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

ADDENDUM NO. 3

RFP for Health Plans – 2022 Plan Year

October 1, 2020

REQUEST FOR PROPOSAL
Health Plans—2022 Plan Year

RFPQ#HSS2020.M1

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This Addendum is being issued to modify the requirements in the above-referenced Request for Proposal, as amended by Addendum No. 1 (issued on September 23, 2020) and Addendum No. 2 (issued September 25, 2020), (collectively, the "RFP") and to respond to additional questions and requests for clarification received by or before the Deadline for RFP Questions (2:00 p.m. PDT on Wednesday, September 30, 2020).

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 shall prevail. Section references below are to the RFP and are provided for convenience of reference only.

Additional Addenda to this RFP will be issued in response to additional questions and requests for clarification received by or before the Deadline for RFP Questions.

A. Modifications to RFP:

Reserved.

B. Questions & Answers

1. **Q:** To what does Appendix XX ("Performance Guarantees and Contingent Discounts") in Sec. 5.5, E.1 Form of Agreement P-600 refer?

   A: Appendix XX ("Performance Guarantees and Contingent Discounts") refers to a future Appendix to the agreement between the City/SFHSS and Selected Respondent(s) with will be dependent on the proposal(s) of those Selected Respondent(s). This Appendix will contain any all performance guarantees, fees-at-risk, contingent discounts and similar service level agreements and

guarantees, including, but not limited to, those already identified in the RFP, such as within RFP Section 5.6 (Performance Guarantees).

2. **Q:** To what does Appendix XX (Data Requirements) in Sec. 5.5, E.1 Form of Agreement P-600 refer?

   A: Appendix XX (Data Requirements) refers to a future Appendix to any agreement between the City/SFHSS and Selected Respondent(s) containing. This Appendix will contain all applicable Data Requirements (RFP Section 5.7.23) as well as any applicable reporting requirements (for example, RFP Sections 5.7.11, 5.7.15, 5.7.22.16), and other terms and conditions necessary for the safe, secure and reliable transfer of data pursuant to the agreement.

3. **Q:** Has complete monthly claims data for Blue Shield of California been provided through the Greater Insight Platform? Will SFHSS provide a minimum of fifteen months of HMO claims, broken out by plan (Access+ vs TRIO) and broken out by fee-for-service, capitation, and pharmacy?

   A: Additional HMO claims information was posted to TBS/Greater Insight on September 28, 2020. This includes a split of claims by Access+ and Trio by using the "decoder" provided in the "SFHSS current vendor claims and enrollment data for GI 090520.xls" file posted in the Reference Documents section. Capitation information is not available.

4. **Q:** What scenarios are being requested in the RFP with respect to carrier selection and what additional plan designs are recommended?

   A: Please refer to the Addendum No. 2, Question 21 and the Answer thereto regarding the System Competition Model. Respondents are advised that the System Competition Model is a single example of one possible solution for the 2022 plan year. It not the only possible solution. As a result of the RFP, for example, a single Respondent may propose a PPO plan in combination with one or more HMO plans that in the aggregate accommodate the full Non-Medicare Population. SFHSS could also recommend as a result of the RFP, for example, two Respondents, one Respondent with an HMO solution, and one Respondent with an HMO and a PPO solution that, together, accommodate the Non-Medicare Population.

5. **Q:** Will SFHSS provide data broken out for Bay Area versus non-Bay Area?

   A: No, not at this time.

6. **Q:** What scenarios are being requested in the RFP with respect to splits'? In addition to the current split of active/early-retiree, is the RFP requesting regional splits? Will SFHSS provide data broken out for Bay Area versus non-Bay Area? Will SFHSS

provide the total cumulative claims and/or the current experienced percentage of total claims for active versus early retiree and for Bay Area versus non-Bay Area?

A: Respondents are asked to provide additional splits (e.g., Bay Area v. Non-Bay Area) on the financial submission. These are in addition to the current structure which includes a split for active v. early retiree members. Respondents have been provided the necessary census data for splits which gives age/gender/plan enrollment. However, for the purposes of this RFP, split claims by age/gender/plan enrollment will not been provided. However, with the demographic information contained within the 2020 SFHSS Demographic Report, Respondents are able to provide applicable split quotes based on assumed risks cores.

