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

ADDENDUM NO. 4

RFP for Health Plans – 2022 Plan Year

October 8, 2020

REQUEST FOR PROPOSAL
Health Plans—2022 Plan Year

RFPQ#HSS2020.M1

CONTACT: Michael Visconti, michael.visconti@sfgov.org, (628) 652-4645

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),Addendum No. 2 (issued September 25, 2020), and Addendum No. 3 (issued October 1, 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 may be issued in response to additional technical questions regarding access to TBS/Greater Insight and requests for clarification regarding the TBS/Greater Insight platform. Please see Section C, below, regarding technical questions and responses regarding the TBS/Greater Insight platform.

A. Modifications to RFP:

1. RFP Section 3.5.4 (Proposal Structure), Section 3 (Executive Summary) shall be modified as follows:

Section 3: Executive Summary (word / page limit: **3,000** words or **six (6)** pages)
Respondent Executive Summary shall include, at minimum, the following information:

- Respondent's business name, address, telephone number, email address and fax number. Respondent's legal formation (e.g., corporation, LLC, non-profit, etc.), and the year the entity was substantially organized as it now exists.

- Respondent's legal formation (e.g., corporation, LLC, non-profit, etc.), and the year the entity was substantially organized as it now exists.
- The name of any sole proprietor, partners, or principal officers, as appropriate.
- Respondent's greater organizational structure, including parent company, subsidiaries and partners, recent acquisitions or mergers (within the last two (2) years), or any known future acquisitions or mergers.
- The primary account manager or executive responsible with overseeing or carrying out Respondent's responsibilities if awarded a contract as a result of the RFP.
- Respondent's agent for service of process (name and address) and/or the name and address of the entity that receives legal notices for Respondent.
- Respondent's Federal Employer Tax Identification Number and a completed IRS W-9 form.
- Respondent's proposed subcontractors.
- If the Proposal is being submitted by Respondent in partnership, cooperation or association with one or more Joint Respondents or Subcontractors:
  - A full and complete listing of all Joint Respondents, including addresses, telephone numbers, email addresses and fax numbers.
  - Legal formation of each Joint Respondent.
  - Primary responsibilities of each Joint Respondent if Respondent is awarded a contract as a result of the RFP.
  - Length of relationship between each Joint Respondent and Respondent.
- Respondents shall provide five (5) references for which Respondent has performed similar services during the past five (5) years. For each reference, Respondent shall include a brief description (two (2) **paragraphs**) of the work, covered lives, number of years under contract, and contact information. At least two (2) references should have at least 12,000 covered lives, or be the largest accounts held by Respondent.
- If any of the above information in unavailable for Respondent entity, Respondent must submit the same or similar information from Respondent's parent entity, if available.

Please also note the response below to Question 20 below.

2. Q: Please confirm SFHSS' intent regarding the contract period for Selected Respondent(s) (RFP Page 17 compared to the Questionnaire).

A: Respondents are expected to propose solutions that will be *available to* SFHSS and members of the Non-Medicare Population for at last five (5) years (plan years 2022 through 2026) (see RFP page 17).

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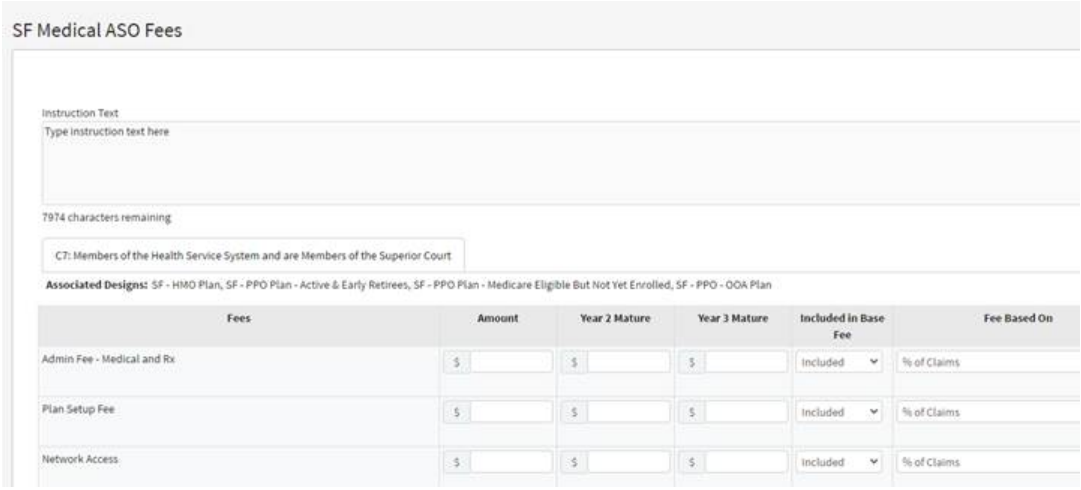
For the purposes of the Proposal and Questionnaire Respondents are asked to provide rates for the first three (3) plan years (2022, 2023, and 2024).

Please see the below screenshot and example from the section requesting a three-year administrative fee quote.



B. Questions & Answers

1. **Q:** What is the enrollment in Brown and Toland and Hill Physicians for the Blue Shield of California Access+ and TRIO HMO plans in San Francisco? Who are the ACO partners in the TRIO HMO for SFHSS? What additional information can be provided by SFHSS?

