**Request for Proposals for Medicare-Enrolled Participants in the State of Wisconsin and Wisconsin**

**Public Employer Group Health Insurance Programs**

**ETD0050 IYC Medicare Advantage Plan**

**ETD0051 Medicare Plus Plan**

**Issued by**

**State of Wisconsin**

**Department of Employee Trust Funds**

**On behalf of the Group Insurance Board**

RFP Release Date: March 7, 2024

Table of Contents

[Table of Contents 2](#_Toc160700805)

[Exhibits, Appendices, and FORMS 2](#_Toc160700806)

[1 General Information 4](#_Toc160700807)

[2 Preparing and Submitting a Proposal 22](#_Toc160700808)

[3 Proposal Selection and Award Process 29](#_Toc160700809)

[4 Proposer Attestations/confirmations 35](#_Toc160700810)

[5 Program Specifications and Requirements 36](#_Toc160700811)

[6 General Questionnaire 36](#_Toc160700812)

[7 Technical Questionnaires 42](#_Toc160700813)

[8 Network Submission Requirements 72](#_Toc160700814)

[9 Cost Proposal 74](#_Toc160700815)

[10 Contract Terms and Conditions 77](#_Toc160700816)

Exhibits, Appendices, and FORMS

* Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement, including these documents:
* Certificate of Coverage (ET-2180)
* Uniform Benefits Schedules of Benefits (for the 2025 plan year)

• GHIP for Members: State of Wisconsin Retirees with Medicare; Local Traditional Plan for Employees/Retirees/COBRA; Local Retirees with Medicare Including LAHP (ET-2108sb)

• GHIP for Members in the Local Deductible Plan: Employees, Retirees and COBRA Continuants (ET-2158sb)

* Medicare Plus Certificate of Coverage (ET-4113)
* Appendix 1 – 834 Overview & Companion Guide
* Appendix 2 – Pharmacy Data Specifications
* Appendix 3a – Wellness Data Specifications – WebMD ONE Health Assessment Results
* Appendix 3b – Wellness Data Specifications – WebMD Biometric Data
* Appendix 3c – Wellness Data Specifications – Wellness – Coaching Outcomes
* Appendix 4 – Medical Claims Data Specifications
* Appendix 5 – Provider Data Specifications
* Appendix 6 – State Employer Group Roster (ET-1404)
* Appendix 7 – Local Employer Group Roster (ET-1407)
* Appendix 8 – Premium Rate Bid Tool (sample)
* Appendix 9 – Non-Disclosure Agreement among Vendor, the Department, and Board Actuary
* Appendix 10 – Pro Forma Contract (sample)
* Appendix 11 – Department Terms and Conditions (rev. 12.01.2023)
* Appendix 12 – Data Supplier Agreement (sample)
* Appendix 13 – Non-Disclosure Agreement (Data Out) (sample)
* Appendix 14 – Grievance Report Template (sample)
* FORM A – Proposal Checklist
* FORM B – Attestations/Confirmations
* FORM C – Subcontractor Information
* FORM D – Request for Proposal signature page
* FORM E – Vendor Information
* FORM F – Vendor References
* FORM G – Designation of Confidential and Proprietary Information

# 1 General Information

The Wisconsin Department of Employee Trust Funds (Department) is soliciting Proposals from qualified vendors that can provide nationwide Medicare Advantage preferred provider option (PPO) and/or regional Medicare Advantage HMO services to Medicare-eligible Group Health Insurance Program (GHIP) retirees and Medicare-eligible dependents of retirees. The Department is also soliciting Proposals from qualified vendors that can provide Medicare Plus (Supplemental or Medigap) services to GHIP retirees and Medicare-eligible dependents of retirees.

The purpose of this Request for Proposals (RFP) is to provide interested and qualified vendors with information to enable them to prepare and submit competitive Proposals. The Department intends to use the results of this solicitation to award one or more Contract(s) for the services described herein. The Contract(s) resulting from the RFPs (if Contracts are awarded) will be administered and managed by the Department, with oversight by the State of Wisconsin Group Insurance Board (Board). This RFP document, its attachments, and the Proposal(s) from the awarded Proposer(s) will be incorporated into the Contract(s).

There are two RFPs covered in this document (referred to sometimes herein in the singular as “the RFP” or “this RFP”):

a. RFP ETD0050: IYC Medicare Advantage

b. RFP ETD0051: Medicare Plus

Vendors may submit a Proposal for one or both of the RFPs.

## 1.1 Procuring and Contracting Agency

This RFP is issued by the Department on behalf of the Board. The Department is the sole point of contact for this RFP. The terms “ETF” and “Department” may be used interchangeably in this RFP, its attachments, and linked resources.

Vendors/Proposers are prohibited from contacting any person other than the individual listed below regarding this RFP. Violation of this requirement may result in the vendor/Proposer being disqualified from further consideration.

**Wisconsin Department of Employee Trust Funds**

Procurement Lead:

Beth Bucaida

E-mail: ETFSMBProcurement@etf.wi.gov

## 1.2 Board and Department Authority

This solicitation is authorized under Chapter 40 of the Wisconsin State Statutes. Procurement statutes and rules that govern other State agencies may not be applicable. All decisions and actions under this RFP are solely under the authority of the Board. On November 15, 2023, the Board delegated to the Department the authority to solicit proposals for one or more vendors to provide the services described herein. The Department is acting as an agent of the Board in carrying out any directives or decisions relating to this RFP, the Contract(s), and subsequent awards.

## 1.3 Introduction

The Department administers the Wisconsin Retirement System (WRS), the Group Health Insurance Program (GHIP) for State employers and many Local government entities, and a variety of other public employee benefit programs. (Appendices 6 and 7 – Employer Group Rosters, provide a list of employers who currently participate in the GHIP.) The WRS has consistently ranked among the top 10 largest public pension funds in the United States, providing retirement benefits for more than 663,000 current and former State and Local government employees and their families on behalf of more than 1,500 employers. Participants in the WRS include public school teachers, current and former employees of State agencies and the Universities of Wisconsin, and employees of most State and Local governments. All State WRS members and those from participating Local employers are eligible to enroll in the GHIP. The Department is overseen by independent governing boards and funds are held on behalf of the benefit program beneficiaries in the Public Employee Trust Fund created and regulated under Chapter 40 of the Wisconsin State Statutes.

### 1.3.1 Health Insurance Program Background

The GHIP, administered by the Department and the Department’s contracted health plans (11 plans in 2024, including the Medicare Advantage/Medicare Plus contractor), is a fully-insured plan for employees and retirees (and their survivors) of State agencies and authorities, the Legislature, the Universities of Wisconsin, University of Wisconsin Hospitals and Clinics, over 400 participating Local government employers, and their dependents. (See Appendices 6 and 7 – Employer Group Rosters.) The GHIP makes up one of the largest health plan groups in Wisconsin, spending $1.86 billion in health insurance premiums annually and covering more than 240,000 Participants.