7. **Q:** May a Respondent provide a fully funded quote (for all plans) and a self-funded quote (for all plans)?

A: Yes. However, please note that it is not necessarily the intention of the RFP for a Respondent's proposed self-funded HMO option to perfectly mirror the current contractual terms of the Blue Shield of California (flex-funded) HMO plans.

8. **Q:** From a total risk perspective, in quoting the premium in response to the RFP, should Respondents use the combined claims and census demographics for all covered lives in the Non-Medicare Population (Blue Shield of California Access+ and TRIO, and UnitedHealthcare PPO)?

A: Yes. Furthermore, Respondents are advised to please review Addendum No. 2, Question 10 and the Answer thereto regarding the pooling levels, as well as RFP Section 2.1.15 (Financial Parameters).

9. **Q:** Will the result of the RFP include multiple carriers alongside Kaiser to offer multiple HMO and/or PPO plans? Or a single carrier?

A: As a result of the RFP, SFHSS may recommend and the Health Service Board may select either a single carrier with multiple HMO and PPO plans or two or more carriers with HMO and PPO plans.

10. **Q:** Will Respondents be able to adjust their quoted premium for the 2022 plan year once actual plan enrollment is known following Open Enrollment in 2021? May proposals be conditioned on or rebalanced if multiple carries are implemented for the Non-Medicare population alongside Kaiser for the 2022 plan year?

A: No. SFHSS cannot predict enrollment decisions by members of the Non-Medicare Population for the 2022 plan year (Open Enrollment is in October 2021), and must already obtain approval of the rates for the 2022 plan year from both the Health Service Board (May 2021) and the Board of Supervisors (July

2021), Respondents will not be able to modify or recalculate premiums for the 2022 plan year based on actual enrollment.

11. Q: Regarding the pharmacy component of the Proposal, is SFHSS requesting a transparent bid/proposal?

A: Yes. Respondents are advised to please reference RFP Section 2.1.12 (Pharmacy) wherein SFHSS is looking for "[t]ransparent pharmacy contracting terms with full pass-through of all rebates, kick-backs, and other financial mechanisms such as spread pricing[.]"

12. Q: What is the SFHSS approach to grandfathering prescription drugs and does SFHSS have a pre-existing list of prescription drugs to be grandfathered?

A: For the purposes of the RFP, at SFHSS's sole discretion, routine grandfathering for self-insured lines-of-business, may be requested as a result of formulary changes. All changes are to be reported to SFHSS, per drug, while also indicating utilizing member impact. SFHSS may consider various areas of impact, including but not limited to vulnerable or at-risk populations. For the purposes of evaluating the RFP, disruption to the existing pharmacy coverage will be taken into consideration.

13. Q: When providing pharmacy disruption for the Non-Medicare Population covered by Blue Shield of California (Access+ and TRIO) and UnitedHealthcare, would SFHSS prefer a separate reporting of disruption for Blue Shield of California and UnitedHealthcare, or should that disruption reporting be combined?

A: Reporting of pharmacy disruption for the population covered by Blue Shield of California should be separated from that of UnitedHealthcare.

14. Q: Please provide further references to the desired custom benefit design for fertility, infertility and maternity benefits.

A: Pursuant to RFP Section 5.7.16.6.3 (Maternity, Fertility and Infertility), Selected Respondent(s) are advised to propose comprehensive, best-in-class fertility, infertility and maternity services and support SFHSS members. Respondents are also advised to review RFP Section 5.6 (Performance Guarantees) with respect to member satisfaction, and the accurate and non-discriminatory administration of fertility and infertility benefits to further emphasize the importance of custom and well-administered fertility, infertility and maternity benefits. While current fertility, infertility and maternity benefits for the Non-Medicare Population may be found in the Evidences of Coverage (EOCs) for the respective plans from Kaiser Permanente, Blue Shield of California, and UnitedHealthcare (and any applicable riders thereto), SFHSS continues to strive to improve upon best-in-class benefits for our members, including fertility, infertility and maternity benefits.