   A: As of January 1, 2020, the Blue Shield of California enrollment by ACO within San Francisco is as follows: Brown & Toland (B&T) ACO, Access+ = 7,879, TRIO = 4,586 (Total B&T = 12,465); Hills Physician (Hills) ACO, Access+ = 3,549; TRIO = 4,752 (Total Hills 8,301).

   The B&T ACO (SFHSS-specific for Access+) includes the B&T Group

   The Hills ACO (SFHSS-specific Access+) includes Hills Physician Medical Group, University of California San Francisco, and the Dignity Health groups.

   The ACO partners in TRIO for SFHSS are Brown & Toland, Hill Physicians, Meritage and John Muir.

The IPAs in the counties with the largest enrollment of SFHSS members (Alameda, Contra Costa County, Marin, San Francisco, San Mateo, Santa Clara, Solano, Sonoma) are as follows: Brown & Toland Physicians, Brown & Toland Physicians East Bay, Dignity Health Medical Network – Santa Cruz, Hill Physicians Sacramento Primed Inc, Hill Physicians San Francisco, Inc, Hill Physicians San Joaquin, John Muir Physician Network, Meritage Medical Network – Marin County, Santa Clara County IPA, St. Joseph Heritage Medical Group.

2. **Q:** What percentage of the total Blue Shield of California enrollment, as of January 1, 2020, is enrolled in institutionally (also known as globally) capitated medical groups?

   A: There are no global capitation arrangements under the current HMO plans.

3. **Q:** What does "PG1-All Employees" mean compared to the "PG1-_Rate_0"? Does that mean the rates in "PG1-_Rate_0" won't be an option for All Employees at open enrollment? There are other naming convention questions on many of the other spreadsheets contained within this workbook as well.

   A: In the extract from the TBS/Greater Insight platform you will see some standardized naming conventions. For the example given, "PG1-All Employees" is requesting the fully insured quotation for the HMO plan design while the "PG1-Rate-0" is requesting the fully insured quotation for the PPO plan. These distinctions are noted in the header of the .xls tab vs. the name of the tab itself.

4. **Q:** What is meant by "Physicians [are] required to abide by utilization review rulings"?

   A: The questionnaire is asking that Respondent confirm that network providers are obligated to follow the Respondent's utilization review rules as well as any rulings that come out of the utilization review (approval, denial, etc.).

5. **Q:** What is the HMO cost experience (in-patient, out-patient, professional and behavioral health) for Blue Shield of California Access+ HMO and TRIO HMO?

   Will SFHSS provide utilization information by provider for both hospital and physician claims for the top 25 providers for each subcategory and will the claims be broken out by in-patient, out-patient and emergency room?

   A: Please see additional data posted to TBS/Greater Insight on October 5, 2020: "Additional Claims Detail 10082020.xlsx"

   Claims by provider will not be provided by SFHSS for the purposes of this RFP.

6. **Q:** Please clarify the incurred service and paid dates for the cost experience provided. For example, the exhibits state that data is "Calendar/Fiscal Year – Incurred" with "Run-Out Status = Inside 3 Months".

   Does this mean that the 2018 and 2019 data represent costs for services with service dates in the calendar year but paid through some later date (e.g., paid through end of March for both calendar years 2018 and 2019 incurred claims)?

   Also, which service and paid through dates apply to the 2020 cost data?

   A: The UHC claims data in the "SFHSS current vendor claims and enrollment data for GI 090520.xls" file represents incurred claims within each listed month that have been paid through June 30, 2020. Additionally, the file "UHC City Plan Experience and Membership By Month 06-20.xlsx" posted on October 1, 2020 will be helpful in showing patterns of incurred and paid data by month for the time period contained in the claim lag data.

   The Kaiser claims data in the "SFHSS current vendor claims and enrollment data for GI 090520.xls" file is paid claim dollars for each month displayed, without regard to incurred service dates.

   The Blue Shield data in the ""SFHSS current vendor claims and enrollment data for GI 090520.xls" file are paid in each month, regardless of incurred date.

7. **Q:** What is the difference between 'choice not available' and 'out of area'? What about retirees living outside the lower 48 states? Who are in the Hetch Hetchy population and which department(s) do they work for and what are the eligibility requirements?

   A: Choice Not Available: If a member resides in a zip code which is represented by one HMO plan, or less, the member will be offered the PPO plan at a lower premium rate (currently it is equal to the Access+ HMO rate).

   Out-of-Area: the Out-of-Area (OOA) plan offers the same benefits as the City Plan; however, the out-of-network co-insurance is the same as the in-network (in essence there is not out of network differential). This plan is available to members who reside outside of the continental United States.

   The Hetch-Hetchy population is a smaller group of essential workers, who are under the purview of the San Francisco Public Utilities commission, who are hired to work at the Hetch Hetchy Reservoir, in Moccasin, California. Workers at this site have various roles in the fields of science, technology, operations, maintenance, and engineering. More information about Hetch Hetchy Reservoir can be found on the following website: https://sfwater.org/index.aspx?page=355.

8. **Q:** Is SFHSS requesting a separate retail/90-day pharmacy guarantee?

A: While SFHSS does not currently use a Retail 90 program, Respondents are being asked to provide a separate retail 90 guarantee should SFHSS decide to implement this going forward.

9. Q: Should financial guarantees for pharmacy be provided by product (e.g. HMO and PPO *separately*) or combined (for HMO and PPO), if selected)?

