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LACERS Health Plan Consulting Services RFP Q&A

For March 31, 2023 Posting

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About LACERS and Medical Plans Q&A

1. **Question**: Thank you for providing the information relative to employer contribution. Please provide either (a) average monthly employer contribution for retirees and dependents (b) average service Credit or (c) a revised census that includes service credit by retiree in order to calculate the average employer contribution.

   Answer: LACERS does not provide that information separate from the Actuarial, Statistical, Committee and Board reports posted on LACERS website. Information regarding employer contribution and actuarial assumptions are published. Bidders may find reports using LACERS' website search bar.

2. **Question**: Within the RFP, it is indicated that there are approximately 4,200 members who do not participate in LACERS-sponsored medical plans. Please clarify if these members can choose to re-join the plan during open enrollment. If so, can you confirm if the members listed on the 'No Medical Subscribers' tab within the census is representative of this membership? Do all of these members have both Medicare Parts A and B as primary? If not, can an indicator be added to the census to indicate which member have Medicare Parts A and B as primary?

   Answer: LACERS Retired Members who do not currently participate in LACERS-sponsored medical plans can enroll in a plan during Open Enrollment or when they experience qualifying events; refer to the LACERS Health Benefits Guide. Yes, the members listed on the 'No Medical Subscribers' tab within the census are representative of this membership. Their Medicare Status is unknown and cannot be added to the census.

3. **Question**: Can you explain why 25% of the population has waived coverage and where are they getting coverage?

   Answer: No, LACERS does not ask nor capture that information. LACERS Retired Members can choose to obtain their medical coverage through LACERS-sponsored medical plans or medical plans offered in the health insurance marketplace based on their personal preferences.

4. **Question**: Are the metrics requested for Performance, Trend, and Margin Guarantees in place with the current vendors?

   Answer: Currently, LACERS carriers have Performance Guarantees in place. In addition, LACERS has established various initiatives under the LACERS Strategic Plan (page 13, or 15 of file, of LACERS' Strategic Plan 2019-20 document) for future Performance, Trend, and Margin Guarantees. Additionally, please see Attachment B, tab H "Performance Guarantees" and the attached spreadsheet with update timeframes. If there is a timeframe difference between Attachment B and the attached spreadsheet, the attached spreadsheet should be used as reference.

5. **Question**: Does each current vendor presently provide dedicated Member Advocate resources and phone number?

   Answer: Yes, each carrier provides an account team and as-needed member-specific support, such as a case manager.

6. **Question:** What are examples of the administrative assistance members utilizing through the self-service member tools offered today?

   Answer: Current carriers have either established microsites under the LACERS website and/or have apps members can use to log-in to find doctors, schedule medical appointments, print their medical cards, copies of Evidence of Coverage, etc.

7. **Question**: What metrics are in place for measuring and managing oversight of LACERS members and physicians or other health service providers with respect to service and quality?

   Answer: See response to Question #4.

8. **Question**: Are all incumbent vendors contributing towards LACERS wellness program?

   Answer: Yes.

9. **Question**: Is baseline metric data available by plan for establishing the current level of engagement, clinical adherence, etc. for LACERS Wellness Program?

   Answer: No.

10. **Question**: Confirming that all participants should mirror the current benefits for the plans being quoted per the SPD's, benefit summaries, and enrollment guide? If there is the ability to provide richer benefits at a lower cost than what's in-force, are respondents encouraged to do so?

    Answer: Yes, and yes.

Minimum Qualifications and Scope of Services-Related Q&A

11. **Question**: **Minimum Qualification –** Are incumbent carriers expected to provide Provider Disruption, Facility Disruption, PPO Network Analysis and Prescription Drug Analysis applicable to the coverage they are proposing? If so, please specify the timeframe to analyze for Provider Disruption, Facility Disruption and RX Tier Disruption Summary.

    Answer: Proposers, whether incumbents or non-incumbents, are expected to complete the exercises requested as sent with the data in accordance with the timing provided in the T+RFP and any extensions allowed through the Addendums. Please note some exercises have been modified, and an updated Exercise file was provided after the NDAs were received.

12. **Question**: **Scope of Services –** Are proposers required to provide responses to each service listed in A through L, or just provide applicable exceptions to the services listed? Much of this information overlaps with the RFP Questionnaire, so we do not want to be duplicative.

    Answer: Proposers are asked to specify their ability to provide the services listed in A through L. If a Proposer cannot provide any of the services, the Proposer must so indicate in their response to this RFP in Exhibit C.

13. Question: Please confirm you do not expect bidders to provide written responses to each section in Section II. Minimum Qualifications (Organizational Structure, Strength, and Plan Sponsor Services; Administration Support & Account Management; Member Quality of Care, Resources, and Services; Access to Care/Network; Cost Proposal and Plan Design).
Answer: Proposers are expected to provide responses that clearly demonstrate they meet the minimum qualifications for their Request for Proposal to be considered.

14. Question: Please confirm you do not expect bidders to provide written responses to each item in Section III. Scope of Services. Please confirm it is acceptable for bidders to provide a blanket statement that they have the ability to provide all services in the Scope of Services and note any services they cannot provide.
Answer: Proposers are expected to provide responses that specify their ability to provide the services listed in Section III.

15. Question: Page 15, Item B, 5. Accept eligibility reporting on a monthly or more frequent basis with a twenty-four (24) hour upload turnaround time to assure timely eligibility capture. Please clarify what is typically provided by LACERS in the eligibility reporting. What is the format used for the reports (i.e. Excel or FTP)? Would the report from LACERS include only changes or would the data be a full file for a monthly reconciliation?
Answer: LACERS currently provides carriers with an 834 electronic eligibility file which includes LACERS' full enrollment. This is generated every 3rd week of the month and uploaded for coverage effective the 1st of the following month. Separately, LACERS uploads PDF copies of Medicare plan enrollment forms to the carriers at the end of the month for manual enrollments, as the 834 files do not capture CMS required fields for electronic enrollment.