15. Q: Please provide further references to the desired custom benefit design for gender dysphoria benefits.

A: Respondents are advised to refer to Addendum No. 2, Question 16, and the Answer thereto.

16. Q: What is the intent of providing fully-editable plan documents (e.g. EOCs, SBCs)?

A: SFHSS expects to retain the ability to customize language and benefits for SFHSS members and as such requires the ability to review, edit, and/or correct all plan documents in collaboration with Selected Respondent(s) prior to submission to the California Department of Managed Health Care or other Regulator(s), as appropriate, for approval. Furthermore, providing all plan documents in fully-editable format (e.g. tracked changes, and rationale for each change, may be locked in Microsoft Word format) will allow for full, accurate and expedited review by all parties.

17. Q: Regarding Question 142 in the Questionnaire (under Telemedicine), what is being requested, total cost per virtual visit, per visit cost sharing, the provider cost per visit?

A: Question 142 in the Questionnaire requests the <u>total cost</u> per virtual visit.

18. Q: Regarding Question 143 in the Questionnaire (under Telemedicine), is SFHSS seeking to set the cost sharing for telemedicine within the proposed plan design?

A: In response to Question 143, SFHSS seeks Respondent's most applicable recommendation regarding the share of cost for telemedicine based on Respondent's experience as well as what may be most advantageous for SFHSS and the Non-Medicare Population.

19. Q: Has SFHSS established centers of excellence and/or the criteria for centers of excellence? Is the criteria surrounding establishing centers of excellence, and the leveraging of such centers (including navigation, bundled payments, cost and quality initiatives) expected to be a component of each Respondent's RFP proposal?

A: The criteria surrounding establishing centers of excellence and application thereof, including, but not limited to, criteria, evaluation and re-evaluation, navigating members, bundled payments, cost and quality initiatives, and improved patient outcomes, is expected to be a component of each Respondent's RFP proposal.

20. Q: Will SFHSS accommodate Respondents with an established third-party independent review organization (IRO)?

A: Yes, SFHSS may accommodate established IROs however, Respondents must also accommodate the non-negotiable terms and conditions of RFP Section 5.7.4 (Resolution of Claims and Disputes and Appeals).

21. Q: For the requested "statistics for your utilization management programs for years 2021 and 2020" will 2021 be interpreted to be 2019, as with Addendum No. 2 regarding call center data?

A: Yes, as with Addendum No. 2, Question 15 and the Answer thereto, please enter 2019 utilization management statistics under what appears as 2021 in the TBS/Greater Insight platform. For 2020, partial (Q1, Q2 and Q3) may be provided.

22. Q: Regarding the HTML-based Questionnaire, under the "Network, Providers, Access>>Utilization Management" section, what is meant by the request for the number of admission requests?

A: This would include the number of admits that require some level of utilization review, be it prospective, concurrent, or retrospective.

23. Q: Regarding HTML-based Questionnaire, under the "Network, Providers, Access>>Utilization Management" section, what is meant by the request for the number of denials and percentage of cases referred to [an] MD reviewer and the percentage reviewed for quality?

A: In accordance with the preceding answer, this would include the denials for all admits that require some level of utilization review be it prospective, concurrent, or retrospective.

24. Q: Regarding the HTML-based Questionnaire, under the "Network, Providers, Access>>Utilization Management" section, what is meant by the percentage of case managers?

A: This would include case managers associated with utilization review activities.

25. Q: Regarding the HTML-based Questionnaire, under the "Network, Providers, Access>>Network" section, what is meant by the requests for the percentage of a networks provider's case volume [that] is reviewed for quality and appropriateness each year?

A: The question is asking the percent of cases that are reviewed for quality and appropriateness each year. There is no minimum expectation stated.

26. Q: Please clarify the first question of the Questionnaire under "Legal".

A: The first question under "Legal" asks for levels of corporate and general liability insurance.

27. Q: What ACA notices must a Respondent provide assistance with to SFHSS?

A: Respondent must provide SFHSS with assistance as to any notices required by the Affordable Care Act, for example, the notice to employees of health insurance marketplace coverage options at the time of being hired (Employer Exchange Notice).