A: Financial guarantees should be provided by product and, if applicable, combined.

10. Q: May a Respondent propose separate administration fees for a proposed HMO plan and a proposed PPO plan?

A: Yes, a Respondent may propose separate administration fees for the PPO and HMO plan. One additional set of financial response templates has been posted to the TBS/Greater Insight platform. A notification was sent from the TBS/Greater Insight platform.

11. Q: If a Respondent is proposing a fully insured plan, is Respondent expected to allow for split enrollment?

A: Yes.

12. Q: Please outline the current claims funding arrangement?

A: SFHSS has several arrangements for claims funding that include daily as well as weekly funding via ACH. However, SFHSS is evolving toward a weekly claims funding schedule. At present, the normal turnaround time for claims payment requests is within one (1) to three (3) business days. It should be noted the SFHSS will not accept an imprest or revolving fund arrangement.

13. Q: Will SFHSS provide data for actives versus early retirees (for both the HMO and PPO)?

A: Claims split by active and early retiree were provided in the following files: 'SFHSS current vendor claims and enrollment data for GI 090520.xls' and 'SFHSS_HMO_MedRxClaims_092802020_NoCap.xls'

Claims split by Bay Area/Non-Bay Area are not available for this RFP.

14. Q: Will SFHSS provide an HMO IPA PCP listing including dollar amounts?

A: No, this information will not be provided for this RFP.

15. Q: Under the Alternative Network Section of the Health Plan Questionnaire, for each alternative network being proposed, are Respondents able to duplicate the questions to provide a unique response per network?

A: Yes, a Respondent may submit up to one additional response to the questionnaires. Instructions on how to create the separate template for the HTML-based questionnaire will be provided next week. A notification will be sent when the instructions are available.

For Excel-based questionnaires, please save a separate file and post to the TBS/Greater Insight platform.

Please clearly identify the network that the questionnaires tie to through the name of the file posted.

16. Q: Will SFHSS be able to provide a break out of the pharmacy claims data by NDC, fill date, quantity dispensed, dispensing, days supply, member ID, NABP/NPI (pharmacy identifier), retail/mail filled, AWP, Channel, Brand/Generic Indicator, current tier/formulary indicator, ingredient cost, and Compound Indicator?

A: Updated Rx claims file were posted to GI on 10/6/2020. No further information will be provided or added to this file at this time.

17. Q: Is SFHSS requesting the least disruptive Prescription Drug List (PDL) for the PPO and the HMO plans?

A: Yes.

18. Q: With respect to the RFP Section 5.6 (Performance Guarantees) and the section titles "Reporting and Data Sharing", where will the reporting and data transparency requirements be listed in the group agreement?

A: As specified in the subsection "Reporting and Data Sharing" to RFP Section 5.6 (Performance Guarantees), the required reporting, data sharing, and data requirements will be contained with an agreement resulting from this RFP between the City/SFHSS and Selected Respondent(s). It will include, but not be limited to, transparent reporting of claims data, drug claims data, provider data, and mental health data (RFP Sec. 5.6). It will meet applicable Data Requirements (RFP Sec. 5.7.23) including, but not limited to, subsection 5.7.23.13 (Data Transparency). It will meet required Reporting (RFP Sections 5.7.11 and 5.7.22.16) requirements, and transparency in financial contracting terms, pharmacy terms, and provider contracts, fees, and reimbursements (RFP Sections 2.1.3 "Rate Assumptions" and 2.1.8 "Special Topics"). Furthermore, it may include Respondent's reporting on efforts to promote price and quality transparency (RFP subsection 5.7.24.1 "Quarterly Reporting").

19. Q: Will SFHSS be providing addressed for approximately 500 providers without addresses currently listed in the data?

A: This data is not available for this RFP.

20. Q: Regarding References, in the references section of the Carrier Agreement, Contact Information and Vendor Response Questionnaire there are only four (4) cells for our responses (#24 through #27) but the RFP (RFP Section 3.5.4 (Proposal Structure), Section 3 (Executive Summary)) requests five (5) references. Where should we add our 5th reference?

A: Respondents are advised to respond the request for five (5) references as specified in the RFP within their written Proposal.

Furthermore, as stated above in Section A.1 of this Addendum, RFP Section 3.5.4 has been modified as follows:

(i) SFHSS has expanded the word/page limit to 3,000 words or six (6) pages, and

(ii) SFHSS has clarified that for each reference, the brief description of the work shall be, at most, two *paragraphs*, not two pages.

As for the Questionnaire, Respondents are advised to input a "0" within each of the four cells (#24, #25, #26 and #27) to designate that the required references have been provided within the Proposal itself.

21. Q: The RFP provides a great deal of information about population health management, specific disease management programs, medical second opinion and gender dysphoria but we do not see specific questions in the Questionnaire regarding these services. Where would we include this information?

A: Pursuant to RFP Section 3.5.4 (Proposal Structure), please note the difference between Section 6 (Questionnaire), Section 7 (Non-Financial Elements) and Section 8 (Financial Elements). In addition to providing further detail as part of your response to the Scope of Work, Respondent may include this level of detail within the "Special Populations" section on the "Special Topics" tab of the Questionnaire.