16. Question: Page 17, Item D, 8. Provide LACERS the Medicare plan enrollment forms (senior forms) for the new plan year before LACERS' annual Open Enrollment. How do LACERS participants conduct their enrollment during OE and during a SEP? Are participants required to elect directly through LACERS, who then provides the eligibility enrollment to each

carrier? Or does each participant elect coverage by completing an application directly with the carrier of choice?

Answer: LACERS receives enrollment applications from participants and submits these applications to the respective carriers. LACERS requires all participants to submit Medicare plan enrollment/application forms directly to LACERS. LACERS then provides softcopies (e.g. PDF copies) of these applications to the respective carrier manually through the carrier's portal.

17. **Question**: Page 19, Item G. Member Satisfaction Survey. Provide and coordinate a member survey, online or via mail, for the LACERS Retirees, Survivors and Dependents to measure and monitor the overall satisfaction of its plans. The survey should conform to the National Committee for Quality Assurance (NCQA) requirements and be accredited under NCQA standards, as well as having options for online and mailed surveys. The overall survey costs are to be provided by the carrier. Would LACERS be open to Net Promoter Survey measures currently utilized by the carrier for measuring customer satisfaction? This allows LACERS member satisfaction results to be measured and aligned with the overall book of business.

    Answer: Yes.

18. **Question:** Please outline any care management, wellness, or disease management programs in place today on the Pre-65 population.

    Answer: There are no current programs in place that are specific to the Pre-65 population. The current LACERS Wellness Program is geared towards all members regardless of age.

19. **Question**: Can you please inform us of the specific Wellness Allowance amount?

    Answer: Refer to pages 9, 17, 18 of the RFP for a description of the Wellness requirements. The funds to Wellness also include open enrollment allotments.

Carrier	2020	2021	2022
Anthem (including Blue View Vision)*	$400,000	$250,000	$250,000
Kaiser*	$150,000	$148,725	$148,725

SCAN**	$10,500	$10,500	$10,500
UHC**	$8,500	$8,500	$8,500

*Built into rates
**Not built into rates

RFP Compliance Q&A

20. Question: What is the City's expectations with regard to the Standard Provisions for the City Contracts with form? Are bidders permitted to revise the terms of the Standard Provisions for the City Contracts with form, if needed, to be consistent with federal laws and regulations applicable to the Medicare Advantage program?

Answer: Any requests to carve out an exception to the City's Standard Provisions or LACERS' General Conditions must be provided in writing and included in your proposal for LACERS' consideration. Many of the City's Standard Provisions are grounded in local, state, or federal law, and cannot be altered.

21. Question: In 07_attachment_6_-_bidder_cec_form_55_2 Can you please provide Schedule A and Schedule B referenced in the form?

Answer: Schedule A and B are pages 2 and 3 of Form 55.

22. Question: ***02 Attachment 1 – Confidentiality & Non-Disclosure of Member Information.pdf* file –** This form does not include a signature section. Does the form need to be signed?

Answer: This attachment is informational; it does not need to be signed.

23. Question: ***05 Attachment 4 – Proposer Disclosure Form* –** The Proposer Disclosure form instructs disclosure of personal and business relationships and dates and nature of contacts. Does this include activities for managing in force business as usual (ex. standing bi-weekly meetings, board meetings, etc.)?

Answer: Yes, bidders are instructed to provide information regarding business contacts. Incumbents can provide a general description of business activities, such as, standing bi-weekly meetings, board meetings, daily member-related LACERS contacts, etc.

Proposal Submissions Q&A

24. Question: Will there be a Best and Final Offer (BAFO) period?

Answer: No. Per Page 24 of RFP: Proposals shall include the Proposer's best terms and conditions. Submission of proposal(s) shall constitute a firm and fixed offer to LACERS that will remain open and valid for a minimum of 12 months from the proposal submission deadline. There will be no opportunity provided to improve upon your pricing position nor any content of your RFP response.

25. Question: **Proposal Submission & Evaluation –** The instructions indicate to provide a Microsoft Word version of all components except the questionnaire. For the other (non-questionnaire) tab within the *Attachment A - Exhibits for Medical Plan RFP.xlsx* and *Attachment B - LACERS Exercises for Medical Plan RFP.xlsx* files, may we reply within the original Excel format LACERS has provided?

Answer: Pursuant to the RFP on page 24, submit electronically in the following three (3) different formats: Adobe PDF, Microsoft Word (all components except the questionnaire), and Microsoft Excel (questionnaire only).

26. Question: **Proposal Submission & Evaluation –** The instructions indicate to provide a cover letter and proposal declaration. Are these to be the same document or separate documents? If separate, do we need to repeat items 1-21 in both documents?

Answer: Bidders are to submit all documents as instructed. Items 1-21 do not need to be repeated.

27. Question: Respectfully, could carriers submit the RFP response on the 6th but submit the pricing for Medicare Plans on the 13th to ensure the most accurate pricing after the release of the Final Rate Notice for 2024 CMS Funding?

Answer: See LACERS Medical Plans RFP webpage for addendum regarding RFP submission.

28. **Question**: As a Staff Model and an integrated delivery system providing direct care to members, Kaiser Permanente's 2024 budgeting process is not completed until early April 2023. This budgeting process is very similar to how a hospital system would budget and is distinctly different than other insurance carriers in how premium rates are developed. Given that the 2024 operating budget and subsequent rating model are not finalized until early April 2023, Kaiser Permanente is unable to meet the requested due date of April 6, 2023, for the 2024 RFP in providing renewal rates for health benefits.
    - We would like to request an extension of April 21 to provide commercial rates (Non-Medicare) and the 2024 RFP responses.
    - We would like to request an extension for the Medicare rates to be received June 30th. Kaiser Permanente's rating model for the Medicare Advantage plan is released mid-June.

    We appreciate your time in considering our request for an extension, as this timeframe is the same for other customers (which includes other counties, cities, and school districts in California).
    Answer: See LACERS Medical Plans RFP webpage for addendum regarding RFP submission. In response to the additional request for an extension for Medicare rates till June, please provide as part of the proposal the best possible indication of the Medicare rates for 2024 with an explanation of possible changes to these rates.

