SAN FRANCISCO
HEALTH SERVICE SYSTEM
Affordable, Quality Benefits & Well-Being

ADDENDUM NO. 3

RFP for Medicare Plan (MAPD PPO) Request for Proposal (RFP) for the 2025 Plan Year (RFPQHSS2023.M1)

January 26, 2024

REQUEST FOR PROPOSALS

Medicare Health Plans Plan (MAPD PPO) for the 2025 Plan Year

(RFPQHSS2023.M1)

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This Addendum is being issued to modify the requirements in the above-referenced Request for Proposals (RFP) in response to questions received by or before the Deadline for non-Financial Questions on Friday, January 19, 2024 at 12:00 PM (PST).

One or more addenda will also be issued by or before March 22, 2024, in response to financial questions received by or before the **Deadline for Financial Questions on Friday, March 15, 2024 at 12:00 PM (PST)**.

Please review the terms of the RFP and this Addendum carefully. If there are any inconsistencies between the RFP and the terms of this Addendum, then the terms of this Addendum will prevail.

A. Modifications to RFP

1. The following additional data sets and information will be released to your Authorized Representatives and/or any designated additional representative via eBox following the posting of this Addendum No. 3:

a) Annual Notice of Change Documents
b) New MAPD Experience Data (additional requested pharmacy information)
c) New MMR File
d) New Non-Medicare Census
e) Evidence of Coverage Documents
f) Performance Guarantee Document

B. Questions & Answers

1. Please confirm we were supposed to receive EOCs and ANOCs for "State Health Benefit Plan-Premium Plan."

SFHSS Response:

Please see the new EOCs. These are also available on the SFHSS website.

2. Please confirm the only difference between plan documents 2024-SB/EOC-SFHSS-13694 and 2024-SB/EOC-SFHSS-12786 is that the latter is Part B only versus Parts A & B.

SFHSS Response:

13694 Group is Part A & B. 12786 Group is Part B only.

3. Are members offered a choice between 'standard' and 'premium' plan options today? If so, please provide the plan documents for those plans.

SFHSS Response:

Not applicable. Please review the new EOCs and the links to the SFHSS website that have been provided.

4. **Is SFHSS looking for the proposed plan documents to be submitted with the Non-Financial Proposal on 2/9, or is the completion of tabs A1 & A2 sufficient?**

SFHSS Response:

Please provide plan documents.

5. **Regarding *Tab A9.2 (Non-Financial Questionnaire)*, any deviation from requested, can we include a yes/no response and explanation on *A4.1 Extended Explanations* tab or can we include an additional column within the tab?**

SFHSS Response:

Please just put a "yes" or "no" next to each field. For any fields that are "no", add an explanation in the next column.

6. **How solvent is the Trust?**

SFHSS Response:

The Trust is solvent. Please see the audited financial statements available at https://sfhss.org/sites/default/files/2024-01/January%2011%2C%202024%20SFHSS%20Financial%20Report%20as%20of%20November%2030%2C%202023%20memo_0.pdf.

7. **Please provide the corresponding 12-24 months of medical risk scores and CMS Revenue payments for each of the Medicare Advantage plans. Please indicate if the risk scores and CMS Revenue payments include mid-year and final reconciliation adjustments. Please indicate if the CMS revenue payments are net of sequestration.**

SFHSS Response:

Please refer to the Medicare Eligible Experience Data you received as well as the MMR report. The data does not include all mid-year and final payment adjustments. The CMS Revenue payments have been reduced for sequestration. No additional member data will be provided for the Kaiser population.

8. **Please provide the latest 12-24 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.**
    - **For all of the claim files, confirm if claims are paid or incurred.**
    - **For all of the claim files, what is the paid through date? Has a completion factor been applied?**
    - **For all of the Medicare Advantage medical claim files, please confirm if the claims include additional costs such as Non-FFS costs, vendor fees, provider bonuses, other rider costs, capitation, Part B Rx paid claims, or Part B Rx rebates.**
    - **Were there any benefit changes from the provided claim period to the current year?**

SFHSS Response:

- The claim file you received is through 9/20/2023.
- Claims are incurred and paid.
- Claims do not include Part B rebates.
- The claims file includes all vendor payments for programs for supplemental benefits (vision, hearing, fitness).
- Provider liabilities are included. Part B claims are included, Part B rebates are not.
- Regarding the benefit changes, please review the newly provided ANOCs.
- No additional member data will be provided for the KPSA population.