22. Q: What are the required contributions for early retirees for the 2020 plan year?

A: 2021 early retiree health plan contributions can be found in this weblink to the 2021 non-Medicare retiree rate sheet: https://sfhss.org/sites/default/files/2020-09/2021_Retirees_without_Medicare_RatesOnly.pdf

23. Q: Has SFHSS replaced Teladoc (fka Best Doctors) with another vendor to provide similar services to Teledoc's InterConsultation and Expert Medical Opinion Services and, if yes, what vendor(s)?

A: No, SFHSS did not replace Teledoc with another third-party vendor to provide expert medical opinion services in 2020 however, pursuant to RFP Section 1.2.5, subsection 5, "[f[ollowing the conclusion of the SFHSS partnership with Teladoc, SFHSS placed increased focus on ensuring that Members are aware of procedures for obtaining in- and out-of-plan expert second opinion services." As such, reference to such services has been included in this RFP, including RFP Sections 2.1.8 (Special Topics) and 5.7.23.13 (Data Transparency), as well as in the Questionnaire>>Special Topics>>Innovation section.

24. Q: Why are the employee cost shares lower for the Kaiser plan?

A: Information on SFHSS plan rating, including how member cost shares are set for SFHSS health plans, can be found in the Non-Medicare Healthcare Plan Rating Methodologies Parts 1-4 section. Please see the SFHSS website, Board Education section, or go directly to this weblink: https://sfhss.org/board-meeting/2019-01-01t200000.

25. Q: Pursuant to the annual SFHSS rates and benefits process, if there is a change in benefits from one year to the next, will rates be permitted to be adjusted accordingly?

A: A material change in benefits may be considered grounds for a reasonable, actuarially-based adjustment in the rates for the subsequent year.

26. Q: Can SFHSS provide claims experience by major medical group broken out by Blue Shield Access+ and Trio?

A: Respondent(s) are advised to please reference the additional data posted to TBS/Greater Insight on October 5, 2020: "Additional Claims Detail 10022020.xlsx". No further information will be posted on this subject at this time.

27. Q: Absent specific metrics in the performance guarantee section of the RFP (pages 60 and 61) for Behavioral Health, Cardiovascular, Diabetes, Maternity, Prevention and Screening, and Respiratory, what are to be expected for Respondent(s) if selected?

A: Respondents will meet each metric at the 75th percentile or better for each measure, based on publicly available commercial HMO and PPO data.

28. Q: Pursuant to the Questionnaire regarding the combined voluntary/involuntary removal rate states 2020 and 2021, should Respondents enter 2019 for 2021 and Q1 through Q3 for 2020?

A: For the voluntary/involuntary removal rate, as with the statistics for utilization management programs in Addendum No. 3 and the call center data in Addendum No. 2, the year 2021 be interpreted to be 2019. For the year 2020, please include all currently available data.

29. Q: Regarding Question 36 ("What book-of-business claim cost trend was observed in 2022 relative to 2021 and in 2021 relative to 2020. (e.g. 2018 relative to 2017, and 2017 relative to 2016)"), since this question refers to future dates, please advise for what years we should provide data.

A: Please provide as follows:
2022 = 2020
2021 = 2019
2020 = 2018

30. Q: Regarding Question 40 ("Provide the following statistics for your utilization management programs for years 2021 and 2020."), since this question refers to future dates, please advise how we should complete the fields requestions 2021 data.

A: Please provide as follows:
2020 = 2020
2021 = 2019

31. Q: Regarding Question 120 ("Provide the following statistics for your customer service centers overall (book of business). We are requesting actual results for the customer service centers; therefore, standards should not be provided."), since this question refers to future year, please advise how we should complete the fields requestion 2021 data.

A: Please provide as follows:
2020 = 2020
2021 = 2019

32. Q: Regarding Question 121 ("Please answer the following questions as they relate to your Claims Processing centers overall (book of business)"), since this question refers to future year, please advise how we should complete the fields requestion 2021 data.

A: Please provide the following:
2020 = 2020
2021 = 2019

33. Q: Regarding Question 125 ("Provide the following statistics for the proposed customer service center that will handle the Client account. We are requesting actual results for the proposed customer service center; therefore, standards should not be provided."),

since this question refers to future year, please advise how we should complete the fields requesting 2021 data.

A: Please provide as follows:
2020 = 2020
2021 = 2019

34. Q: Regarding Question 126 ("Please answer the following questions as they relate to Claims Processing center that will handle the Client account:"), since this question refers to future year, please advise how we should complete the fields requesting 2021 data.

A: Please provide as follows:
2020 = 2020
2021 = 2019

35. Q: Regarding Question 139 ("Please answer the following questions as they relate to claims processing for offshore locations:"), since this question refers to future years, please advise how we should complete the fields requesting 2021 data.

A: Please provide as follows:
2020 = 2020
2021 = 2019

36. Q: Regarding Rx questionnaire – Question 78 ("If requested by SFHSS AND should your firm be selected as the PBM, you agree to reimburse SFHSS the full cost of this marketing"), can SFHSS provide clarity around this request and define "full cost of this marketing"?

A: This question was included in error; you are not required to respond to this question. However, please do not remove this row, simply mark your answer as "N/A".

37. Q: In several locations both on the TBS/Greater Insight tool and the Health Plan Questionnaire SFHSS has asked very weighty compound questions that we would like to answer in their entirety but we have been asked to address in 1,000 characters. Would you like us to create attachments to provide our thorough answer in addition?