29. **Question:** Will LACERS consider an extension of the due date, by a minimum of two weeks?
    Answer: See LACERS Medical Plans RFP webpage for addendum regarding RFP submission.

30. **Question:** Given the timing of the question-and-answer period, and to appropriately allow for review of final CMS notice for 2024 which is expected to be released during the first week of April, would you please extend the RFP due date?
    Answer: See LACERS Medical Plans RFP webpage for addendum regarding RFP submission.

31. **Question:** Will LACERS extend the RFP deadline by one week, to Thursday, April 13, 2023 at 5:00 P.M. PST?

Answer: See LACERS Medical Plans RFP webpage for addendum regarding RFP submission.

32. Question: Will a printed copy of the LACERS Proposal be required for submission?

Answer: No. Proposers are to submit their documents via the electronic submission link located on the first page of the Medical Plans RFP, or by USB drive in the mail to the address indicated on said page.

33. Question: Please consider electronic submission only, considering the compressed timeline.

Answer: Yes. You may submit your documents via the electronic submission link located on the first page of the Medical Plans RFP. The maximum file size limit for LACERS' Box upload is 32 GB. If your files are larger, we suggest compressing the folder/files. Bidders are advised to test the upload link prior to the deadline to ensure that the link, systems-related, file size capabilities, and any firewall issues are addressed. Please allow enough time to upload your complete proposal.

34. Question: Would you be willing to accept email or FTP (example: OneDrive) submission as opposed to the link provided in the RFP?

Answer: No. Proposers are to submit their documents via the electronic submission link located on the first page of the Medical Plans RFP, or by USB drive in the mail to the address indicated on said page. Bidders are advised to test the upload link prior to the deadline to ensure that the link, systems-related, file size capabilities, and any firewall issues are addressed. Please allow enough time to upload your complete proposal.

Attachment A Q&A

35. Question: Regarding the subcontractor disclosure form, please confirm this only applies to subcontractors hired specifically for this contract.

Answer: Yes, only subcontractors applicable to this contract.

36. Question: ***Attachment A, tab D – Subcontractor Disclosure –*** What is the expectation for responding fully to requests such as disclosing all subcontractors used? The rules prevent our modifying the template, but we can't respond fully without doing so.

Answer: Bidders are to provide a list of subcontractors that are applicable to this contract. For Attachment A, tab D, a list could suffice; however, the information requested in tab D must be provided for each subcontractor. You may modify the template in Attachment A. The questionnaire (tab I) in Attachment B is the file that should not be modified.

Attachment B Q&A

37. Question: Please clarify the 100-word response limit in the questionnaire is by line of coverage quoted, i.e., 100 words for pre-65 retiree responses and 100 words for post-65 retiree responses.

Answer: The Exercises file was designed with the 100-word response limit in mind, so the response must be concise regardless of which plans your organization is bidding for.

38. Question: Question #10 in the Questionnaire tab asks bidders to identify specific contract provisions we cannot comply with and explanations as to why. Given the RFP's instructions that limit responses to 100 words and prohibit adding rows or referring to attachments, it will not be possible to list and adequately explain every provision we take exception to. Is it permissible in this instance to refer to an attachment so that we are afforded enough space to fully list and explain any exceptions to the General Contracting Provisions and the Standard Provisions?

Answer: Yes; however, the required form must be completed. Questionnaire item #158 remains intact with exception of #10, for which bidders have permission to refer to an attachment to answer the question fully.

39. Question: In the *I Questionnaire* tab, for some questions, we will need to provide separate responses for the pre-65 and Medicare Advantage plans. As such, may we use 200 words in

responses where we address both lines of business, or are we limited to a 100-word response per question?

Answer: Please see response to #37.

40. **Question**: Some of the questionnaire questions ask for an explanation but the format only allows for a drop-down response of Yes or No. Some examples include questions #32, 33 and 34. Confirm in these situations that carriers can use the adjacent cells to provide the requested explanations.

    Answer: Yes. For the situations where the questionnaire item requires a Yes/No response **and** an explanation, the adjacent cells may be used to explain within the parameters of the requirements (i.e. 100 words).

41. **Question**: Some of the questionnaire questions only allow for drop down Yes/No. Confirm carriers can use adjacent cells to provide detail if the response differs by product.

    Answer: For questions that require only a Yes/No answer, unless you are requested to provide details for your answer, a detailed response is not necessary. Please also refer to responses to questions 37 and 40.

42. **Question**: ***Attachment B, I Questionnaire, lines 395-398 –*** The current MAPD and Part D plans are based on Premier formulary. Is LACERS open to considering a plan based on the Enhanced formulary for cost savings?

    Answer: No. The formulary should mirror the current benefit.

43. **Question**: ***Attachment B, J Cost Proposal tab –*** We noticed the Part D Only members are not included (for example, in the Attachment B file, Cost Proposal tab, the Part D members are not listed). The attached rate exhibit is the rate we sold for 2023 for those members. Can we add a section for these members or can we expect an updated Attachment B file with them included?

    Answer: No, these members' Part D premium is not separated out from their Medical Part B only premium – PPO or HMO. Do not add a section for those members.

44. Question: Do we need to send Keenan the data noted in the D1 PPO Analysis Database tab?

Answer: Yes.

45. Question: In the "B Provider Disruption" tab, row 14 says "Provider Data to be provided Carriers". Please clarify what is expected of incumbent carriers on this tab.

Answer: Row 14 of that tab is a placeholder.

46. Question: In the tab "C Facility Disruption", row 13 says "Provider Data to be provide by Carriers". Please clarify what is expected of incumbent carriers on this tab.

Answer: Row 13 of that tab is a placeholder.

47. Question: In tab "E1 Rx Tier Disruption", row 18 says "Provider Data to be provided by Carrier". Please clarify what is expected of incumbent carriers on this tab.

Answer: Row 18 of that tab is a placeholder.

48. Question: In the *I Questionnaire* tab, there is no "comment/details section" as described in the instructions on row 3. Should we add that column ourselves, or will you provide an updated questionnaire template?