28. Q: What required annual notices must Respondent provide assistance with to SFHSS?

A: Respondent must provide SFHSS with assistance as to any required annual notices, for example, the Women's Health and Cancer Rights Act (WHCRA) notices, the HIPAA Notice of Privacy Practices for PHI, the General Notice of COBRA Rights, or any Notice of Modification to the Summary of Benefits and Coverage (SBC).

29. Q: What government reporting responsibilities must Respondent provide assistance with to SFHSS?

A: Respondents must provide SFHSS with assistance as to any current or future required government reporting responsibilities, including, for example, ACA reporting such as W-2, applicable large employer health coverage and annual IRS reporting. This may include future transparency in coverage reporting, cost-sharing disclosures and quality of care reporting.

30. Q: What is the definition of concierge service as used in the HTML-based Questionnaire under the "Network, Providers, Access>>Advocacy/Concierge" section.

A: Concierge services, as used the RFP Questionnaire Section "Network, Providers, Access", is not to be confused with what is commonly termed "concierge medicine" whereby physicians charge patients an out-of-pocket retainer fee for full access to their services. Rather, concierge service is meant to connote a heightened level of customer services, support and assistance for members with regard to navigating the care and benefits available to them, without added fees or payment models.

31. Q: With respect to the HTML-based Questionnaire under section "Carrier Agreement>>Custom Questions", are Respondents expected to provide access to region and national subject matter experts at the request of SFHSS?

A: SFHSS expects no fees or unreasonable limitations or restrictions with regard to accessing the expertise of a Selected Respondent's local, regional and/or national subject-matter-experts (SMEs) in order to provide best-in-class care and benefits to SFHSS members.

32. Q: Can SFHSS provide any additional clarification regarding RFP Section 5.7.16.7.1, subsection 3) (Obesity Management)?

A: Due to the increasing rate of obesity and the inherent health risks, SFHSS expects Respondents to propose comprehensive and effective obesity screening, intervention, management, treatment, and associated wellness programs.

33. Q: In addition to RFP Sec. 1.3.4, what additional information can SFHSS provide regarding the methodology for determining the amounts, timing and process for premium redistribution based on the evaluation of population risk scores?

A: SFHSS fully expects to finalize the exact methodology for premium redistribution in collaboration with the Selected Respondent(s) and in consideration of any proposed methodology by Respondent(s) in response to the RFP. At minimum, we expected to utilize population health risk scores based on enrollment for the 2022 plan year.

34. Q: Where do we submit proposed rates within the Greater Insight platform?

A: Respondent is advised to use the Microsoft Excel and the HTML-based templates in the Greater Insight platform.

35. Q: What is the breakdown of capitation and pharmacy cost experience for the Blue Shield of California Access+ HMO and Trio HMO?

A: Respondents are advised to review the annual presentations to the Health Service Board in March for detailed aggregate reporting of capitation and pharmacy experience for the previous plan year. Currently, capitation covers approximately 35-40% of all medical costs.

36. Q: Will SFHSS provide claims lag triangles that show the claims summarized by incurred and paid month?

A: In response to this question, three files will be posted to TBS/Greater Insight platform on or about October 1, 2020 (with a separate notification to all registered entities). The uploaded files will outline the lag triangles for the PPO Plan, and both the Blue Shield of California HMO plan with the TRIO network and with the Access+ network.

37. Q: Will SFHSS provide medical allowed cost information?

A: The claim information provided is paid claim data, not allowed cost. Respondents have SFHSS plan design information in order to determine plan actuarial values, which can assist, if needed, in a Respondent's calculations for estimated allowed cost.

38. Q: For the medical allowed cost guarantee, can SFHSS confirm how much should be placed at-risk?

A: No. The amount places at-risk is an individual determination to be made by each Respondent.

39. Q: Please confirm if the claim data provided to date is paid claim data.

A: Correct. Please refer to Question 36 and the answer thereto.

40. Q: If two or more Respondents are selected as a result of the RFP, will each Selected Respondent be permitted to modify its proposed Medical Allowed Cost Guarantee?

A: If two or more Respondents are selected as a result of the RFP, SFHSS must retain the proposed Medical Allowed Cost Guarantee proposed by each Respondent for the 2022 plan year.