A: SFHSS will permit expanded responses under the "Strategic Alignment" and "Special Topics" tabs however attachments will not be permitted. However, Respondent(s) are further advised that pursuant to RFP Section 3.5.3 (Relevant Information), irrelevant responses and superfluous information may be disregarded.

38. Q: In the TBS/Greater Insights tool 'Organizational Financial Stability' section, SFHSS has asked for financial information for future years: 1. Premium Revenue; 2022.

In the TBS/Greater Insights tool, Organizational Financial Stability section you have asked for financial information for future years: 2. Premium Revenue; 2021

In the TBS/ Greater Insights tool, Organizational Financial Stability section you have asked for financial information for future years: 3. Premium Revenue; 2020

A: Please provide as follows:
2022 = 2020
2021 = 2019
2020 = 2018

39. Q: In the TBS/Greater Insights tool, Organizational Financial Stability section you have asked for financial information for future years: 4. Total Revenue; 2022

In the TBS/Greater Insights tool, Organizational Financial Stability section you have asked for financial information for future years: 5. Total Revenue; 2021

In the TBS/Greater Insights tool, Organizational Financial Stability section you have asked for financial information for future years: 6. Total Revenue; 2020

A: Please provide as follows:
2022 = 2020
2021 = 2019
2020 = 2018

40. Q: In the TBS/Greater Insights tool, Organizational Financial Stability section you have asked for financial information for future years: 7. Net Income; 2022

In the TBS/Greater Insights tool, Organizational Financial Stability section you have asked for financial information for future years: 8. Net Income; 2021

In the TBS/Greater Insights tool, Organizational Financial Stability section you have asked for financial information for future years: 9. Net Income; 2020

A: Please provide as follows:
2022 = 2020
2021 = 2019
2020 = 2018

41. Q: Regarding City Plan PPO: the file "SFHSS current vendor claims and enrollment data for GI" indicates there are 943 active/COBRA subscribers and 910 Early retirees in the latest month of 6/2020. However, the enrollment census data file indicates 1029 active subscribers, 758 early retirees, 10 leave of absence, 2 leave with pay and

52 survivors. The active and early retiree subscriber counts from these two source files don't match.

Can you please explain why the actives and early retiree subscribers counts from these two source files are different, by almost 10%?

Can you please explain how you categorize leave of absence, leave with pay and survivor subscribers (in active/cobra vs early retirees)?

A: Please refer to the census information provided as of August 31, 2020 as it has the most recent information regarding plan enrollments, including the UHC PPO plan.

Survivors are to be grouped with Retirees. Leave of Absence/Leave with Pay are to be grouped with Actives.

Headcount information for the current UHC PPO plan in the "SFHSS current vendor claims and enrollment data for GI" file was provided to SFHSS by UHC but has not yet been audited by SFHSS.

The census information provided by SFHSS as of August 31, 2020 was taken from the SFHSS PeopleSoft database.

42. Q: Will SFHSS please provide large claims data for the City Plan PPO for experience period of 6/1/2019 to 5/31/2020 (12 months) which coincides with the claims experience period?

A: At this time, SFHSS has provided calendar year claims experience. No additional subsets will be provided at this time.

43. Q: Are providers unhappy with the current carrier arrangement?

A: Provider satisfaction with current carrier arrangements are not within the purview of SFHSS.

44. Q: How do the Access+ and TRIO networks compare in San Francisco, Alameda, Contra Costa, and San Mateo counties?

A: In addition to the response provided above in B.1 above, Respondent(s) may reference publicly available information regarding TRIO, such as https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/trio-hmo/network-and-service-area.

45. Q: What are the retiree eligibility criteria?

A: Please refer to the Member Rules on the SFHSS website and the Charter for the retiree eligibility criteria. Links are provided within the RFP.

46. Q: What entities are listed in the Partner section of the RFP?

A: Section 1.2.4 (SFHSS Partners) is intended to list the names of all currently contracted entities that will continue into the 2022 plan year regardless of the outcome of the RFP. UnitedHealthcare is listed here because as a result of the RFP, UHC will continue to support Medicare-eligible retirees with a Medicare Advantage health plan.

47. Q: How are the current Blue Shield ACO cost and quality metrics identified?

A: Specifics as to how the cost and quality metrics are identified within the BSC ACO contracts is proprietary and will not be released.

48. Q: How does the premium reallocation with risk adjustment formula (RFP page 19, Sec. 1.3.4) work?

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. Please see Addendum No. 3, Question 33, and the Answer thereto.

49. Q: Will SFHSS disclose the bond ratings for any prospective Respondents?

A: Pursuant to RFP Section 1.5.1 (Minimum Qualifications), it is required, at the time a Respondent's Proposal is submitted, that "Respondent meets a Standard and Poor's', Moody's or AM Best financial rating of "A-" ". Prior to that time, SFHSS is unable to disclose the bond ratings of any proposed Respondent to the RFP.

50. Q: In RFP Section 1.3.1 (Value-Based Payment Models), what is meant by the final bullet point ("Network steerage towards high quality, integrated health providers that will advance primary care practitioners")?

A: This bullet point refers to how SFHSS seeks to leverage primary care with a focus of placing primary care physicians at the center of care delivery for patients.

51. Q: What is the SPARC tool, referenced on page 21 of the RFP?

What is the purpose of Attachment 3 (ACO Standards and Reporting) to RFP Section 5.5 (Standard Agreement)?