Answer: Please provide your response under "Response" (columns C-H of the spreadsheet), unless otherwise indicated in this Q&A. A friendly reminder that instructions in Row 3 also indicate "Do NOT add columns, rows, or cells to the questionnaire format."

49. Question: **Qualifying Questions #11 "Does your company have any potential or perceived conflict of interest involving relationships your company may have with LACERS' current or prospective service providers, governing authorities, advisors, or other interested parties"** – Please provide definitions of conflict of interest involving relationships and prospective service providers. Please also provide definitions of other interested parties.

Answer: Please consult with your legal counsel and disclose any relationships between your company and LACERS' current or prospective service providers, governing authorities,

advisers, City officials, or other interested parties who have decision-making authority that may be viewed as influential for this contract award because of financial or other incentives. (continued)

Additionally, Bidders are required to abide by Attachment 3, LACERS' Ethical Contract Compliance Policy, including completing Attachment 4, Proposer Disclosure Form. In addition, bidders are provided the list of LACERS' Form 700 filers. Any firm or representative seeking a contract or contract extension/renewal with LACERS is a "Restricted Source" as defined by the City's Governmental Ethics Ordinance, Los Angeles Municipal Code Section 49.5.1 and is subject to this policy. Any Board Member, Staff member, City Attorney, LACERS consultant, or anyone working on LACERS' behalf which has any privileged information about the potential contract is subject to this policy and to the City's Governmental Ethics Ordinance.

50. **Question**: **Qualifying Questions #13 "Assuming a ratification clause is included into the Contract, is your company willing to provide services to LACERS prior to the full execution of a completed Contract?" –** Please confirm this question is not applicable to incumbent carriers.

    Answer: Proposers are expected to enter information into ALL cells designated for responses. If the question does not apply, enter "N/A" into the cell. Incumbent carriers who receive the contract award still need a ratification clause for the new contract.

51. **Question: Rating Questions #22 "Describe any technological improvements your company has planned for 2023-2025 (e.g. internet-related services, online eligibility, etc.) and the effect on enrolled members." –** Please clarify technological improvements. (Operational, Medical, etc.)

    Answer: Proposers are expected to describe any technological improvements planned for 2023-2025 (e.g. internet-related services, online eligibility, database upgrades, new apps, microsite upgrades, etc.) and any possible effects on enrolled Members.

52. **Question**: **Rating Questions #23 "Will any portion of this contract be outsourced or subcontracted to other companies?" –** Does this question refer to vendors and providers? Please clarify the definition of outsourced and subcontractor. Is this referring to operational only or medical?

    Answer: This question does not refer to network providers. Rather, the "outsourced or subcontracted to other companies" refer to outsourced services used in order to assist with the administration of the LACERS health plan.

53. **Question**: **Administration Support and Account Management #45 "Confirm that upon your selection you will develop, within two weeks, an implementation project plan clearly and fully addressing all required steps, key roles and responsibilities of your team, timeline and key dates, risk assessment review and contingency planning, and requested administrative, recordkeeping, and payroll support of LACERS to ensure the timely delivery of benefits on January 1, 2024. [Yes/No]" –** Please confirm this question is not applicable to incumbent carriers.

    Answer: Proposers are expected to enter information into ALL cells designated for responses. If the question does not apply, enter "N/A" into the cell.

54. **Question**: **Administration Support and Account Management (Billing and Eligibility) #54 "Monthly Enrollment Reports by Plan Type and Membership Segment" –** Does this refer to full enrollment or new/and or terminated?

    Answer: It refers to all enrolled and terminated membership. It is a full enrollment file. A separate report may be generated for new, changes and/or terminated records.

55. **Question**: **Administration Support and Account Management (Plan Sponsor Services) #66 "Provide the turnover rate for account team personnel of the last five years." –** Should the answer be in percentage or total number?

    Answer: Please provide both in percentage and in total number.

56. **Question**: **Member Quality of Care, Resources, and Services (Member Advocacy and Support Services) #108 “Would you be willing to provide a dedicated FTE Member Advocate resources onsite available in person at LACERS or remotely.” –** Please provide the definition of an FTE (example: 8:00 am to 5:00 pm, Tuesday, Wednesday, and Thursday)
Answer: LACERS’ normal business hours are Monday through Friday 7:00 am to 4:00 pm Pacific Time.

57. **Question**: **Prescription Drug Management (Online Resources) #118 “Have you produced videos that could be used by a client for marketing or educational purposes? [Yes/No] If "Yes", provide two samples.” –** Are Brainshark presentations acceptable?
Answer: Acceptable.

58. **Question**: **Prescription Drug Management (Wellness Resources) #123 “Please verify that you will provide wellness coaching services for LACERS' subscribers and dependents. [Yes/No] Indicate what services are included and whether those services are restricted in any way to members (e.g. only available if the member has been diagnosed with a chronic care condition).” –** Please define and clarify wellness coaching resources.
Answer: Health and Wellness coaching is the use of evidence-based skillful conversation, clinical interventions, and strategies to actively and safely engage patients in health behavior change. The LACERS Wellness program works in conjunction with the health plan carriers to connect members to their health coaching services, such as chronic condition programs, etc. Refer to page 18, items #3 and #4 for a description of the health and wellness coaching service requirements.

59. **Question**: **Prescription Drug Management (Wellness Resources) #126 “Please describe programs and resources available specifically to address mental health and substance abuse.” –** Please clarify if the programs are for treatment, prevention, or general communication.
Answer: The programs are for treatment, prevention, and general communication.

60. Question: **Prescription Drug Management (Condition Management Resources) #127 "Confirm that you provide Condition Management (CM) programs [Yes/No] and that the costs of these programs are included in LACERS fully insured premiums. [Yes/No]" –** Please define and clarify Condition Management.

Answer: Disease and Condition Management Programs support the management of chronic diseases, such as heart disease, chronic obstructive pulmonary disorder, asthma, coronary artery disease and diabetes.

61. Question: Are carriers required to conduct a GEOAccess regarding pharmacies or does the information required on Attachment B, tab E1, column AA suffice?

Answer: Attachment B, tab E1, column AA suffices.