9. **Please confirm 2022 Risk Scores include Final Payment.**

SFHSS Response:

Not confirmed, these are not included.

10. **Please confirm 2023 Risk Scores include Mid-Year Adjustments.**

SFHSS Response:

Not confirmed, these are not included.

11. Please advise which UHC plan(s) should be quoted for the pre-65 population/split families.

SFHSS Response:

Respondents should provide quotes for all three plans currently available to the non-Medicare portion of split families. This includes the UHC PPO, UHC Doctors Plan EPO, and UHC Select Plan EPO.

12. Please provide at least fifteen (15) months of monthly Blue Shield of California non-Medicare claims data broken out by fee for service, capitations and pharmacy as well as corresponding large claims data including status and/or diagnosis.

SFHSS Response:

Blue Shield of California non-Medicare plans, including any capitation, claims, service fees, and/or pharmacy services are out of Scope for this RFP. The City will require more information on the rationale for obtaining this data, before considering this request.

13. Please provide at least fifteen (15) months of monthly HealthNet non-Medicare claims data broken out by fee for service, capitations and pharmacy as well as corresponding large claims data including status and/or diagnosis.

SFHSS Response:

Health Net non-Medicare plans, including any capitation, claims, service fees, and/or pharmacy services are out of Scope for this RFP. The City will require more information on the rationale for obtaining this data, before considering this request.

14. Please confirm that it is the group's intent to provide updated claims data for all carriers as well as Medicare and non-Medicare populations through January or February 2024 in March for the April financial response.

SFHSS Response:

SFHSS desires to provide as much data to ensure a fair bidding process. At this time outside of updating data or clarifying data that has been released we are not planning to re-run data for longer periods to capture additional claims information.

15. Please confirm the United EPO plans were added as of January 2023. If not please provide prior period claims data.

SFHSS Response:

UnitedHealthcare became the administrator for non-Medicare plans available to non-Medicare covered lives of families where one or more covered life is Medicare and covered by the UHC MAPD PPO plan on January 1, 2023. In 2022, Blue Shield of California was the plan administrator for the non-Medicare "split family" plans.

Blue Shield is not able to separate the claim experience during 2022 for these non-Medicare "split family" covered lives from the overall 2022 plan claim experience for all SFHSS members covered in the Blue Shield HMO and PPO plans.

16. Please provide an explanation for the highlighted sections of the United claims file provided.

SFHSS Response:

Please clarify which file and columns you are referring to.

17. Please provide updated United claims data which outlines actual membership by month as this does not appear accurate in the current reports as the last month of data shows over 1,000 members while the RFP and census show a membership value in the low 900 range.

SFHSS Response:

A new census file and monthly headcount summary will be posted for carriers to review. These updated files show consistency between the two (2) data sources for a total of around 1,024 covered lives.

18. Please provide the Blue Shield of California non-Medicare plan designs.

SFHSS Response:

Blue Shield of California non-Medicare plans, including any capitation, claims, service fees, and/or pharmacy services are out of Scope for this RFP. The City will require more information on the rationale for obtaining this data, before considering this request.

19. Please provide the HealthNet non-Medicare plan designs.

SFHSS Response:

Health Net non-Medicare plans, including any capitation, claims, service fees, and/or pharmacy services are out-of-scope for this RFP. The City will require more information on the rationale for obtaining this data, before considering this request.

20. Please outline any disease management and/or wellness programs that are included in the non-Medicare population plans today.

SFHSS Response:

More information on the current non-Medicare plans under UHC can be found at the SFHSS microsite on UHC's website: https://www.whyuhc.com/sfhss.

21. Please confirm the current United non-Medicare plans are ASO today. If so is the intent for carrier's to quote these plans as ASO or both ASO and fully insured?

SFHSS Response:

The UHC non-Medicare plan offering is currently self-funded. We are requesting both a self-funded and a fully insured quote on these plans.

22. For the current Blue Shield of California and Health Net flex funded non-Medicare plans would the group prefer for carriers to provide a flex funded quote as well if they have the ability or does the group desire true fully insured quotes as part of this RFP?

SFHSS Response:

Blue Shield of California and Health Net non-Medicare plans are out-of-scope for this RFP.

23. For the current Flex Funded non-Medicare HMOs is the group looking for carriers to quote these as an ASO product conversion as part of the ASO requested or will these plans remain as HMOs?