A: The Standardized Plan ACO Reporting for Customers, or SPARC, is a valuable tool provided by the nonprofit entity Catalyst for Payment Reform (https://www.catalyze.org/). Applicable and relevant (to this RFP) provisions of the SPARC ACO reporting, pursuant to RFP FN 20, are provided in Section 5.5 (Standard Agreement), in Attachment 3, which is available on the SFHSS website at https://sfhss.org/RFPs. It should be noted that Attachment 3 is included in RFP Section 1.5.2, the baseline expectations for the 2022 plan year for any Selected Respondent(s).

52. Q: What are the IBM (fka. Truven) data requirements?

A: Data Requirements are provided in RFP Section 5.7.23. Any references to data requirements in RFP Section 5.7.22 should be directed to 5.7.23. Provider satisfaction with current carrier arrangements are not within the purview of SFHSS.

53. Q: Is there utilization data of Sutter facilities and within the Blue Shield plans?

A: Sutter is in-network for BSC Access+ HMO. For BSC TRIO HMO, Sutter CPMC is in-network. Additional specific utilization data, beyond what is already provided, will not be provided at this time for the RFP.

54. Q: How will contributions be structured between plans?

A: Pursuant to Question 24 and the Answer thereto (above), Respondents are advised to review the Non-Medicare Healthcare Plan Rating Methodologies Parts 1-4, including Part 2, in the SFHSS website under Board Education.

55. Q: Please elaborate on the intent of the Benefits Administration Credit located on the Financial Exhibit. Is there an expected amount, scope of services this credit is intended for and is an external vendor/partner already in place to provide this service?

A: It is at the discretion of the Respondent to determine the amount of any allowances offered to SFHSS for use towards benefits administration, audit, etc.

56. Q: Regarding all credits and allowances, it is to the discretion of each bidder to the amount proposed for each or does SFHSS have projections to use?

A: It is at the discretion of the Respondent to determine the amount of any allowances offered to SFHSS for use towards benefits administration, audit, etc.

57. Q: Regarding the question "What book-of-business claim cost trend was observed in 2022 relative to 2021 and in 2021 relative to 2020. (e.g. 2018 relative to 2017, and 2017 relative to 2016)

A: For this question, please provide as follows:
2022 = 2020
2021 = 2019
2020 = 2018

58. Q: Please confirm if SFHSS is looking for projected or observed trends.

A: SFHSS is looking for observed trends.

59. Q: Regarding the question "Describe any "buy-up" SBC support services and include associated fees." - would SFHSS please clarify this question and provide examples?

A: It is the Respondent's obligation to clearly identify any additional costs associated with creating/delivering (as required) SBCs. Buy-up options may include, but are not limited to, language translation, printing/mailing costs, etc.

60. Q: Under the section "Org Financial Stability" - please confirm that these dates should be 2018, 2019, and 2020 rather than 2020, 2021, and 2022.

A: For this question, please provide as follows:
2022 = 2020
2021 = 2019
2020 = 2018

61. Q: Will Respondent(s) receive capitated claims data broken out between the Blue Shield Access+ and the Blue Shield Trio Plan HMOS?

A: This information is not available at this time or for the purposes of this RFP.

62. Q: For the claim data we have received on pharmacy, can you please provide the number of unique member utilizers for total enrolled during the time frame of the claim file 1/1/19 – 12/31/19?

A: There is a deidentified member ID included on each claims file which should help Respondent's identify unique member utilizers for the data time period.

63. Q: Using the Web Forms Questionnaire 7 Tab: a. For questions allowing the 'Drop Down' option – how do we respond for a few cases in which we need to Agree and Disagree? An example may be that we can provide Claim Reporting for Self-Funded but not for Fully Insured.

A: It is at Respondent(s) discretion to determine how to respond including utilizing the additional areas within the RFP and Questionnaire permitting additional responses (see, for example, Question 21 and the answer thereto, above).

ADDENDUM NO. 4

64. Q: Questionnaire 4 Tab: RFP notes 2021 stats. However, we interpret that 2019 and 2020 YTD are needed? Can you please confirm?

A: Please provide as follows:
2020 = 2020
2021 = 2019

65. Q: Please provide clarification on the CAHPS PG and benchmark. Should the metric read "Rating of Health Plan #42 (8,9,10 response) and the which benchmark should we use, CA All LOB Average or the PPO and EPO Average?

A: Yes, the metric is at least an 8 out of 10 so would include 9 and 10. Should be based on NCQA regional response (or state if regional not available). For an HMO offering, please refer to HMO statistics, and for PPO, only PPO stats. If both, Respondent, may use a weighted average by enrollment as of the first of January of the metric year.

66. Q: For carriers responding to both the PPO and the HMO proposal, will the performance guarantees be measured separately by plan or will they be combined over the total population of the carrier?

A: Performance guarantees will be measured separately if only one product is selected as a result of the RFP. If both or multiple products are selected (HMO and PPO) SFHSS and Selected Respondent may use a weighted average.

67. Q: For carriers responding to both the PPO and the HMO proposal. Are the credits and budgets to be applied separately by plan or will they be combined over the total population of the carrier?

A: Separate.

68. Q: For carriers responding to both the PPO and the HMO proposal. Would you expect separate Rx guarantees by plan or will they be combined over the total population of the carrier?

A: Rx performance guarantees will be measured separately if only one product (HMO or PPO) is selected as a result of the RFP. If both or multiple products are selected (HMO and PPO) SFHSS and Selected Respondent may use a weighted average.