62. Question: The performance guarantees categories of clinical management: What criteria is LACERS using for the clinical measures and will there be a standard template for the carrier to report results?

Answer: There is currently no template or criteria for clinical management. However, LACERS is exploring additional initiatives – please see the LACERS 2023 Pension Symposium, Wellness Program slides 7-11 (or pages 113-117 of Board Agenda & Symposium Presentations PDF) located here.

63. Question: Please confirm the PPO network Analysis tab is not applicable to fully-insured Medicare Advantage HMO and PPO offerings.

Answer: Please note the Provider Analysis exercises (B-D1) have been simplified and only apply to the commercial coverage (PPO, HMO and alt. Narrowed network HMO).

Attachment C Q&A

64. Question: Based on Attachment C PDF page 33, are 90-100 day supplies allowed on all Tier 4 medications for all plan designs?

Answer: Please note the Prescription Drug Analysis exercises (E1-E2) have been simplified to inclusion of the Medicare and Commercial top 25 drugs. Exercise no longer addresses tiering.

Census/Data-Related Q&A

65. **Question**: Are there general assumptions on enrollment that can be shared with respect to the "additional plan" (Medicare Supplement including RX and PPO Part B only plan with PDP) since it is not currently offered?

    Answer: No.

66. **Question**: For all of the claim files, please confirm if claims are paid or incurred.

    Answer: Paid.

67. **Question**: Please provide the latest 24 months of medical claims, including corresponding member counts by month for each product/plan, for Medicare eligible retirees only (claims should exclude under 65 spouses/dependents and non-Medicare eligible retirees).

    Answer: Claim files have been provided. No other data will be provided.

68. **Question**: Please provide monthly risk score/revenue data for the Medicare Advantage plans.

    Answer: Plan experience has been provided. No risk score/revenue data for Medicare Advantage plans will be provided.

69. **Question**: Please provide current MA population risk score for both medical and Rx. Risk scores are preferred to be provided as monthly averages for the corresponding months of claims data provided. Regarding the provided risk scores, the following information is required:

    - Time period (e.g., calendar year average, recent month, etc.)
    - Estimated or actual mid-year payment and final reconciliation

Answer: Plan experience has been provided. No risk score/revenue data for Medicare Advantage plans will be provided.

70. Question: **Medicare-specific –** Please provide the following member level pharmacy data (the member level data as requested below will not reveal any information about the incumbent cost structure):

- A member level RX claim file for all Medicare retirees for each RX plan. We will need one file that contains claim level information. The information should be provided in summary as well as in detail format. The detail format file should be in delimited text format, inclusive of a header row. The data should be provided for the Medicare eligible population we are quoting. Such as both Medicare eligible pre- and post-65s, including disabled. The File should include:
  - Unique Member ID
  - Pharmacy ID
  - NDC-11
  - AWP
  - Dispense Date
  - Retail vs. Mail Indicator
  - Days supply
  - Quantity or Units Dispensed
  - Duplicate records and originals/reversals should be removed
  - Not required, but useful information:
    - Current Formulary Tier
    - Low Income Status (Yes/No indicator)

Answer: No further information will be supplied.

71. Question: **Medicare-specific –** We need Rx member months for the same year claims have been provided (by month if possible). This should be provided for Medicare-eligible members only and will be used to convert insured pricing to a PMPM basis.

Answer: Plan experience shows enrollment.

72. Question: **Medicare-specific –** Please provide a Rx file that contains member information: Member ID, Risk Score, DD/MM/YYY Y of risk score, Zip Code.

Answer: No further information will be provided.

73. Question: **Medicare-specific –** If member level utilization data is not available, please provide: the generic dispense rate (GDR) for the current Rx plan(s), Total Utilization (PMPM), Allowed Claims (PMPM), and Paid Claims.

Answer: No further information will be provided.

74. Question: **Medicare-specific –** Are the monthly paid claims net of manufacturer rebates, network contracting, manufacturer gap discounts, CMS reinsurance, member paid amounts, low-income subsidies, etc.

Answer: Monthly paid claims represent the paid amount made by LACERS via premium payment.

75. Question: Can you please provide calendar year 2022 medical allowed and medical claims paid by month for the Anthem Medicare Advantage Passive PPO?

Answer: No further information is being provided.

76. Question: Can you please provide the following information provided for pharmacy for the Anthem Medicare Advantage Passive PPO?

- Member ID (member count should be very close to the unique ID count)
- NDC (9 or 11 digit, must contain leading zeros)
- Date of Service (fill date)
- Mail/Retail Indicator
- Quantity
- Days' Supply
- Date range of data

Answer: Please note the Prescription Drug Analysis exercises (E1-E2) have been simplified to include the Medicare and Commercial top 25 drugs. Exercise no longer requires data being requested in this question.

77. **Question:** Can we see the full year Risk Adjustment Factor (RAF) for 2022 for the Anthem Medicare Advantage Passive PPO?

    Answer: No.

78. **Question**: When we should expect the data to run the disruption reports?

    Answer: Provided and available since 3/20/23.

79. **Question**: A detailed Rx Claims file is needed for the formulary and network disruption; can this be submitted?

    Answer: Please note the Prescription Drug Analysis exercises (E1-E2) have been simplified to include the Medicare and Commercial top 25 drugs. Exercise no longer requires data being requested in this question.

80. **Question**: Disruption file - the file provided does not include addresses which may impact the results, specifically with regards to the HMO. Can you provide an updated file with addresses included or should we assume that all providers are based in CA?

    Answer: No further data will be provided.

81. **Question**: **Anthem Blue Cross PPO** – There are two experience files provided for the BC PPO Incentive plan. One labeled "BC PPO Incentive-FFS - CLR" and the other is labeled "BC PPO Incentive-FFS-RX - CLR". Both files include enrollment, FFS claims, Rx claims and premium. The Rx claims are the same in each file. The files have different enrollment, different FFS claims and different premium. The filed labeled FFS shows an MLR of 72.93% over the 3-year period while the Rx file shows an MLR of 81.86%. Why are there two sets of data and which is correct?