SFHSS Response:

The existing Flex-Funded, non-Medicare HMO Plans are out of Scope for this RFP. The Group is not looking for quotes or conversions of these existing plans to a different design or carrier.

24. Will there be greater detail on the non-financial components criteria for the selection? Not instead of just the a few bullet points that are in there now.

SFHSS Response:

SFHSS is looking for a carrier partner who can support our goals and objectives. SFHSS will be reviewing the following categories: questionnaire responses, formulary disruption, pharmacy network disruption, claims disruption, provide performance guarantees and willingness to share data.

25. Seeing that you know there could be some impacts to the inflationary Reduction Act and knowing what some of those reimbursements could be coming out and you know the final call letter from CMS obviously could impact what that rate could be. What that change or differential could mean to the rate if anything.

SFHSS Response:

Yes, the Inflation Reduction Act and the restructuring of the Part D benefit introduces uncertainty. SFHSS asks that you be as competitive as possible as we work together to manage the changing market.

26. For the Non-Medicare Split Dependents, would SFHSS consider a quote on a Minimum Premium basis (consistent with the current non-Kaiser HMO active/early retiree plans) instead of a traditional fully insured offer?

SFHSS Response:

Yes, SFHSS would consider a financial proposal on a Minimum Premium basis.

27. What is the Kaiser Part B only rate?

SFHSS Response:

A very small percentage of the Kaiser population is Part B only, less than 1%. The rate is currently the same for Part B only as Part A&B members.

28. What is the UHC Part B only rate?

SFHSS Response:

The total per member per month 2024 Medicare Part B premium is $897.14 as documented in the June 2023 MAPD PPO presentation to the Health Service Board. This premium is not segmented into Medical and Pharmacy components by the current MAPD PPO plan insurer. Same % increase each year.

29. As the Coverage Gap Discount program is going away in 2025, please provide updated rate build up documents for completion that appropriately reflect the changes to the Part D program for 2025 and beyond.

SFHSS Response:

Please use that line item to represent Manufacturer Discount Payments that will be paid, just not in the Coverage Gap.

30. Please add tiering status to the pharmacy claims utilization information provided.

SFHSS Response:

This information is not available.

31. Around formularies, is there an opportunity to look at alternative formularies that could be leaner while still being robust enough to be able to satisfy the needs of your retirees.

SFHSS Response:

Currently, SFHSS has a broad, but not completely open formulary. SFHSS is concerned about formulary disruption but is open to proposed bidders providing two formulary options. Please provide your closest matching formulary for scoring and you may provide one, alternative leaner formula and an associated pricing decrement.

32. There is a partial formulary included in the Plan Guide. Can a copy of the full formulary be provided?

SFHSS Response:

The formulary booklet (PDF) that we have is the Comprehensive Formulary booklet which is part of our Plan Guide (and based on the CMS template). The booklet contains drugs that are on the CMS file of Part D coverable drugs. CMS allows us to cover drugs that are NOT on their reference list, but those are not listed on the Comprehensive Formulary booklet because the booklet doesn't allow listing of these drugs. Non-Part D eligible drugs are listed in the Additional Drug Coverage portion of the Plan Guide: https://retiree.uhc.com/sfhss/drug-look-up.

33. If a copy of the full formulary is not available, please confirm the following:

- **Does the plan include the most comprehensive formulary available through the incumbent?**
- **Is the current formulary considered an Open or Closed Formulary?**
- **Does the formulary exclude any drugs on the Part D drug list?**
- **Are generic drugs included on Tier 2 and Tier 3?**
- **Non-Part D drugs for prescription vitamins and mineral products, drugs for sexual or erectile dysfunction, and cough and cold drugs seem to be covered in the current plan based on the information provided at the end of the Plan Guide. Are any additional Non-Part D drugs covered, such as agents when used for weight loss, weight gain or anorexia, agents used to promote fertility, and/or agents used for cosmetic purposes or hair growth?**

SFHSS Response:

The formulary is the most comprehensive formulary available through the incumbent. It is an Open Formulary defined as all Part D drugs in brand and generic form. There are no Part D exclusions, and all generics are on Tier 1.

The Non-Part D rider or bonus drug list covers drugs in these categories: analgesics, weight loss, urinary tract infections, Heparin flush to prevent line blood clots, dermatologics for dry or itchy skin, hemorrhoids, irritable bowel, sexual and erectile dysfunction, prescription vitamin and minerals, cosmetic, cough and cold, thyroid and fertility.

34. In order to provide a disruption analysis in addition to experience rating Part D, 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)**

SFHSS Response:

No additional information will be provided about the Kaiser population at this time.

35. As it relates to Member months, we also 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.

SFHSS Response:

No other information will be provided about the Kaiser population at this time.

36. Please provide an MMR report for most recent month (MMR provided is from December 2022).

SFHSS Response:

Additional information for the Kaiser population will not be provided at this time.

37. Is SFHSS open to formulary alternatives, or will they consider cost share changes to best optimize the plan for 2025 IRA restructure and potential cost savings?

SFHSS Response:

At this time, we are requesting a bid based on the current design and the closest matching formulary. You may provide one alternative, leaner formulary.

38. In order to ensure we can accurately review the provided claim data, please provide a member-based census including DOB, gender, zip code and current plan indicator (standard or premium).

SFHSS Response:

The current census file should meet your needs. Please review the revised EOC information.

39. In the Early Retiree tab of the census we received, there are members who are listed as having Kaiser coverage today. Please confirm whether this refers to the Kaiser Senior Advantage plan or a separate Kaiser Non-Medicare plan.

SFHSS Response:

Unless the early retirees are also Medicare eligible assume these are in the Kaiser Non-Medicare plan. Very few retirees are Medicare eligible and under 65.

40. Please confirm whether any members listed in the Early Retirees tab should be included in our MAPD quote if they will be 65 by the time of the effective date.

SFHSS Response:

These members have a may have a choice of options (Kaiser plans or UHC) when they attain Medicare eligibility. SFHSS will defer to you to determine how you want to consider these potential members.

41. The RFP includes census counts in a number of places that do not seem to tie. Specifically, we see:

a. The Population Summary on page 1 of the RFP indicates that the non-Medicare of split contracts are in the following plans:

i. 1,132 members in the UHC Commercial non-Medicare plan
ii. 524 members in the UHC Doctors Plan
iii. 115 members in the UHC Commercial non- Medicare PPO
iv. 3 UHC Medicare Eligible and Not Enrolled in Medicare – Commercial non-Medicare

b. The Excel file called Medicare RFP Census Data from SFHSS.xls shows the following:

i. 201 members enrolled in UHC plans (significantly lower than the 1,132 referenced in the RFP summary)
ii. 3,104 members in Blue Shield plans (The RFP summary does not indicate that there is any enrollment in Blue Shield plans.)

c. The claims experience includes enrollment in the following three plans:

iii. PPO – 260
iv. Select EPO – 548
v. Doctors PPO - 213

The differences between all of these data sources are material. We need a complete census of the specific population we are being asked to quote, with definitions of any fields that are not clear such as 'Coverage Tier Description' on the census file.

SFHSS Response:

SFHSS recognizes the opportunity for further clarity as it relates to the membership counts illustrated on page 1 of the RFP, and for those contained under Section 3.1 (Non-Medicare Retirees) and 3.2. (Medicare Retirees). To better define and clarify the membership counts, SFHSS has issued the most up-to-date counts, based on 2024 enrollment.

Additionally, SFHSS would like to clarify that in the updated counts, there are direct counts of Members and direct counts of Dependents on each respective plan; the counts are not representative of a familiar connection. SFHSS has assessed that the direct counts are more appropriate for Bidders to review, so that the appropriate population size per plan may be assessed.

42. For C7) Geoaccess, please confirm which census should be used to run the requested Non-Medicare Geoaccess reports.

SFHSS Response:

A new census will be provided, and you may use this file for the GeoAccess. The revised census will represent the non-Medicare split families in scope for this RFP.

43. Can we please have a census of UHC non-Medicare members only (e.g., non-Medicare split family members) with a plan identifier?

SFHSS Response:

Please see file: SFHSS Non-Medicare split family plans covered lives ONLY_Census_012324.xlsx, which will be released shortly.

44. The RFP contains one EXCEL file called SFHSS Non-Medicare Claims by Month.xls that shows claims for three plans – PPO, Select EPO and Doctors Plan. The lives in these three plans add up to 1,021 members. It is not clear from the column headers what these claims represent and who generated them.

Please provide either a complete claims report for all of the lives we are being asked to quote on, or additional information explaining what these claims represent.

SFHSS Response:

Please see the revised spreadsheet with the non-Medicare counts.

45. Data is included in rows 16 – 29565, blank in rows 29566 – 32599, and included again between rows 32600 – 96292. Please confirm rows 29566-32599 were intended to be left blank, and that we should consider all other populated rows when completing the medical disruption analysis.

SFHSS Response:

Provider data was incorrectly duplicated on both 2022 and 2023 Provider tabs.

- Providers 2022 tab: Should delete starting at row 34159 to end of the tab.
- Providers 2023 tab: Should delete starting at row 29566 to end of the tab.

46. Should we be matching the current UHC plans for this scenario or the Kaiser Senior Advantage Plan?

This question was asked under the heading of "Illustrative Scenario Replacing Kaiser." As replacing Kaiser is out-of-scope for the RFP, SFHSS - Contracts is reaching out to the sender to validate intent, and to reiterate the scope of the RFP.

SFHSS Response:

Please develop a matching passive PPO using the Kaiser design for illustrative pricing. SFHSS is studying their options for future opportunities.

47. As it relates to incumbent plans:

a. Are there differences on the networks between the UHC Choice Plus and Select Plus plans?

b. Assuming there are differences, how do the Choice Plus and Select Plus networks differ between UHC's full PPO network?

c. With the UHC Doctors Plan, is it a mandatory component to have a PCP requirement? Is this requirement necessary for all bidders to provide under this plan?

SFHSS Response:

The Select Plus network is only available in California while the Choice Plus network is available outside of California. These two EPO plans cover in-network providers only, which differs from the PPO plan which covers both in- and out-of-network providers. The UHC Doctors Plan does require that members select a Primary Care Provider. Bidders are encouraged but not required to have a plan that requires a Primary Care Provider.

48. Page 12 of the RFP states there are 5,396 non-Medicare retirees and 3,908 dependents on the Non-Medicare plans for 9,304 members however the census is only showing a total of 9,231 non-Medicare members. Please confirm either provide an updated complete census with all current non-Medicare members or confirm that the census is correct for the purposes of this RFP.

SFHSS Response:

Please see response to Question 41.

49. Regarding the benefit language around the 12 additional one-way rides post-discharge, what criteria do they follow to allow these at time of discharge under UHC today?

SFHSS Response:

The baseline criteria are that this benefit becomes available for up to 30 days following all inpatient and skilled nursing facility discharges. The qualifying discharge is the only eligibility requirement.

50. Please confirm the funding arrangement for the UHC non-Medicare split family population.

SFHSS Response:

The three non-Medicare UHC plans are currently self-funded.

51. Given the current state of the Part D program and introduction of the IRA and direct negotiation of fair price for 2026, please confirm a Medical only multi-year guarantee will be accepted as part of the RFP process along with firm 2025 Rx pricing being submitted in August 2024.

SFHSS Response:

Please put your most competitive offer for SFHSS to evaluate.

52. What MAPD plan design would SFHSS like quoted for the 1/1/2026 UHC/Kaiser replacement quote? The Kaiser Sr Adv HMO is different than the UHC MAPD PPO plan? Confirm SFHSS would like one or two MAPD plan offerings effective 1/1/2026 to replace UHC and Kaiser.

SFHSS Response:

Please quote the Kaiser plan design as closely as possible as a passive PPO and provide the actuarial value of the plan. This process informs a potential future strategy.

53. Please provide claim data including incurred and paid amounts, membership by month & risk scores for the Part B only population.

SFHSS Response:

This information is not available.

54. The medical and pharmacy claim data provided is aggregated for the 'standard' and 'premium' plans, please provide a file with them separated by plan.

SFHSS Response:

The claim file is correct. Please review the new EOCs.

55. You have provided the following data for the medical provider disruption analysis:

- **Name**
- **Address**
- **Specialty**
- **National Provider Identification Number (NPI) (missing)**
- **TIN**
- **Claims totals associated with each provider**

Please add NPI data to the medical claims file.

SFHSS Response:

At this time, NPI is not available. Please use TIN and the other fields to perform your analysis.

56. The claim file states the claims include all benefits in the EOC. Does this include all vendor payments for programs like fitness, etc.?

SFHSS Response:

Yes.

57. Do the claims include provider risk liabilities and Part B rebates?

SFHSS Response:

Provider liabilities are included. Part B rebates are not included.