69. Q: Will SFHSS detail any current budgets, credits or waivers that are in place today?

A: This information is not available at this time or for the purposes of this RFP.

70. Q: Are capitation charges included in the current Blue Shield claims? If not, what are the current capitation charges?

A: Capitation costs are not included in the medical paid claim data (including medical claim lag information) provided to Respondents. For insight on historical capitation and other costs within the Blue Shield HMO plans offered by SFHSS to its members, please reference annual Health Service Board presentations on Blue Shield plan experience delivered each March via the Board Documents area of the SFHSS website.

71. Q: On the minimum premium plan, what's the current funding and fee structure?

A: The most recent Blue Shield of California plan financial information was presented to the Health Service Board on March 12, 2020 (2019 experience) and on May 28, 2020 (2021 renewal). Materials for these meetings can be accessed in the Board Documents section of the SFHSS website. SFHSS is responsible for claims paid up to the $1 million individual large claim pooling attachment point, and there is a maximum liability limit set at 125% of total expected plan claim cost.

72. Q: Will the City/SFHSS allow carriers to use offshore services provided that we disclose these services and describe how we protect PHI?

A: In most circumstances, no. The City's default position is that all potentially sensitive data must be hosted and accessed on shore. In order for SFHSS to allow data to be hosted or accessed offshore, there must be a compelling reason and detailed security precautions, and several high-level City stakeholders must approve.

73. Q: In MM LM 2 - Question 2 ("In the event that an adjudication error results in overpayments by Client, the supplier shall assume all costs of the audit and shall reimburse Client for all overpayments plus interest within ten (10) business days of notice of overpayment"), is Respondent considered the "supplier" and what types of overpayments (e.g., health care service claims, administrative fees, other) are referenced?

A: Yes, Respondent is considered the supplier, and examples of overpayments may include, but are not limited to, health care service claims and administrative fees.

74. Q: In MM LM 2 Question 4 #2 (What was the combined voluntary / involuntary removal rate from your network for calendar year 2021?), do you mean 2019?

A: Correct, this should read 2019, please enter 2019 data under 2021.

75. Q: In MM LM Question 4 #3 (What is your standard advance period before terminating a network location?), do you mean before we terminate a provider?

A: This question encapsulates the termination of providers, withdrawal from a service area and the termination of medical groups and hospitals.

Regarding providers, this question is posed to inquire of your standard advance period when an individual provider or facility either is terminated by the Health plan for any reason. It is understood that regulators have requirements surrounding required notices if this occurs, however, SFHSS would like to understand your notice time periods for both communication to the Employer and to members.

Regarding withdrawing from a service area, this question is posed to inquire of your standard advance period when your organization withdraws from a service Area. It is understood that regulators have requirements surrounding required notices if this occurs, however, SFHSS would like to understand your notice time periods for both communication to the Employer and to members.

Regarding medical groups and hospitals, SFHSS's concern is that the removal or termination of medical groups and/or hospitals has the greatest likelihood of a negative impact to our members. If you are selected, SFHSS will be requiring monthly reporting on medical groups and/or hospitals that have contractual agreements with your organization to provide medical services that are scheduled to expire or terminate. This question is asking to obtain your current standard notice period which you would inform the employer and/or members of planned medical groups and/or hospitals termination.

76. Q: Do the questions in MM LM 2 Question 4 #106 and #108 (What are the specific criteria used to identify cases for case management? [and] What percent of cases are typically identified for case management services?) refer to Behavioral Case Management or Physical Case Management or both?

A: Questions 106 and 108 include any form of case management.

77. Q: MM LM 2 Question 4 #121. With respect to providing claims-related data for 2020 and 2021, do you mean 2019?

A: Please provide as follows:
2020 = 2020
2021 = 2019

78. Q: In MM LM Question 4 #154 ("Describe your transparency solutions."), are you referring to cost transparency, quality transparency, or both?

A: Both cost transparency and quality transparency.

ADDENDUM NO. 4

79. Q: In the Reporting Section Question #7 ("How frequently are periodic claim export files available? Please confirm these will be available at least monthly and by what business day?"), please confirm that you are referring to claim data transmittal files.

A: This refers to any reporting available to SFHSS.

80. Q: In the Reporting Section Question #54 ("Confirm you will provide standard and *ad hoc* reporting using elements provided in the eligibility file provided by SFHSS. These cuts could include age, gender, union, department, race/ethnicity, employee/early retiree, etc."), please confirm that the monthly eligibility file will include the union code associated with the member.

A: Confirmed.

81. Q: In the Pharmacy Network Disruption there are two tabs – one titled Incumbent 1 and the other Incumbent 2 – does this refer to Blue Shield Access+ and Blue Shield Trio or something else. For example, are you looking for our broad network to minimize disruption and our narrow network that is less expensive but excludes Walgreens?

A: Incumbent 1 is BCBS and Incumbent 2 is UHC. Respondent responses should reflect SFHSS' current network design which is a broad retail network.

82. Q: In the RFP, Section 3.5.5, #16, it states that "Substitute Personnel shall not automatically receive the hourly rate of the individual or position being replaced…". If higher or lower, are you proposing that we adjust our administrative fees accordingly?