    Answer: See updated experience explaining plan coverage.

82. Question: **Anthem Blue Cross HMO** – There are two experience files provided for the BC HMO plan. One labeled "Blue Cross HMO – CLR" and the other is labeled "Blue Cross HMO RX – CLR". Both files include enrollment, FFS claims, Rx claims and premium. The Rx claims are the same in each file. The files have different enrollment, different FFS claims and different premium. The filed labeled FFS shows an MLR of 89.18% over the 3-year period while the Rx file shows an MLR of 93.56%. Why are there two sets of data and which is correct?

Answer: See updated experience explaining plan coverage.

83. Question: **PPO PB Incentive** – There are two experience files provided for the PPO PB Incentive plan. One labeled "PPO PB Incentive – CLR" and the other is labeled "PPO PB Incentive RX – CLR". Both files include enrollment, FFS claims, Rx claims and premium. However, the data is different in each file. Why are there two files and which is correct?

Answer: See updated experience explaining plan coverage.

84. Question: **Medicare Supplement** - PBP Plus file shows 212 subscribers with 214 members. However, there are 3835 subscribers identified on the census as enrolled in Anthem Medicare Preferred PPO. Can you share detail on the discrepancy? Will you be submitting experience for the Medicare Preferred PPO enrollees?

Answer: Please see the revised experience reports which clearly identify each line of coverage.

85. Question: Medicare Supplement - PBP Plus file does not include any Rx claims. Can you supply the Rx claims for the Medicare Supplement plan?

Answer: Please see the revised experience reports which clearly identify each line of coverage.

86. Question: Can you submit data on the UHC plans?

Answer: No, not available.

87. Question: Large claims were not provided. Please provide for at least the most recent 12-month period separately for the Medicare-eligible retirees including the claim amount, diagnosis and status.

Answer: See updated experience explaining plan coverage.

88. Question: Additional claims data is required, will you be submitting Large Claims Data?

Answer: Yes, large claims data has been provided.

89. Question: Large claims were not provided. Please provide for at least the most recent 12-month period separate for the Pre-65 population included the claim amount, diagnosis and status.

Answer: Large Claim data has been provided.

90. Question: Please provide large claims data for the pre-65 population separately including dollars, diagnosis and status for the same most recent rolling 12 period as the claims data. If possible to provide additional periods as well that is also appreciated.

Answer: Large Claim data has been provided.

91. Question: Please provide a complete member level census included at a minimum: Date of Birth, Gender, Tier Code, Plan selection, home zip code, Medicare eligibility indicator

Answer: Provided as of 3/17/23.

92. Question: Please provide at least 24 months of monthly claims data for the Pre-65 population separate of the Medicare eligible population. Experience should include corresponding lives as well as medical, pharmacy and capitations data spiked out.

Answer: Provided as of 3/20/23.

93. Question: Please confirm the 6 claims files sent Monday 3/20 are for the Pre-65 non-Medicare population only. If not, please clarify what populations they are covering.

Answer: See updated experience explaining plan coverage.

94. Question: Please confirm if the files labeled as BC PPO Incentive and PPO PB Incentives are for the Anthem Pre-65 population? If not please explain which population is covered in each file. If yes please explain why these are reported on separately and respond to the clarification questions below:

- The lives, medical claims, pharmacy claims and premium don't match between these 4 files. Please explain why and verify which version is correct.
- Additionally, for the 2 BC PPO incentives files and the 2 PPO PB Incentives again the lives, claims and premium information is not consistent. It would stand to reason even if all 4 files are not one population the 2 files named the same would be for the same population so please explain why the values do not align.

Answer: See updated experience explaining plan coverage.

95. Question: What is the difference between the Anthem BC PPO Incentive and PPO PB Incentive? The census file lists only subscribers with Anthem PPO or Anthem Med. Preferred. Which members have BC PPO Incentive versus PPO PB Incentive?

Answer: Please see the revised experience reports which clearly identify each line of coverage.

96. Question: Please confirm if the LACERS – Blue Cross HMO- CLR and LACERS- Blue Cross HMO RX files are both for the pre-65 population. If not please explain which populations are covered in which file. If yes, then please clarify the following elements:

- For HMO lives in the Blue Cross HMO-CLR file appear to be higher than the census, is there a reason? Additionally, they do not align with the lives noted in the Blue Cross HMO RX file. Please explain.
- Additionally, the Medical, pharmacy, capitation and premium values do not match between these two files even though they are for the same period. If they are the same population, please explain why they are not aligning, and which file is correct.

Answer: See updated experience explaining plan coverage.

97. Question: For both HMO files the capitation lives do not match the medical/Rx lives. Please explain why.

Answer: See updated experience explaining plan coverage.

98. Question: If both HMO claims files are for the Pre-65 population, please explain why the census provided only shows roughly 735 Anthem HMO pre-65 retirees but the Blue Cross HMO-CLR file shows 929 and the Blue Cross HMO RX – CLR file shows about 758. Please explain the changes in enrollment.

Answer: Please see the revised experience reports which clearly identify each line of coverage.

99. Question: Please explain why the claims provided for the Pre-65 PPO population do not align with the enrollment in the census of around 764 subscribers.

- BC PPO Incentive -FFS – CLR shows 477 subscribers in the most recent month
- BC PPO Incentives – FFS RX – CLR show 341 subscribers in the most recent month
- PPO PB Incentives – CLR shows 427 subscribers in the most recent month
- PPO PB Incentives RX – CLR shows 427 subscribers in the most recent month

Answer: See updated experience explaining plan coverage.

100. Question: Please provide incurred monthly medical claims for the most recent 12 months of data for members and dependents who have Medicare as their primary coverage on the Anthem Nationwide PPO plan along with monthly member counts that tie with the medical claims.

- If claims are reflective of incurred dates, indicate the "paid through" date.
- Please indicate if the MA medical claims include any costs for each of the following:
    - Non-Medicare Covered Fee-for-Service Costs (i.e., private duty nursing, routine vision/dental/hearing/OTC, etc.)
    - Clinical/Quality/Disease Management Program Costs

    - Fitness/Travel Programs
    - IBNR
    - Part B Rx Claims

Answer: Paid claims have been provided. Incurred claims will not be provided. Paid claims reflect paid claim cost only. No management fees nor other fees are included.

101. **Question**: Please provide incurred monthly Rx claims for the most recent 12 months of data for members and dependents who have Medicare as their primary coverage on the Anthem Nationwide PPO plan along with monthly member counts that tie with the medical claims.

- Please indicate whether the claims have been reduced for the following:
    - Pharmaceutical discount in the coverage gap
    - Manufacturer Rebates
    - Catastrophic Reinsurance
    - Member cost share
    - If the Rx claims are not net paid, indicate what is included in the claims data.
    - Indicate if the pharmacy data contains any, or all, of the Part B Rx claims
- If included, please list any Non-Part D drugs or lifestyle drugs covered on the current Part D plan

Answer: Paid claims have been provided. Incurred claims will not be provided. Paid claims reflect paid claim cost only. No adjustments have been made to the paid claims.

102. **Question**: Please provide a Detailed Pharmacy report with a minimum of 12 months of data for members on the Anthem Nationwide PPO plan.

Answer: Provided in the experience report.

103. **Question**: Please confirm when bidders will receive the data necessary to complete the required Medical Provider disruption, Facility Disruption, and Rx Tier Disruptions.

Answer: All information has been provided. Exercises for Network disruption and RX valuation have been modified. Data has been provided.

104. **Question:** Upon receipt of data please advise if follow up questions will be allowed.

Answer: No**.**

Uncategorized/Miscellaneous Q&A

105. **Question**: Please confirm whether or not there were any benefit changes during the provided claims period to the current plan benefits.

Answer: No benefit changes during the claims period to current plan benefits.

106. **Question:** Please confirm whether or not there were any benefit changes to any of the Rx plans from claim period year to the current.

Answer: No prescription drug plan design changes from 2022 to 2023.

107. **Question**: Please indicate if any benefits changed from the claims experience period to the current benefit period. If yes, please provide the benefit summaries that would correspond with each benefit period.

Answer: No plan design changes.

108. **Question**: For the National Passive MAPD PPO Plan, is the definition of “In-Network” meant to include providers contracting or also those that are not contracted but able to bill Medicare?

Answer: Yes.

109. **Question**: For the “Additional Plan” the RFP references LACERS is considering implementing. Does the decision timeline for this mirror the decision timeline in the RFP?

Answer: The alternate plan “Narrowed network HMO” are to be determined by the provider. A similar benefit design to the full HMO network would be preferred.

110. **Question**: What are the PDP benefit design specifications that should be used for the "Additional Plan?"

Answer: PDP benefit design specifications should mirror plan designs.

111. **Question**: The RFP stipulates respondents must hold their rates outside of any enrollment stipulations or underwriting guidelines. With respect to LACER's consideration of adding the "Additional Plan," are there measures that LACERS's is considering for mitigating the potential for adverse selection?

Answer: No plan design changes.

112. **Question:** Is LACERS offered a GMAPD HMO Plan currently, if so, which plan?

Answer: Kaiser, UHC, and SCAN are all GMAPD HMOs. Anthem is a Passive PPO GMAPD plan.

113. **Question**: Will UHC remain in place or should we include with the Anthem Population for quoting purposes?

Answer: LACERS is exploring all options available based on bid submissions.

114. **Question:** Is SCAN remaining in place similar to Kaiser?

Answer: LACERS is exploring all options available based on bid submissions.

115. **Question**: Commission Level?

Answer: LACERS' Health and Welfare Consultant does not receive a commission.

Category	Performance Metric	Description
Account Management	**Account Management Satisfaction**	A minimum average score of 4.0 will be attained on the Account Management Satisfaction Survey (AMSS)
	Annual Performance Report	Provide an Annual Plan Performance Report including analysis and recommendations for the previous reporting period from the carrier delivered no later than 60 days from close of the plan year
	Availability for Periodic Meetings and Open Enrollment	Available to meet for periodic meetings and 2-4 times for open enrollment
	Eligibility Error Reports - Ongoing	Provide 100% eligibility error (discrepancy) reports within 7 business days
	Management Reports	Standard automated reports made available to LACERS no later than 25 calendar days following the end of the month, quarter, semi-annually, and annually as requested, including financial, utilization, data warehouse updates, and clinical information
	Performance Guarantee Objectives Results Report	Performance Guarantee Report will be submitted no later than April 1st of the following year. Penalty remittance will be issued to LACERS within 30 days of reporting, subject to executed agreement
	Plan Implementation	Minimum of 95% of all tasks will be completed by the dates specified in the implementation plan agreed to by the Parties
	Responsiveness to Client Calls and Emails	Minimum responsiveness: one (1) business day
Accreditation and Reporting	**HEIDS Reporting**	Report within one month after NCQA public release
	National Committee for Quality Assurance (NCQA) Accreditation	Maintain NCQA accreditation
Case Management	**High Dollar Claimant Outreach**	A minimum of 95% of Identified Members who accumulate $75,000 or more of Paid Claims in a rolling 12 month period will receive successful contact or at least 2 attempted outreach telephone calls from the carrier within 30 calendar days of identification by the carrier. This Guarantee will include both medical and Prescription Drug Claims. This Guarantee does not include pediatric cases
	Member Outreach for Post Discharge Counseling	A minimum of 90% of Identified Members will receive successful contact from the carrier or receive at least 2 attempted outreach telephone calls from the carrier within 3 business days of notification of discharge where the Identified Member had a length of stay of 3 days or greater. This Guarantee does not include admissions related to maternity or behavioral health services
	Member Outreach for Preadmission Counseling	A minimum of 90% of Identified Members will receive successful contact from the carrier or receive at least 2 attempted outreach telephone calls from the carrier prior to a scheduled medical or surgical admission when the carrier receives notice at least 7 calendar days prior to the medical or surgical admission date. This Guarantee does not include admissions related to maternity or behavioral health services
Claim Administration	**Appeals**	A minimum of 95% of all Appeals will be resolved in accordance with the following Department of Labor required timeframes
	Claim Processing Turnaround Time	90% of non-investigated medical Claims will be processed within 14 calendar days; 99% non-investigated medical Claims will be processed within 30 calendar days
Customer Service: Calls	**Average Speed of Answer**	Within 30 seconds for 85% of the calls
	Call Abandonment Rate	Maximum 3% for non-Medicare plans; Maximum 5% for Medicare plans
	Call Quality	A minimum of 85% satisfaction of call quality
	First Call Resolution	A minimum of 90% of member calls will be resolved during the initial contact with no further follow-up required.
	Ongoing ID Cards Issuance	A minimum of 99% of ongoing ID cards will be mailed to Members within 10 business days of processing of an accurate eligibility file

LACERS Current Performance Guarantee Metrics

Category	Performance Metric	Description
Customer Service: ID Cards	**Open Enrollment ID Card Issuance**	100% of ID cards will be mailed to Open Enrollment participants within 10 calendar days from Employer's effective date provided that the carrier receives an accurate eligibility file. Due to LACERS processing a full file, regular and Open Enrollment is sent no earlier than 10 business days (LACERS defined) before the effective date.
Customer Service: Member Satisfaction	**Member Satisfaction**	A minimum average score of 90% will be attained on the service skills component of the member satisfaction survey
	Member Satisfaction with Carrier Website and/or Website Features	A minimum 80% satisfaction rating
Customer Service: Processing	**Processing of Ongoing Eligibility Information**	100% of Employer's ongoing electronic eligibility files will be processed timely. Timely processing is defined as electronic eligibility files processed and updated on the eligibility database within 3 business days of receipt of an eligibility file. This does not apply to a defective eligibility file. A Defective Eligibility File is defined as an eligibility file that has issues that prevent carrier's processing of the file.
Customer Service: Website	**Website Availability (excluding scheduled maintenance and downtime)**	A minimum availability of 98.5%
Disease Management	**Identification and Predictive Model**	Provide reports of quality assurance process to ensure that all eligible (covered under the benefit plan) risk members identified for outreach are referred to case management or disease management, as appropriate
	Including, but not limited to: **· Adult BMI Assessment** **· Appropriate Medication for People with Asthma** **· Beta Blocker Treatment After Heart Attack** **· Breast Cancer Screening** **· Cervical Cancer Screening Rate** **· Chlamydia Screening Women (All Ages)** **· Cholesterol Management After Acute CV Event** **· Colorectal Cancer Screening** **· Controlling High Blood Pressure** **· Diabetes, Blood Pressure Control** **· Diabetes, Eye Exam Rate** **· Diabetes, Glycemic Control Rate** **· Diabetes, Comprehensive Care** **· Diabetes Nephropathy Testing/Identification** **· Diabetes Statin Management** **· Flu Shots for Older Adults** **· Heart Failure ACE Inhibitors/ARB** **· Monitoring for Persistent Medications** **· Persistent Asthma Prescription Drug** **· Pneumonia Vaccination** **· Statin Therapy for Patients with Cardiovascular Disease** **· Treatment for Upper Respiratory Infection (Children)**	Unless a Quality Benchmark has been established by LACERS in Attachment B, tab H "Performance Guarantee", threshold to be determined based on NCQA's national average or otherwise indicated by LACERS
Medical Claim Payment Accuracy	**Claim Financial Accuracy**	A minimum of 99% of medical Claims will be paid or denied correctly
	Claim Payment Accuracy	A minimum of 97% of medical Claims will be paid or denied correctly
Network Stability	**Network Alerts**	A minimum of 95% of Network Alerts will be communicated either verbally, via email, or mail at least 25 days prior to the termination date
	Provider Accessibility	There will be a 5% or less change in Member Access to Network Providers

LACERS Current Performance Guarantee Metrics

Category	Performance Metric	Description
Prescription Drug	**Prescription Drug Clinical Management**	Provide 2023 Performance Guarantees for the clinical management of the prescription drug program
	Prescription Drug Discounts	Provide 2023 Performance Guarantees for the AWP or MAC discounts of the prescription drug program
	Prescription Drug Dispensing Fee	Provide 2023 Performance Guarantees for the dispensing fee of the prescription drug program
	Prescription Drug Rebates	Provide 2023 Performance Guarantees for prescription drug discounts.
Prescription Drug Claims	**Claims Accuracy - Mail Order**	Percent of retail claims processed without payment errors will be 99.00% or greater
	Claims Accuracy - Retail	Percent of retail claims processed without payment errors will be 99.00% or greater
	Claims Processing Turnaround Time - Mail Order Claims (not requiring intervention)	Provide mail order turnaround time for clean electronic claims of 99.00% of claims not requiring intervention processed within an average of two (2) business days
	Claims Processing Turnaround Time - Mail Order Claims (requiring intervention)	Provide mail order turnaround time for clean electronic claims of 98.00% of claims requiring intervention processed within an average of five (5) business days
	Prescription Drug Dispensing Accuracy - Mail Order	The dispensing accuracy rate will be 99.00% or greater for mail order
	Prescription Drug Dispensing Accuracy - Retail	The dispensing accuracy rate will be 99.00% or greater for retail order
Quality of Care	**Including, but not limited to: · Counseling for Nutrition · Follow-up After Hospitalization for Mental Illness · Prenatal Care Rate · Weight Assessment and Counseling for Children/Adolescents**	Unless a Quality Benchmark has been established by LACERS in Attachment B, tab H "Performance Guarantee", threshold to be determined based on NCQA's national average or otherwise indicated by LACERS
	Condition Care Engagement Rate	More than 65% of Identified Members who are contacted telephonically and enrolled in a Condition Care Program shall substantially complete at least 1 assessment for a Condition Care Program.
	Condition Care Enrollment Rate	More than 75% of Identified Members who are contacted telephonically will agree to telephonic enrollment in a Condition Care program
Security Breach	**Security Breach Notification**	Notification is determined by a regulator to be consistent with applicable law and percent of membership impacted.
	Security/Data/PHI Breach Notification	Notification in a timeframe consistent with applicable law