58. Does the data include all mid-year and final payment adjustments?

SFHSS Response:

No.

59. Regarding the *2023 Providers Tab*, data is included in rows 16 – 29565, blank in rows 29566 – 32599, and included again between rows 32600 – 96292.

Please confirm rows 29566-32599 were intended to be left blank, and that we should consider all other populated rows when completing the medical disruption analysis.

SFHSS Response:

Provider data was incorrectly duplicated on both 2022 and 2023 Provider tabs.

- Providers 2022 tab: Should delete starting at row 34159 to end of the tab.
- Providers 2023 tab: Should delete starting at row 29566 to end of the tab.

60. Regarding the *Ancillary _2022 and Ancillary_2023 Tabs,* Line 16, Column U on both Ancillary tabs is populated with the verbiage "Please Leave Blank."

Please confirm if this note is intended for Line 16 only.

SFHSS Response:

Please ignore the "Please leave Blank". Provider Status (CP, NCH, NCNH) is the column that should be filled out on all tabs.

61. Regarding *Tab A4: Provider Engagement and Network Adequacy, Line 82,* Based on utilization, SFHSS would like to monitor critical providers in the Bay Area. Once identified, on an annual basis, will you share provider status for both contracted and non- contracted providers on a monthly basis. The status includes any disputes, threats of leaving the network, contract end dates, or not taking the plan for non-contracted providers that will impact

SFHSS members. Will you work to coordinate communications with members if needed with SFHSS.

This question references both monthly and annual reporting. Please clarify the frequency being requested.

SFHSS Response:

The desire is to define critical providers on an annual basis. Once defined SFHSS is asking for monthly updates.

62. Is the premium provided on the medical experience report the combined Medicare Advantage and Part D premium?

SFHSS Response:

The published plan premium includes pharmacy costs. The original summary information provided is the medical only portion. We have provided a revised file that includes Total Revenue and Total Premiums, which includes pharmacy costs.

63. The published UHC monthly premium is $454.37. However, the premium calculated from the 'Total Plan Premium' column in the claims submitted is $224. Please explain this discrepancy.

SFHSS Response:

A new experience file will be provided. The original or initial file did not include the CMS revenue or plan premium attributed to the prescription drug benefit.

64. Will a wholly owned subsidiary of the carrier be allowed to be offshore?

SFHSS Response:

The City offshore provisions are contained within 13.5.2 (Use of City Data and Confidential Information) and 13.11 (Data Transmission). The City does not disallow a company's decision offshore part or all of their organization, wholly owned or otherwise. However, Contractors are prohibited from accessing City Data, as defined under Section 1.3, from outside the continental United States.

65. As it relates to *Page 26, Section 12.*4.3, this section indicates SFHSS will "…adjust the fees of this Agreement for any Communications Materials that are not distributed in accordance with the terms of this Section 12.4…"

Please indicate the fees to which these are related, as we did not see fees tied to Communication Materials in Section 12.4 or the Performance Guarantees listed in Tab A10 of the Non-Financial Questionnaire. Please provide an example of how the percentage adjustments referenced in this section might be applied.

SFHSS Response:

The "fees" which are mentioned in Section 12.4 of the Draft Agreement would be defined as either administrative fees/premium paid by the City, for the Services as a whole. These adjustment amounts are in addition to the Performance Guarantees, as suggested in Section 3.3.1 (Payment). As mentioned in Section 12.4.3, the assessment occurs quarterly, based on the Administrative/premium payment made by the City for the Services.

An example of this would be as follows: in the instances where in Quarter 1, the Vendor makes one (1) distribution of Communication Materials, which are not distributed in accordance with the terms of this Section 12.4, the Vendor payment shall be adjusted by the City by 0.5%:

- Total Administrative Fee/Premium paid by the City for Quarter 1 = $10,000,000
- 0.5% adjustment = $50,000
- Adjusted Total Administrative Fee/Premium for Quarter 1 = $9,950,000

66. Can you share additional details as to whom specifically may reach out to our provided references and general timeframe when they can expect to be contacted?

SFHSS Response:

References will not be contacted by the RFP Evaluation Panel. The SFHSS Contracts Unit may contact references listed for verification purposes only, including, but not limited to, Minimum Qualifications to Bid (6.3.1, 6.3.2) and Baseline Expectations (6.3.3) if deemed necessary by SFHSS prior to selection of the highest ranked respondent.