A: Pursuant to RFP Section 3.5.5 subsections 15 and 16, should a Selected Respondent reassign key staff or the Account Executive during the term of a future agreement, Respondent should make every reasonable effort to provide Substitute Personnel for review and approval by SFHSS. Often, this Substitute Personnel may be a senior supporting member of the staff of the outgoing key staff member or Account Executive. The purpose of subsection 16 is to state that by default, the incoming Substitute Personnel is not expected to automatically receive (although may receive if warranted) the identical hourly rate of the individual or position being replaced.

83. Q: We are considering proposing flex funded plans in our bid. Under Prepare to Bid in the Greater Insights portal, we have two options for entering our information: Fully Insured HMO and Self-Funded HMO. Do we enter Flex Funded bid information in the Fully Insured HMO Proposal or the Self-Funded HMO Proposal Section?

A: Respondent may use the self-funded proposal section or provide an attachment outlining your alternative funding arrangement.

84. Q: For a flex funded quote, where do we enter key financial information regarding individual and aggregate stop loss rates, in addition to projected capitation costs, projected fee-for-service medical costs, projected pharmacy costs and overall projected premium rates for the coverage period?

A: Respondent may use the self-funded proposal section or provide an attachment outlining your alternative funding arrangement.

85. Q: The Medical ASO Fees section under Prepare to Bid SF-HMO is labelled with the following title: "C7: Members of the HSS and are members of the Superior Court". Why is this very specific labeling for the Superior Court population included? Do we need to provide cost and premium projections for separate SFHSS populations? If yes, please identify which separate populations need to have separate submissions and explain how to submit separate financial figures since we only see one input area for our submission.

A: This labeling is reflective of the SBCs input into the system and may be disregarded. Respondents should provide one quote for the four employers represented by SFHSS.

86. Q: There appears to be only one input section for financial submissions. We plan to provide quotes for two separate HMO networks to be offered side-by-side. How do we enter financial rates and factors separately for our two networks in the Prepare to Bid section and in the ACO Questionnaire?

A: One additional set of financial response templates has been posted to the TBS/Greater Insight platform. A notification was sent when the additional templates became available.

[Technical questions and responses regarding the TBS/Greater Insight platform are provided on the next page]

C. Technical Questions regarding the TBS/Greater Insight platform and submission of Proposals:

1. **Q:** Under the Prepare Bid tab, there is a section called "Questionnaire Confirmation".

   Can you confirm what is needed in that section?

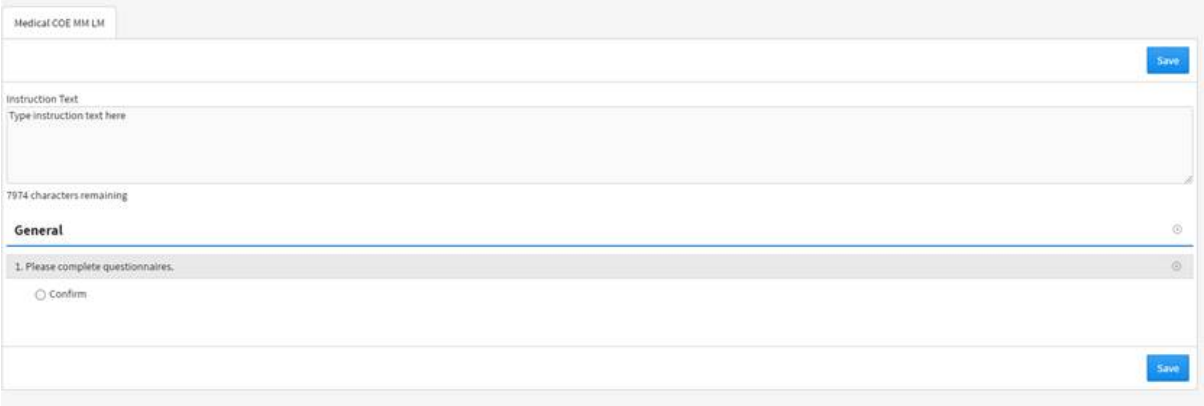
   A: This is a system requirement, Respondent's should select "Bid".

2. **Q:** Under "Questionnaire Confirmation", there is a BID button. What should we be indicating?

   A: This is a system requirement, Respondent's should select "Bid".

3. **Q:** Under "Questions", it says to please complete questionnaires, but there is no questionnaire in that section. We noticed the tab says, "medical COE", so was wondering if we are missing an additional set of questionnaires? We are currently in receipt of 2 questionnaires- "Health Plan Questionnaire" and "San Francisco Health Plan RFP 01012022"?

   A: This is a system requirement, please click on the radial button and hit save. After Respondent completes the Prepare Bid tab, then they can move to the Questionnaire tab and compete the questionnaire. A screenshot of this is below.



4. **Q:** Regarding the exhibits to add additional ASO options, is there an exhibit where a Respondent can add an additional Fully Insured network option to its proposal, e.g. a financial tab in the Standard Questionnaire document?

A: This will be updated in TBS/Greater Insight and a notification will be sent once it is available.

5. **Q:** Regarding the new questionnaire posted to TBS/Greater Insight, are the questions are identical to the prior version.

A: The materials are identical. If a Respondent wishes to extract their current Questionnaire responses and then modify (similar to a file/save as) Respondents would go to the 'At A Glance' on the right-hand side of the screen and click on 'RFP Template Extract' in the Reports section. From there, Respondent could open the file and modify answers. Here is a screen shot: