claim examiner name (reviewer)
EE_SSN	CHAR	10	Employee SSN
PT_SSN	CHAR	10	Patient SSN

PT_FNAME	CHAR	15	Patient first name
PTREL	CHAR	1	Patient relationship
PT_STAT	CHAR	3	Patient status (UB92 discharge status)
LOC	CHAR	4	HealthSmart location code
COV_CODE	CHAR	1	HealthSmart coverage code
PTAGE	NUMBER	22	Patient age at date of service
PTDOB	DATE	7	Patient DOB
PTSEX	CHAR	1	Patient gender
STUDT_STAT	CHAR	1	Student status
HCN	CHAR	1	Handicapped indicator
MEDCR_CLM	CHAR	1	Medicare indicator
MEDCR_MEDCL_ELECT	CHAR	1	Medicare eligible indicator
MEDCR_HOSP_ELECT	CHAR	1	Medicare Part A indicator
MEDCR_ELIG_START	DATE	7	Medicare effective date
EE_ZIP	CHAR	11	Employee ZIP
MARTL_STAT	CHAR	1	Marital status
MARTL_DATE	DATE	7	Married date
EE_STAT	CHAR	1	Employee status
ELIG_START	DATE	7	Eligibility effective date
ELIG_STOP	DATE	7	Eligibility ending date
PPO_ID	CHAR	4	PPO ID
PROV_ID	CHAR	11	Provider ID
PROV_NAME	CHAR	30	Provider Name
PROV_ZIP	CHAR	11	Provider ZIP code (pay to)
PROV_TYPE	CHAR	3	Provider type
PROV_SPEC	CHAR	6	Provider specialty
WV_FLG	CHAR	1	In-state vs. out of state
BEN_YEAR	NUMBER	22	Benefit year
INCUR_DATE	DATE	7	Beginning date of service
STOP_DATE	DATE	7	Ending date of service
ENTRY_DATE	DATE	7	Keypunch / read date
ADMIT_DATE	DATE	7	Admission date (if applicable)
CONFN_START_DATE	DATE	7	Confinement start date (if applicable)
CONFN_STOP_DATE	DATE	7	Confinement stop date (if applicable)
DISCH_DATE	DATE	7	Discharge date (if applicable)
RECVD_DATE	DATE	7	Claim received date
ADJ_DATE	DATE	7	Adjustment date
PRCSS_DATE	DATE	7	Processed date
SUB	NUMBER	22	Submitted charge
NOT_COVER	NUMBER	22	Not covered amount
PAID	NUMBER	22	Amount paid
MM_DED	NUMBER	22	Major medical deductible
COINS	NUMBER	22	Coinsurance paid
INELG_AMT	NUMBER	22	Ineligible amount
RANDC	NUMBER	22	Reasonable and customary charge
COB	NUMBER	22	COB collected
BASE_AMT	NUMBER	22	Base amount
MEDCR_RDCTN	NUMBER	22	Medicare reduction

BASIC_DED	NUMBER	22	Base deductible
RX_DED	NUMBER	22	Pysc / Drug deductible
PPO_DSCNT	NUMBER	22	PPO discount
PROC_SCHED_AMT	NUMBER	22	Procedure schedule amount
DAY	NUMBER	22	Days
VISIT	NUMBER	22	Number of visits
SAVNG	NUMBER	22	Unbundling savings
INELG_AMT_1	NUMBER	22	Ineligible amount 1
INELG_AMT_2	NUMBER	22	Ineligible amount 2
INELG_AMT_3	NUMBER	22	Ineligible amount 3
INELG_AMT_4	NUMBER	22	Ineligible amount 4
INELG_AMT_5	NUMBER	22	Ineligible amount 5
GROSS_PAID	NUMBER	22	Gross paid
RANDC_70TH	NUMBER	22	70th percentile of R and C
RANDC_80TH	NUMBER	22	80th percentile of R and C
RANDC_90TH	NUMBER	22	90th percentile of R and C
OOP	NUMBER	22	Out-of-pocket
CD_COINS	NUMBER	22	Coinsurance 2
MEDCR_ALLOW	NUMBER	22	Medicare allowed
MEDCR_PAID	NUMBER	22	Medicare paid
ALLOW	NUMBER	22	Covered charges
CHECK_NBR	CHAR	10	Check number
TAPE_DATE	DATE	7	Tape date
PAID_DATE	DATE	7	Paid date
EOB_TYPE_1A	CHAR	1	EOB type 1
EOB_TYPE_2A	CHAR	1	EOB type 2
REV_CODE_NEW	CHAR	4	Revenue code detail
EXTRA_CONTR	CHAR	1	Extra contractual allowance flag
PROC_DETL	CHAR	8	Procedure detail
EE_UNIQU_ID	CHAR	12	Employee unique id (HealthSmart)
PT_UNIQU_ID	CHAR	4	Patient number (HealthSmart)
IN_OUT_FLG	CHAR	1	Instate / out of state flag
SAVNG_IND	CHAR	1	Savings indicator
TTL_SAVNG	NUMBER	22	Total savings (not valid)
APC	VARCHAR2	5	APC code
APC_STATUS	VARCHAR2	1	APC status code
APC_LINE_FLAG	VARCHAR2	1	APC pricing flag
APC_ALLOW	NUMBER	22	APC allowed
APC_OUTLIER	NUMBER	22	APC outlier allowance
DRG_INLIER	NUMBER	22	DRG inlier payments
DRG_OUTLIER	NUMBER	22	DRG outlier payments
DRG_LOW_VOLUME	NUMBER	22	DRG low volume payments
DRG_BILLED	NUMBER	22	DRG billed amount
DRG_ALLOW	NUMBER	22	DRG allowed amount
DRG_TRANSFER	NUMBER	22	DRG transfer payments