41. Q: Should Respondents quote pharmacy for fully-insured plans as fully insured as well? What about ASO plans?

A: For fully insured plans, Respondents shall propose a fully-insured pharmacy benefit. Similarly, for any proposed self-insured ASO plan, Respondents shall propose an ASO self-insured pharmacy benefit.

42. Q: Please confirm the period of the financial proposal and contract period to be three (3) years beginning January 1, 2022 and ending December 31, 2024 (e.g. the 2022, 2023 and 2024 plan years)?

A: Confirmed. Please note that in the Rx Questionnaire (3 of 3) on the Financial Questionnaire tab, row 81, there is a reference to the contract period being 1/1/2021 through 12/31/2023. This is incorrect. The contract period is effective 1/1/2022 through 12/31/2024. Respondents are advised to read the questionnaire as such.

43. Q: Are all members enrolled in an HMO plan with SFHSS as of January 1, 2020 within scope of this RFP?

A: Eligible members of the Non-Medicare population will be permitted to select any applicable plan (accounting for any geographic restrictions) for themselves and th as of the open enrollment period for the 2022 plan year. Pursuant to the RFP, this includes the 94,452 (as of January 1, 2020) covered lives within the Non-Medicare population, including the 23,273 enrolled in the Blue Shield of California Access+ HMO and the 12,053 enrolled in the Blue Shield of California TRIO HMO, as well as the 56,14 enrolled in the Kaiser HMO. As

noted throughout the RFP, the Kaiser HMO plans will be retained for the 2022 plan year regardless of the outcome of the RFP.

44. Q: How many HMO plans is the SFHSS expecting to contract with?

A: The number of HMO plans is entirely dependent on the evaluation of the proposals submitted by Respondents. As a result of this RFP, SFHSS may recommend one or more HMO plan(s) as a result of this RFP. The recommended HMO plan(s) may be provided by the same carrier as a PPO plan, or by different carriers (akin to the current state with Blue Shield of California and United Healthcare).

45. Q: May Respondents propose membership thresholds or minimum enrollment requirements?

A: No. Enrollment will not be known until after Open Enrollment for the 2022 plan year (October 2021).

46. Q: Are there any limitations on eligibility for the future PPO plan for 2022?

A: No, there are not limitations on eligibility for the future PPO plan in 2022, similar to the current PPO plan (UnitedHealthcare ASO-PPO).

47. Q: Per the "Health System Models - System Competition Scenario" in RFP Section 1.3 (Objectives), is SFHSS expecting to select three (3) carriers and three (3) HMO plans as a result of this RFP?

A: No, the Health System Competition Scenario is intended as an example whereby as a result of the RFP, two or more HMOs from different carriers could be selected. As noted in this and previous Addenda to the RFP, one or more HMOs may be selected as a result of this RFP, and the selected carrier for the PPO may or may not be the same carrier providing one or more than one of the HMO plans selected.

48. Q: May a Respondent propose a fully-insured HMO or a self-insured EPO (exclusive provider organization) or a self-insured HMO, or an alternative non-PPO plan option and also propose a PPO plan in response to the RFP?

A: Yes. Respondents are permitted to propose one or more non-PPO and a PPO plan option in response to the RFP.

49. Q: Pursuant to the System Competition model (RFP Sec. 1.3), can a Respondent propose different rate proposals based on the number of HMO carriers?

A: No, Respondents must propose a single rate proposal irrespective of the number of HMO carriers ultimately selected. As noted in the RFP, this addendum and

other addenda to the RFP, one or more than one carrier may be selected as a result of the RFP, the System Competition model denotes "(Carrier 1/2/3)" to note that as a result of the RFP, more than one carrier may provide additional HMO plan options for the 2022 plan year (in addition to the Kaiser Permanente HMO plan which will be carried over from the 2021 to 2022 plan year).

50. Q: If the result of the RFP is more than one additional HMO from more than one carrier, what will be the expected enrollment in the two plans?

A: SFHSS in unable to determine the open enrollment elections and/or modifications of eligible SFHSS members for the 2022 plan year, nor the future distribution of the 94,452 covered lives within the Non-Medicare Population as of January 1, 2022.

51. Q: Where can Respondents submit charges and factors other than administrative fees for a flex-funded proposal (including any alternative proposals to the fully-insured proposal section)?

A: The TBS/Greater Insight platform allows for an attachment, "alternative funding method", for this purpose and other alternative funding proposals.

52. Q: Should the 'Bay Area' rate eligibility be defined by the home ZIP code and/or county of the Subscriber?

A: Yes.

53. Q: How are the Medicare-eligible-but-not-enrolled population identified within the RFP and the data within the Greater Insight platform?

A: Pursuant to the RFP, FN12, there are only 121 Medicare-eligible members not enrolled in Medicare and enrolled within the "City 20" plan under the UnitedHealthcare PPO. These individuals are a sufficiently small population and as such are not separately identifiable within the TBS/Greater Insight data.

54. Q: Are Respondents permitted to propose tiered administration fees based on the number of covered lives ultimately enrolled for the 2022 plan year?

A: No. SFHSS cannot predict enrollment decisions by members of the Non-Medicare Population for the 2022 plan year (Open Enrollment, October 2021), and furthermore, must obtain approval of all fees and premiums for the 2022 plan year from both the Health Service Board (May 2021) and the Board of Supervisors (July 2021). A such, Respondents will not be able to modify or recalculate premiums for the 2022 plan year based on actual enrollment.

55. Q: Is there a required Local Business Enterprise goals or associated requirements pursuant to San Francisco Administrative Code, Chapter 14B (Appendix E-1, Section 10.6)?

A: No. Pursuant to the Pre-Proposal Conference Call and Agenda thereto, the requirements of Chapter 14B have been waived for any agreements resulting from this RFP.

56. Q: Should Respondent assume that only our responses to the Questionnaire and the language of any final agreements will be binding, and that any statements or other requests presented in the RFP without a clear opportunity to agree/disagree or otherwise modify the language shall not be binding?

A: Please refer Addendum No. 2, Question 20, and the response thereto. Respondents are reminded that failure to meet any minimum requirements of the RFP may result in rejection of a Respondent's proposal. Furthermore, Respondents are advised that the rejection of, or failure to meet, any required, non-negotiable components of the RFP will be evaluated as such by the RFP panel.

57. Q: With respect to RFP section 5.7.23.10 (Data Integration) and the coordination and integration of data sets across multiple sources, and the reporting and integration of data from the SFHSS Well-Being Division, what is the frequency and quantity of files and feeds that Respondents should expect if selected as a result of this RFP?

A: Respondents should expect monthly, quarterly, bi-annual and annual data files, including for those from the Well-Being Division. Furthermore, for integration of the APCD (All-Payer Claims Database/Data Warehouse), expect at minimum every four to six months as SFHSS will required a least one quater (three months) of utilization accompanied by a one month lag at the close of each quarter.

58. Q: Will SFHSS provide an HMO large claim report with diagnoses? If so, for what time period?

A: This information is available in the "SFHSS current vendor claims and enrollment data for GI 090520.xls" file located in the Reference Documents section of the TBS/Greater Insight platform

59. Q: Will SFHSS provide a PPO large claim report with diagnoses? If so, for what time period?

A: This information is available in the "SFHSS current vendor claims and enrollment data for GI 090520.xls" file located in the Reference Documents section of the TBS/Greater Insight platform

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60. Q: Are non-Medicare retiree rates the same as the Active Rates for the HMO Access+, Trio, and PPO plans? If not please provide the current rates for these individuals.

A: Currently rates are split for Active versus Early Retiree members. Information on the current rates may be found on the SFHSS website.

61. Q: Please provide an explanation for the differences between the requested pre-implementation audit, medical claims and operations audit and the fee transparency audits.

A: The pre-implementation audit would occur prior to the effective date and would be for the purposes of validating the plan designs and eligibility rules were accurately set up in the Respondent's system. The other audits could be performed at SFHSS' discretion once the plan is up and running with the appropriate amount of claims to create a statistically valid audit outcome.

62. Q: Is there a specific amount requested for the medical claims and operations audit?

A: Unless otherwise stated, Respondents should provide their recommended audit budget that is available for SFHSS use annually.