Health insurance benefits in the GHIP (except for Medicare Plus, a group Medicare supplement) conform to a prescribed “Uniform Benefit” package. The Department’s contracted health plans follow the Board’s guidelines for eligibility and program requirements and participate in an annual premium rate bid process.

There are four variations of out-of-pocket costs in the “Uniform Benefits” available to both active and retired State and Local employees, including Medicare-enrolled retirees. See Table 1.

**Table 1. State and Local GHIP**

**In-Network Uniform Benefits / Program Options (POs)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **For HMOs and some PPOs: Represents benefits for in-network providers** | **State and Local Medicare retirees and Local employees****PO 2**[**\***](#TableFootnote)**/12 Health Plan Medicare or Local Traditional Plan** | **PO 4**[**\***](#TableFootnote)**/14 IYC Local Deductible Plan** **For employees and all retirees whose Local employer has chosen this PO** | **State and Local PO 1\*/6**[**\***](#TableFootnote)**/16/8\*** **IYC Health Plan****For employees and non-Medicare retirees** | **State and Local PO 1\*/7**[**\***](#TableFootnote)**/17** **High Deductible Health Plan (HDHP)****For employees and non-Medicare retirees** |
| **Uniform Benefits** | Deductible (Unless otherwise noted, it is an overall deductible) | No deductible | $500 Individual $1,000 FamilyExcept as required by federal law.Does not apply to prescription drug copayments.  | $250 Individual $500 FamilyExcept as required by federal law. Does not apply to office visit and prescription drug copayments. | $1,600 Individual $3,200 FamilyExcept as required by federal law. *Note:* Deductible must be met before coverage begins. For family coverage, full family deductible must be met. Deductible includes prescription drug coverage. Once met, office visit and prescription drug copayments apply up to OOPL. |
| Office Visit Copayment | None | None | $15 Primary Care, $25 Specialty Care. Applies to OOPL but not deductible. | After deductible $15 Primary Care, $25 Specialty Care. Applies to OOPL. |
| Coinsurance | None except 20% for durable medical equipment, adult hearing aids and adult cochlear implants.  | After deductible, none except 20% for durable medical equipment, adult hearing aids and adult cochlear implants.  | After deductible you pay 10% except for office visit copayments. | After deductible you pay 10% except for office visit and prescription drug copayments. |
| Annual out-of-pocket limit (OOPL):includes deductible and coinsurance | None except up to $500 Individual for durable medical equipment and adult cochlear implants. Plan pays no more than $1,000 for each adult hearing aid. See etf.wi.gov. | After deductible, none except up to $500 Individual for durable medical equipment and adult cochlear implants. Plan pays no more than $1,000 for each adult hearing aid. See etf.wi.gov. | $1,250 Individual $2,500 Family  | $2,500 Individual $5,000 Family |

\* Program Option (PO) includes dental coverage with no deductible and a $1,000 per individual annual benefit maximum with 100% coverage of fillings and specified diagnostic and preventive services; and 90% coverage for non-surgical extractions and 80% coverage of certain basic services. Also includes 50% coverage up to $1,500 per child for orthodontia.

Table 2 includes the current standard benefits package available to IYC Medicare Advantage-enrolled Participants. For more details, see the Certificate of Coverage (ET-2180) and Schedules of Benefits of Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement.

**Table 2. 2025 Medicare Advantage Traditional and Deductible Benefit Designs**

|  |  |
| --- | --- |
| IYC Medicare Advantage Benefit Designs |  |
|   | **State and Local Traditional Benefit Design** | **Local Deductible Benefit Design** |
| Annual Medical Deductible\*  | **Plan pays:** Part A inpatient hospital deductible of $1,600 and Part B deductible of $226 | **Plan pays:** Part A inpatient hospital deductible of $1,600 and Part B deductible of $226 |
|  |  |
| **Participant pays:** $0 | **Participant pays:** $500 individual / $1,000 family plan deductible, then as described below |
| Annual Medical Coinsurance | **Plan pays:** Part A-varying coinsurance for hospital inpatient and skilled nursing facility care Part B deductible and 20% coinsurance | **Plan pays:** Part A-varying coinsurance for hospital inpatient and skilled nursing facility care Part B deductible and 20% coinsurance |
|  |  |
| **Participant pays:** $0 except as listed below | **Participant pays:** $0 except as listed below |
| Annual Medical Out-of-Pocket Limit  | Up to $500 per individual for durable medical equipment as listed below | Deductible and up to $500 per individual for durable medical equipment as listed below |
| Outpatient illness/injury related services | **Plan pays:** Part B deductible and 20% coinsurance | **Plan pays:** Part B deductible and 20% coinsurance |
|  |  |
| **Participant pays:** $0 | **Participant pays:** After plan deductible, $0 |
| Emergency Room Copayment | **Plan pays:** Part B deductible and 20% coinsurance | **Plan pays:** After plan deductible, Part B deductible and 20% coinsurance |
|  |  |
| **Participant pays:** $60 copayment (waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer) | **Participant pays:** After plan deductible, $60 copayment (waived if admitted as an inpatient directly from the emergency room or for observation for 24 hours or longer) |
| Hospital   | **Plan pays:** 100% as medically necessary, plan providers only. No day limit | **Plan pays:** 100% as medically necessary, plan providers only. No day limit |
|  |  |
| **Participant pays:** $0 | **Participant pays:** After plan deductible, $0 |
| Licensed Skilled Nursing FacilityMedicare covered services in a Medicare approved facility  | **Plan pays:** After Medicare,100% as medically necessary, for the first 120 Days per benefit period, plan providers only Beyond 120 Days, $0 | **Plan pays:** After Medicare,100% as medically necessary, for the first 120 Days per benefit period, plan providers only Beyond 120 Days, $0 |
|  |  |
| **Participant pays:** $0 for the first 120 days, full cost after 120 Days | **Participant pays:** After plan deductible, $0 for the first 120 Days, full cost after 120 Days |
| Licensed Skilled Nursing Facility(Non-Medicare approved facility licensed in a state) If admitted within 24 hours following a hospital stay | **Plan pays:** 100% as medically necessary for the first 120 Days per benefit period  | **Plan pays:** 100% as medically necessary for the first 120 Days per benefit period  |
|  |  |
| **Participant pays:** 0% for the first 120 Days per benefit period. 100% after 120 Days | **Participant pays:** After plan deductible, 0% for the first 120 Days per benefit period. 100% after 120 Days |
| Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies | **Plan pays:** If Participant has not met the Part B deductible, 80%If Participant has met the Part B deductible but has not met the $500 out-of-pocket limit (OOPL) per participant, 0%If Participant has met the Part B deductible and the $500 OOPL per participant, 20% | **Plan pays:** If Participant has not met the Part B deductible, 80%If Participant has met the Part B deductible but has not met the $500 out-of-pocket limit (OOPL) per participant, 0%If Participant has met the Part B deductible and the $500 OOPL per participant, 20% |
|  |  |
| **Participant pays:** 20% up to $500 OOPL per participant; after OOPL, $0 | **Participant pays:** After plan deductible, 20% up to $500 OOPL per participant; after OOPL, $0 |
|  |  |
| Home Health ServicesUnder an approved plan of care, part-time services of an RN, LPN or home health aide; physical, respiratory, speech or occupational therapy; medical supplies, drugs, lab services and nutritional counseling.   | **Plan pays:** 100% for reasonable and necessary visits | **Plan pays:** 100% for reasonable and necessary visits |
|  |  |
| **Participant pays:** Full cost of visits not covered by Medicare  | **Participant pays:** After plan deductible, full cost of visits not covered by Medicare  |
| Hearing ExamFor routine exams | **Plan pays:** 100% | **Plan pays:** 100% |
|  |  |
| **Participant pays:** $0 | **Participant pays:** After plan deductible, $0 |
|  |  |
| Hearing ExamFor illness or injury | Plan pays: Part B deductible and 20% coinsurance | Plan pays: Part B deductible and 20% coinsurance |
|  |  |
| **Participant pays:** $0 | **Participant pays:** After plan deductible, $0 |
| Hearing Aid (per year) | **Plan pays:** 80% for adults up to plan paid of $1,000 every three years (does not count toward OOPL) | **Plan pays:** 80% for adults up to plan paid of $1,000 every three years (does not count toward OOPL) |
|  |  |
| **Participant pays:** 20% coinsurance and 100% of costs exceeding plan payment of $1,000 | **Participant pays:** After plan deductible, 20% coinsurance and 100% of costs exceeding plan payment of $1,000 |

### 1.3.2 Medicare Plus (Supplement or Medigap) Benefit Design

Table 3 includes the **Medicare Plus** plan benefit design available to Medicare-enrolled members on a retiree contract. For more details, see the Certificate of Coverage (ET-4113) of Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement. The Medicare Plus plan permits Participants to receive care from any qualified healthcare provider in the United States and worldwide, for services covered by the plan. **Note:** Medicare-determined amounts change annually. 2025 amounts will be updated when they are released by the federal government.

**Table 3. 2024 Medicare Plus Benefit Design**

|  |
| --- |
| Medicare Plus 2024 Benefit Design |
| Annual Medical Deductible  | **Plan pays:** Part A inpatient hospital deductible of $1,632 and Part B deductible of $240 |
|  |
| **Participant pays:** $0 |
| Annual Medical Coinsurance | **Plan pays:** Part A-varying coinsurance for hospital inpatient and skilled nursing facility care Part B deductible and 20% coinsurance |
|  |
| **Participant pays:** $0 except as listed below |
| Annual Medical Out-of-Pocket Limit  | None |
| Outpatient illness/injury related services | **Plan pays:** Part B deductible and 20% coinsurance |
|  |
| **Participant pays:** $0 |
| Emergency Room  | **Plan pays:** Part B deductible and 20% coinsurance |
|  |
| **Participant pays:** $0  |
| Hospital Semiprivate room and board and miscellaneous hospital services and supplies such as drugs, x-rays, lab tests and operating room  | **Plan pays:** 100% as medically necessary. Day limit per a confinement after lifetime reserve days is exhausted, is 120 Days. |
|  |
| **Participant pays:** $0 |
| Licensed Skilled Nursing FacilityMedicare covered services in a Medicare approved facility  | Requires a 3-Day period of hospital stay**Plan pays:** After Medicare, 100% as medically necessary for the first 120 Days per benefit periodBeyond 120 Days, $0 |
|  |
| **Participant pays:** $0 for the first 120 Days, full cost after 120 Days |
| Licensed Skilled Nursing Facility(Non-Medicare approved facility licensed in a state) If admitted within 24 hours following a hospital stay | **Plan pays:** 100% as medically necessary for the first 120 Days per benefit period  |
|  |
| **Participant pays:** 0% for only the same type of expenses normally covered by Medicare in a Medicare Approved FacilityMaximum daily rate for up to 30 Days per confinement. 100% after 30 Days |
| Medical Supplies, Durable Medical Equipment and Durable Diabetic Equipment and Related Supplies | **For Medicare Approved Supplies****Plan pays:** Part B deductible and 20%**Participant pays:** $0 |
|  |
| **For Supplies not covered by Medicare****Plan pays** $0**Participant pays:** Full cost of supplies |
|  |
| Home Health ServicesUnder an approved plan of care, part-time services of an RN, LPN, or home health aide; physical, respiratory, speech or occupational therapy; medical supplies, drugs, lab services and nutritional counseling.   | **Plan pays:** 100% for medically necessary visits |
|  |
| **Participant pays:** $0 as approved by Medicare.Full cost of visits not covered by Medicare  |
| Hearing ExamFor routine exams | **Plan pays:** 0% |
|  |
| **Participant pays:** Full cost of routine hearing exam |
|  |
| Hearing ExamFor illness or injury | **Plan pays:** Part B deductible and 20% coinsurance |
|  |
| **Participant pays:** $0 |
| Hearing Aid (per year) | **Plan pays:** $0 |
|  |
| **Participant pays:** Full cost of hearing aid |

### 1.3.3 Medicare Options

Below is a description of the current plans available to Medicare-enrolled members:

a. **It’s Your Choice (IYC) Medicare Advantage**

In 2019, UnitedHealthcare (UHC) was contracted by the Department to administer the GHIP’s only Medicare Advantage plan. This plan, offered on a fully-insured basis, is a nationwide passive PPO plan that allows Participants to use any healthcare provider in the United States and its territories that accepts Medicare. This plan also matches “Uniform Benefits” offered by the other Department-contracted health plans with minor exceptions. There are two benefit variations offered under this plan as described in Table 2 above. Note: Proposers are requested to provide pricing for only the Medicare Advantage State and Local Benefit Designs outlined in Table 2 for a nationwide Medicare Advantage PPO and/or a regional Medicare Advantage HMO plan(s). Segal will apply a relative value factor to the quote for the Traditional Benefit Design to account for the difference in plan design for the Deductible Plan.

b. **Medicare Plus**

UHC offers this Medicare Plus (Supplement or Medigap) plan as part of the GHIP. This plan is offered on a fully-insured basis and is available to Medicare eligible retirees, their dependents and survivors. This plan generally pays only Medicare deductibles and coinsurance. This plan permits Participants to receive care from any qualified healthcare provider in the United States and worldwide, for services covered by the plan. See Table 3 above.

c. **Health Plan – Medicare (See Program Options 2/12 and 4/14)**

The Health Plan–Medicare plan includes “Uniform Benefits” offered currently by 10 Department-contracted, fully-insured health plans. The Health Plan–Medicare plan coordinates with Medicare coverage, meaning Medicare pays first and the Health Plan–Medicare plan pays second. Frequently, Participants in this plan were enrolled in their current health plan prior to becoming eligible for Medicare. That means that when the Participant retired or the retired Participant’s dependent became Medicare eligible, their benefits may have changed from a Program Option other than PO2/12, to those of PO2/12. See Table 1. The Health Plan–Medicare is not part of this RFP.

### 1.3.4 Pharmacy Benefits

Pharmacy benefits are based on a four-level design with various cost-sharing and applicable out-of-pocket limits (OOPL). This self-insured benefit is available to all GHIP members including members enrolled in the Medicare Advantage plan. See Table 4 below.

**Table 4. 2025 Plan Year Medicare Pharmacy Benefit Plan Design**

|  |
| --- |
| Copayments/Coinsurance |
| Level 1 | $5 Copayment | Preferred generic drugs and certain lower-cost preferred brand name drugs. |
| Level 2 | 20% Coinsurance ($50 max) | Preferred brand name drugs and certain higher-cost preferred generic drugs. |
| Level 3 | 40% Coinsurance ($150 max) | Non-preferred brand drugs and certain high-cost generic drugs for which alternative/equivalent preferred generic and brand name drugs are covered.  |
| Level 4 (Preferred) | $50 Copayment | Includes **only** specialty drugs filled at a preferred specialty pharmacy. |
| Level 4(Non-Preferred) | 40% Coinsurance ($200 max) | Specialty Drugs filled at a pharmacy **other than** a Preferred Specialty Pharmacy. |
| Out-of-Pocket Limits\* |
| Level 1 & 2 | $600 individual / $1,200 family |
| Level 3 | $9,450 individual / $18,900 family |
| Level 4 (Preferred) | $1,200 individual / $2,400 family |
| Level 4 (Non-Preferred) | No Out-of-Pocket Limit\* |

\*In addition to the out-of-pocket limit (OOPL), all copayments/coinsurance apply toward the federal Affordable Care Act (ACA) annual combined medical and prescription drug maximum out-of-pocket (MOOP) limits; $9,450 for an individual and $18,900 for a family in 2024. **Note:** The MOOP amounts change annually. 2025 amounts will be updated when they are released by the federal government.

Participants have creditable coverage through an Employer Group Waiver Program (EGWP) administered by the current Department-contracted Pharmacy Benefit Manager and are also provided with a wraparound benefit to supplement the EGWP. Pharmacy Benefits are not part of this RFP.

### 1.3.5 Uniform Dental Benefit

The uniform dental benefit is also a self-insured benefit. State employees and retirees who participate in the GHIP may opt in or out of uniform dental coverage during the annual Open Enrollment period. Local employers that participate in the GHIP choose whether to offer the uniform dental benefit to their employees and retirees. If they do, their employees and retirees may choose whether or not they want the uniform dental benefit. The Uniform Dental Benefit is not part of this RFP.

### 1.3.6 Enrollment Information

**Table 5. 2024 Enrolled Members by Medicare Plan Options**

|  |  |  |  |
| --- | --- | --- | --- |
| Health Plan / Benefit Design | State | Local | Total |
| Medicare Plus | 4,293 | 150 | 4,443 |
| IYC Medicare Advantage | 16,368 | 758 | 17,126 |
| IYC Health Plan - Medicare | -  | - | -  |
|  Quartz | 7,909 | 543 | 8,452 |
|  Dean Health Plan | 5,819 | 417 | 6,236 |
|  GHC-South Central WI | 1,335 | 191 | 1,526 |
|  Network Health Plan | 1,302 | 97 | 1,399 |
|  All others | 2,288 | 196 | 2,484 |
| TOTAL | **39,314** | **2,352** | **41,666** |

**Table 6. 2024 Enrolled Members by non-Medicare Plan Options**

|  |  |  |  |
| --- | --- | --- | --- |
| Health Plan / Benefit Design | State | Local | Total |
| Access Plan | 3,617 | 201 | 3,818 |
| State Maintenance Plan (SMP) | 28 | 1,155 | 1,183 |
| IYC Health Plan  | -  |  - | -  |
|  Quartz | 67,483 | 7,517 | 75,000 |
|  Dean (not Access Plan or SMP) | 36,124 | 6,110 | 42,234 |
|  Network Health Plan | 22,019 | 4,855 | 26,874 |
|  HealthPartners | 8,103 | 106 | 8,209 |
|  GHC-South Central WI  | 9,369 | 7,696 | 17,065 |
|  All others | 23,063 | 5,131 | 28,194 |
| **TOTAL** | **169,806** | **32,771** | **202,577** |

### 1.3.7 Premium Payments

**State retirees** are solely responsible for payment of their health insurance premiums. They may have their premiums paid in one of the following ways:

1. If eligible, they can use their accumulated sick leave that has been converted to credits to pay health insurance premiums (previous research has shown that State employees can retire with sizable sick leave balances that will typically last 6-10 years into retirement);
2. Deductions from their monthly annuity payments;
3. Direct payments to the health plan; or
4. Life insurance may be converted to pay for health insurance premiums under certain circumstances.

**Local retirees** may have their premiums paid in one of the following ways:

1. Their employer may contribute towards the premium;
2. They may have deductions taken from their annuity payment;
3. They may make direct payments to their health plan; or
4. Life insurance may be converted to pay for health insurance premiums under certain circumstances.

### 1.3.8 Open Enrollment

Dates for the annual Open Enrollment Period are set by the Board each year and are typically in September - October. Program and benefit changes are primarily disseminated to eligible participants via employer groups and the Department’s website.

### 1.3.9 Gain Sharing

The Board is interested in gain sharing agreements with the Contractor(s). The Board requests that Proposers provide with their Proposal an annual gain-sharing arrangement, based on Medical Loss Ratios for each year.

### 1.3.10 Wellness Benefits

The Well Wisconsin Program is available to GHIP Subscribers and spouses enrolled in a GHIP health plan. It provides wellness, mental health, and chronic condition management benefits such as a web portal with educational resources, wellness challenges, and self-directed coaching, biometric health screenings, lifestyle management coaching, condition management coaching, stress specialty coaching, and more. Except for IYC Medicare Advantage Participants, participants in the Well Wisconsin Program can earn a $150 incentive for completing health and well-being activities. IYC Medicare Advantage Subscribers and spouses can participate in the Wellness Program, but they cannot earn the incentive. The Well Wisconsin Program is managed by a single third-party administrator contracted with the Department, WebMD. WebMD shares wellness data, as outlined in Appendices 3A, 3B, and 3C with participants’ health plan to assist with overall care coordination. The Well Wisconsin Program is not part of this RFP.

### 1.3.11 Data Warehouse Vendor

The Board contracted with Merative for data warehouse services. Exhibit 1 – State of Wisconsin Group Insurance Program – Medicare Advantage and Medicare Plus Program Agreement Sections III.D.5 Data Warehouse File Requirements and III.D.6 Data Warehouse File Submission Quality include Contractor requirements related to data submissions and data integration with the Department’s data warehouse.

### 1.3.12 Insurance Administration System Vendor

The Department is in the process of implementing an Insurance Administration System (IAS) for benefits enrollment and management. The Contractor(s) awarded a Contract(s) under RFPs ETD0050-51 will be required to submit data to and receive data from the Department and the IAS at no additional cost to the Department.

### 1.3.13 Additional Background Information

Table 7 provides links to additional background information. This information is provided to assist Proposers in completing an RFP response.

Table 7. Background Information

|  |  |
| --- | --- |
| Title | Web Address |
| Open Enrollment Period Materials | <https://etf.wi.gov/its-your-choice/2024/state-employee-and-retiree-health-plan-supplemental-benefits/health-insurance-retirees-medicare>  |
| 2024 Health Benefits Decision Guide for Retired State Employees | <https://etf.wi.gov/resource/2024-health-benefits-decision-guide-state-wisconsin-group-health-insurance-retirees>  |
| 2024 Health Benefits Decision Guide for Local Traditional Plan | <https://etf.wi.gov/resource/2024-health-benefits-decision-guide-local-traditional-plan-insurance-employees-and-retirees>  |
| 2024 Health Benefits Decision Guide for Local Deductible Plan | <https://etf.wi.gov/resource/2024-health-benefits-decision-guide-local-deductible-plan-insurance-employees-and-retirees>  |
| Wisconsin State Statutes Chapter 40 | <https://docs.legis.wisconsin.gov/statutes/statutes/40> |
| ETF Insurance Complaint Information | <https://etf.wi.gov/resource/etf-insurance-complaint-form>  |

## Future State: Project Scope and Objectives

1. The Department seeks one or more health plans to provide services to State and Local Medicare Participants and to:
* Expand offerings to Medicare-enrolled Participants that have lower monthly premium costs than current;
* Deliver high quality, high value services;
* Offer excellent benefit packages; and
* Provide Subscribers with a choice of plans.

b. The Contractor(s) must be a partner with the Department in developing strategies to improve the health of Participants and must actively educate and engage Participants in preventive healthcare, appropriate healthcare utilization, and wellness. The Board will determine the overall Medicare program strategy based on RFP results.

### 1.4.1 Medicare Advantage Service Areas

a. The Medicare Advantage Contractor(s) must have Medicare Advantage services available in any of the following service areas:

1. Nationwide service area; or

2. Regional service areas within Wisconsin and/or adjoining states.

1. The Department’s expectation is to obtain services, as specified in this RFP. The Board may elect to award one or more contracts to serve the nationwide service area and may also award multiple contracts for a regional service area as a result of this RFP. The Board may elect to award no contracts.

c. Proposers are encouraged to provide competitive quotes with gain-sharing arrangements. The Board will determine the overall program strategy based on RFP results.

### 1.4.2 IYC Medicare Advantage Benefit Plan Proposals

a Vendors submitting a Proposal for the **IYC Medicare Advantage** program must be able to provide all services listed under Uniform Benefits, the current standard benefits package available to IYC Medicare Advantage-enrolled Participants, described in **Table 2 – 2025 Medicare Advantage Traditional and Deductible Benefit Designs**, and further described in the Certificate of Coverage (ET-2180) and the Schedules of Benefits of Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement. These benefits can be offered for a nationwide Medicare Advantage PPO and/or a regional Medicare Advantage HMO plan(s).

b. Proposers are not being asked to provide a separate quote for the Local Deductible Benefit Design in **Table 2. 2025 Medicare Advantage Traditional and Deductible Benefit Designs**. Instead, the Board’s actuary, Segal, will apply a relative value factor to the price quoted for the Medicare Advantage Traditional Benefit Design to account for the difference in plan design.

### 1.4.3 Medicare Plus Plan Proposals

Vendors submitting a Proposal for **Medicare Plus** must be able to provide all services listed in Table 3 above. **Table 3** includes the Medicare Plus plan benefit design available to Medicare-enrolled members on a retiree contract. The Medicare Plus plan permits Participants to receive care from any qualified healthcare provider in the United States and worldwide, for services covered by the plan. Vendors submitting a Proposal for Medicare Plus must provide pricing for the Medicare Plus benefit design outlined in Table 3. For more detail see the Certificate of Coverage (ET-4113) of Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement.

### 1.4.4 All Proposals

1. Contractors shall remain responsible for Contract performance regardless of any work performed or Services provided by the Contractor’s Subcontractors.
2. The selected Proposal(s) will become part of the Contract(s). Information described in the Proposal response regarding programming and capabilities must be available to all eligible Participants unless otherwise noted in the Proposal. For example, a small pilot program must be clearly described as such.

## 1.5 Definitions and Acronyms

Words and terms shall be given their ordinary and usual meanings. Where capitalized in this RFP, the following definitions and acronyms shall have the meanings indicated unless otherwise noted. The meanings are applicable to the singular, plural, masculine, feminine, and neuter forms of the words and terms.

**Board** means the State of Wisconsin Group Insurance Board.

**Business Day** means each Calendar Day except Saturday, Sunday, and official State of Wisconsin holidays (see also: Calendar Day, Day).

**Calendar Day** refers to a period of twenty-four (24) hours starting at midnight.

**Calendar of Events** means the schedule of events in [Section 1.9](#_1.9_Calendar_of).

**Confidential Information** means all tangible and intangible information and materials being disclosed in connection with the Contract, in any form or medium without regard to whether the information is owned by the State of Wisconsin, a Contractor, or by a third party, which satisfies at least one of the following criteria: (i) Individual Personal Information under Wis. Stat. § 40.07 and Wis. Admin. Code ETF § 10.70; (ii) Personally Identifiable Information under Wis. Stat. § 19.62(5); (iii) Protected Health Information under HIPAA, 45 CFR 160.103; (iv) proprietary information; (v) non-public information related to the State of Wisconsin’s employees, customers, technology (including databases, data processing and communications networking systems), schematics, specifications, and all information or materials derived therefrom or based thereon; (vi) information expressly designated as confidential in writing by the State of Wisconsin; (vii) all information that is restricted or prohibited from disclosure by State or federal law, including Medical Records as governed by Wis. Stat. § 40.07 and Wis. Admin. Code ETF § 10.01(3m); or (viii) any material submitted by the Proposer in response to a Department solicitation that the Proposer designates confidential and proprietary information and which qualifies as a trade secret, as provided in Wis. Stat. § 19.36(5) or material which can be kept confidential under the Wisconsin public records law.

**Contract** means the written, signed agreement resulting from the successful Proposal and subsequent negotiations that incorporates, among other documents, this RFP and its exhibits, appendices and forms, the successful Proposer's Proposal as accepted by the Department, an updated Exhibit 1 - State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement, an updated and executed Appendix 10 – Pro Forma Contract, its exhibits, subsequent amendments, and other documents as agreed upon by the Department and the Contractor.

**Contractor** means a Proposer who is awarded a Contract(s) pursuant to this RFP and is a party to an executed Contract with the Department.

**Cost Proposal** means the document submitted by a Proposer that includes Proposer’s costs to provide the Services. The Cost Proposal is one of the required documents all Proposers must submit. The Cost Proposal is described in [Section 9](#_9_Cost_Proposal) and elsewhere in this RFP.

**Day** means Calendar Day unless otherwise indicated.

**Department** or **ETF** means the Wisconsin Department of Employee Trust Funds.

**GHIP** means the State of Wisconsin Group Health Insurance Program for employees, retirees and survivors (including their dependents) of State agencies and authorities, the Legislature, University of Wisconsin System, University of Wisconsin Hospital and Clinics, and almost 400 participating Local government employers.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996.

**Local** means a Wisconsin public employer as defined under Wis. Stat. § 40.02 (28), other than the State, which has acted under Wis. Stat. § 40.51 (7), to make healthcare coverage available to its employees, retirees, survivors and their dependents.

**Open Enrollment Period** means the enrollment period referred to in Department materials that is available at least annually to eligible participants, allowing them the opportunity to enroll for coverage in benefit plans offered by the Board. Dates for the annual Open Enrollment Period are set by the Board each year and are typically in September - October. Program and benefit changes are primarily disseminated to eligible participants via employer groups and the Department’s website.

**Participant** means the Subscriber or any of the Subscriber’s dependents who are eligible for both Medicare Parts A and B, are entitled to benefits under the GHIP and are eligible to be enrolled in a plan included in this RFP.

**Proposal** means the complete response of a Proposer submitted in the format specified in this RFP, which sets forth the Services offered by a Proposer and Proposer’s pricing for providing the Services.

**Proposer** means any individual, firm, vendor, company, corporation, or other entity that submits a Proposal in response to this RFP.

**RFP** means Request for Proposals.

**Services** means all work performed, and labor, actions, recommendations, plans, research, and documentation provided by the Contractor necessary to fulfill that which the Contractor is obligated to provide under the Contract.

**State** means the State of Wisconsin.

**State Statutes** or **ss** or **Wisconsin Statutes** or **Wis. Stat.** means Wisconsin State Statutes referenced in this RFP, viewable at: [http://www.legis.state.wi.us/rsb/stats.html](https://etf.wi.gov/resource/2024-health-benefits-decision-guide-local-traditional-plan-insurance-employees-and-retirees).

**Subcontractor** means a person or company hired by the Contractor to perform a specific task or provide Services as part of the Contract.

**Subscriber** means a retiree, or their surviving dependent(s), who has been specified by the Department as eligible to enroll in and entitled to receive medical benefits under the GHIP.

**Uniform Benefits** means the benefits described in the Certificate of Coverage (ET-2180) and Schedules of Benefits of Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement.

**Universities of Wisconsin** means the Universities of Wisconsin system with locations across the State.

**WRS** means the Wisconsin Retirement System.

Also see the definitions in Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement.

## 1.6 Clarifications

Vendors must submit all questions concerning this RFP via email (no phone calls) to **ETFsmbProcurement@etf.wi.gov**. The subject line of the email must include “ETD0050-51” and the email must be received on or before the due date identified in [Section 1.9](#_1.9_Calendar_of) Calendar of Events, for vendor questions. Vendors are expected to raise any questions they have concerning this RFP at this point in the process. Do not include any information within your questions that would identify your company as all submitted questions will be shared publicly on the Department’s website.

Vendors are encouraged to submit any assumptions or exceptions during the above process. All assumptions and exceptions listed must contain a rationale as to the basis for the assumption/exception. The Department will inform vendors what assumptions/exceptions are acceptable to the Department.

Questions must be submitted as a Microsoft Word document (not a .pdf or scanned image) to [ETFSMBProcurement@etf.wi.gov](https://etf.wi.gov/node/15551) using the formatted table included below. Copy and paste this table into your Word document and add rows as necessary.

Table 8. Format for Submission of Clarification Questions

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Q # | RFP / Appendix # and Section # | RFP Page | Question/Rationale | Department Answer |
| Q1 |  |  |  |  |
| Q2 |  |  |  |  |
| Q3 |  |  |  |  |

Q# = Vendor’s question. Leave the “Department Answer” column blank as this is where the Department will enter its replies.

Vendor’s email must include the name of Proposer’s company and the person submitting the question(s) in case the Department needs to follow up. A compilation of all vendor questions and the Department’s answers, along with any RFP updates, will be posted to the Department website at <https://etf.wi.gov/node/35426> on or about the date indicated in [Section 1.9 Calendar of Events](#_1.9_Calendar_of), for Department posts responses to vendor questions.

If a vendor discovers any significant ambiguity, error, conflict, discrepancy, omission, or other deficiency in this RFP, the vendor should, upon discovery of such an issue, send an email to **ETFsmbProcurement@etf.wi.gov**with “ERROR re ETD0050-51” stated in the email subject line and explain such error. **Failure to raise any such cognizable error immediately but no later than before the Proposal submission deadline will result in a bar on subsequently raising the issue.**

If it becomes necessary to update any part of this RFP, updates will be published on the Department’s website listed above.

## 1.7 Vendor Conference

There is no scheduled vendor conference for this RFP. A vendor conference is an opportunity for vendors to ask questions. If the Department decides to hold a vendor conference, a notice will be posted on the Department’s website at <https://etf.wi.gov/node/35426>. Note: Unless this notice is posted, no conference will be held.

## 1.8 Reasonable Accommodations

The Department will provide reasonable accommodations, including the provision of informational material in an alternative format, for qualified individuals with disabilities, upon request.

## 1.9 Calendar of Events

Listed below are dates by which actions related to this RFP must be completed. If the Department finds it necessary to change any of the dates and times listed below, it will do so by posting an addendum to this RFP on the Department’s website (listed above). No other formal notification will be issued for changes in the estimated dates.

Table 9. Calendar of Events

|  |  |
| --- | --- |
| **Due Date** | **Event / Deliverable** |
| March 7, 2024 | Department issues RFP (Release Date) |
| **April 4, 2024** | - Appendix 9 – **Non-Disclosure Agreement** among Vendor, the Department, and Board Actuary due (email to ETFsmbProcurement@etf.wi.gov) |
| **April 4, 2024** | - Vendor **questions** due (email to the Department at ETFsmbProcurement@etf.wi.gov)- Vendor **letter of intent to submit a Proposal** requested (email to the Department at ETFsmbProcurement@etf.wi.gov) |
| May 30, 2024\* | The Department posts **responses** to vendor questions at <https://etf.wi.gov/node/35426>  |
| **July 11, 2024** **by 12:00 PM Central** | **Proposals Due:** Non-Cost documents: Proposers must upload all non-Cost Proposal documents via BOX. See [Section 2.7](#_2.7_Instructions_for).Cost documents: Proposers must upload and submit their Cost Proposal documents [Cost Proposal workbook(s), Network Access Tool (for IYC Medicare Advantage HMOs only), Accessibility Report(s), and Medical Provider Utilization (for Nationwide Medicare Advantage passive PPO Service Area and Medicare Plus Proposals)] to their secure workspace on the Segal system. (Workspaces will be created upon confirmation of receipt of a signed NDA). See Sections 2, 8 and 9. |
| September/October 2024\* | Proposer presentations to the RFP evaluation team |
| **February 19, 2025** | Group Insurance Board meeting |
| **May 1, 2025** | SOC 2 Type 2 Report and Letter of Attestation due, if not included with the Proposal (email to the Department at ETFsmbProcurement@etf.wi.gov. See Section 3.3.b. |
| **September 30 – October 25, 2025** | **Open Enrollment Period for the 2026 plan year** |
| **January 1, 2026** | **Benefits for the 2026 plan year begin** |

***\** All due dates are firm except those with an asterisk.**

**Note:** It is the desire of the Department that the Contract(s) be signed prior to the end of May 2025 as the Contractor(s) will assist with the implementation, transition, and member communication involved with any benefit program structure changes for the 2026 plan year. All such work must be completed prior to the commencement of the Open Enrollment Period for the 2026 plan year.

## 1.10 Contract Term

One or more separate Contracts may be awarded pursuant to this RFP. The term for each Contract for providing Services will commence on the date a Contract is executed and extend through December 31, 2028 (Initial Term), unless terminated earlier per the terms of the Contract.

Premiums will be reviewed and negotiated annually.

The Board retains the option, by mutual agreement of the Board and the Contractor, to renew the Contract for two (2) additional two (2) year periods extending the Contract through December 31, 2032, subject to the satisfactory negotiation of terms, including pricing. Extensions beyond this may occur as needed for a period of one (1) year (or less) to transition services to another service provider during a transition period.

**Note:** The Contractor(s) will assist the Department with implementation, transition, and Participant communication prior to Services being made available for the 2026 plan year. This implementation and transition period will begin after a Contract is executed and continue until implementation and transition are completed. The Contractor(s) will begin providing and administering the Services on the launch date of September 9, 2025.

## 1.11 No Obligation to Contract

The Board reserves the right to cancel this RFP for any reason prior to the issuance of a notice of intent to award a Contract(s). The Board does not guarantee to purchase any specific dollar amount. Proposals that stipulate that the Board will guarantee to purchase a specific quantity or dollar amount will be disqualified.

## 1.12 WI Department of Administration eSupplier Registration

The Wisconsin Department of Administration’s eSupplier Portal is available to all businesses and organizations that want to do business with the State. The eSupplier Portal is not being used for this solicitation for the submission of any Proposer documents. The eSupplier Portal allows vendors to see details about pending invoices and payments, allows vendors to receive automatic, notices of bid opportunities, and, in some cases, allows vendors to respond to State solicitations.

For more information on the eSupplier Portal, and to register, go to:

[https://esupplier.wi.gov/psp/esupplier/SUPPLIER/ERP/h/?tab=WI\_BIDDER](https://vendornet.wi.gov/GenProcurement/StrategicSourcing.aspx?tab=WI_BIDDER).

This is not a mandatory requirement.

## 1.13 Retention of Rights

All Proposals become the property of the Department upon receipt. All rights, title and interest in all materials and ideas prepared by the Proposer for the Proposal, and provided to the Department, will be the exclusive property of the Department and may be used by the Department and the State at its discretion.

# 2 Preparing and Submitting a Proposal

## 2.1 Incurring Costs

Neither the State nor the Department are liable for any costs incurred by vendors in replying to this RFP, making requested oral presentations, or demonstrations.

## 2.2 Letter of Intent

A letter of intent indicating that a vendor intends to submit a response to this RFP is *highly encouraged* (see due date in [Section 1.9 Calendar of Events](#_1.9_Calendar_of)). In the letter, identify the vendor’s organization/company name; list the name, location, telephone number, and email address of one or more persons authorized to act on the vendor’s behalf. Submit the letter of intent via email to [ETFsmbProcurement@etf.wi.gov](https://docs.legis.wisconsin.gov/statutes/statutes/40). The pertinent RFP number(s) must be referenced in the subject line of vendor’s email. The letter of intent does not obligate a vendor to submit a Proposal.

## 2.3 Appendix 9 – Non-Disclosure Agreement among Vendor, the Department, and Board Actuary

a. By the due date specified in [Section 1.9 Calendar of Events](#_1.9_Calendar_of), email the signed Appendix 9 – Non-Disclosure Agreement among Vendor, the Department, and Board Actuary to the Department at: ETFsmbProcurement@etf.wi.gov

b. After submitting Appendix 9 to the Department, the data recipient(s) designated in Appendix 9 will receive a system generated email from Segal with a link to a secure workspace. Once your designated recipient(s) clicks the link, they will have access to the secure workspace and the secure data associated with this RFP. The Network Access Tool discussed in [Section 8](#_8_Network_Submission) (applies to the IYC Medicare Advantage Plan only) and the documents listed [Section 9](#_9_Cost_Proposal) below will be made available.

**\*\*\*You must complete and submit Appendix 9 to the Department in order to receive important documents/data needed to submit your Proposal.\*\*\***

## 2.4 Proposal Due Date and Time

1. Proposers are solely responsible for ensuring that all required documents are received by Segal and the Department (as the case may be) on or before the deadlines stated in [Section 1.9 Calendar of Events](#_1.9_Calendar_of).

b. Documents received by the Department or Segal, as the case may be, after the date and time specified in [Section 1.9 Calendar of Events](#_1.9_Calendar_of) will not be accepted and will be disqualified. All required non-cost Proposal and Cost Proposal documents must be submitted by the specified due date and time. If any document or portion of the non-Cost Proposal or Cost Proposal is submitted late, the entire Proposal will be disqualified. Proposers may request, via an email to the intended recipient (Segal or the Department) the time and date their documents were received.

c. Neither the Department nor Segal take any responsibility for Proposer submissions or emails that are captured, blocked, filtered, quarantined, or otherwise prevented from reaching the proper destination server by any anti-virus or other security software.

## 2.5 Non-Cost Proposal Documents

Proposal submission must include all Proposer documents responsive to the RFP(s) for which the Proposer is submitting a response (RFP ETD0050 for IYC Medicare Advantage and/or RFP ETD0051 for Medicare Plus). The Department reserves the right to exclude/disqualify any Proposal from consideration that does not include the requested documents.

Include the following documents in your Proposal:

a.  **Cover Letter:** This signed letter must be written on the Proposer’s official business stationery and be signed by an official that is authorized to legally bind the Proposer. Include in the letter:

* Name and address of company/Proposer
* Name, title, signature, telephone number and email address of Proposer’s authorized representative
* Name, title, telephone number, and email address of representative(s) who may be contacted by the Department if questions arise regarding the Proposal
* The RFP title(s) and number(s) for which you are submitting a response: ETD0050 for Medicare Advantage and/or ETD0051 for Medicare Plus
* Executive summary regarding the Proposal
* Date the Proposal was authored

b. **Completed Forms:** complete and upload the following forms to [BOX](https://etf.box.com/s/s8sop8vquchxkuerc1g3tu2ub2ncsoqn) (these forms may be included in a single .pdf file)

* Form A – Proposal Checklist
* Form B – Attestations/Confirmations
* Form C – Subcontractor Information
* Form D – Request for Proposal Signature Page
* Form E – Vendor Information
* Form F – Vendor References
* Form G – Designation of Confidential and Proprietary Information
* Current Form W-9 Request for Taxpayer Identification Number and Certification (get the latest form from the Department of the Treasury, Internal Revenue Service: https://www.irs.gov/pub/irs-pdf/fw9.pdf)

**Form Requirements:**

**Form C – Subcontractor Information:** If awarded a Contract, Contractors have a continuing obligation to submit an updated Form C to the Department as Subcontractors are added / removed.

**Form F – Vendor References.** Proposers must provide at least four (4) references in Form F. References may be contacted to determine the quality of work performed and personnel assigned to the project, etc. The results of any reference checks may be used by evaluation committee members for scoring Proposals. Other reference requirements are stated in Form F. The Department reserves the right to contact other states, agencies, and individuals, about the Proposer even if not listed as references by the Proposer.

**Form G – Designation of Confidential and Proprietary Information.** All Proposers have a continuing obligation to submit an updated Form G up to the date the Department’s Notice of Intent to Award a Contract(s) is issued if the Department requests additional information that the Proposer claims is confidential or proprietary. Merely designating submitted information “confidential” or “proprietary” on the submitted document is insufficient.

c. **Responses to Section 6 General Questionnaire**

d. **Responses to Section 7 Technical Questionnaires**

e. **Assumptions and Exceptions:** If the Proposer has assumptions and/or exceptions to any RFP term, condition, exhibit, appendix, specification, or form, etc. pertaining to this RFP the Proposer must follow the instructions in [Section 2.7.4](#_2.7.4_Instructions_for) below for submitting assumptions and exceptions. If the Proposer has no assumptions or exceptions the Proposer must provide a statement to that effect in their Proposal.

f. **Promotional Materials:** Only provide promotional materials if they are relevant to a specific requirement or request specified in this RFP. If provided, all materials must be included with the response to the relevant requirement and clearly identified as “promotional materials.” Electronic access to such materials is preferred, which includes web links.

## 2.6 Unredacted / Redacted Non-Cost Proposal Documents

a.  **IF** your Proposal includes confidential and/or proprietary information, you must upload two versions of your Proposal, an unredacted version and a redacted version:

1. It is preferred that a single, ***unredacted*** Proposal file including the documents listed above in Section 2.5 Non-Cost Proposal Documents be uploaded to [BOX](https://etf.box.com/s/s8sop8vquchxkuerc1g3tu2ub2ncsoqn). The Proposal file must be labeled with **Proposer’s name +** the text **“Unredacted Proposal” + the appropriate RFP number** Proposer is responding to: RFP ETD0050 Medicare Advantage or RFP ETD0051 Medicare Plus. This file must contain all electronic, unredacted Proposal files in Microsoft Word/Microsoft Excel, and/or Adobe Acrobat 9.0 (or above) format. The Department requires that all files have optical character recognition capability (not a scanned image). **Do not include Cost Proposal documents in this file.** Cost Proposal documents must be provided to Segal.

2. It is preferred that a single, ***redacted*** Proposal file including the documents listed above in Section 2.5 Non-Cost Proposal Documents be uploaded to Box. The Proposal file must be labeled with **Proposer’s name +** the text **“Redacted Proposal” + the appropriate RFP number(s)** Proposer is responding to: RFP ETD0050 Medicare Advantage and/or RFP ETD0051 Medicare Plus.This file must contain all electronic Proposal files in Microsoft Word/Microsoft Excel, and/or Adobe Acrobat 9.0 (or above) format **EXCLUDING or REDACTING** all Proposer confidential and proprietary information/documents listed in Form G – Designation of Confidential and Proprietary Information. **Do not include Cost Proposal documents in this file.** Cost Proposal documents must be provided to Segal. Cost Proposals cannot be redacted.

**Redacted documents/files:** The Department may need to electronically send redacted Proposals to members of the public and other Proposers when responding appropriately to public records requests. Note that no matter what the method the Proposer uses to redact documents in this file, the Department is not responsible for checking that the redactions match the Proposer’s Form G – Designation of Confidential and Proprietary Information. The Department is not responsible for checking that the redactions, when viewed on-screen via electronic file, cannot be thwarted. The Department is not responsible for responding to public records requests via printed hard copy, even if redactions are only effective on printed hard copy. The Department may post redacted Proposals on the Department’s public website in exactly the same file format the Proposer provides, and the Department is not responsible if the redacted file is copied and pasted, uploaded, emailed, or transferred via any electronic means, and somehow loses its redactions in that process.

* Redact only material you, the Proposer, authored. For example, do not redact the requirement or question you are responding to, only the answer.
* Do not redact page numbers. Page numbers should remain visible at all times, even if the whole page is being redacted.
* List a descriptor of the redacted items on Form G – Designation of Confidential and Proprietary Information; sign the form only once. Add as many lines/pages to Form G as necessary.

b. **IF** your Proposal does not include confidential and/or proprietary information, just upload the unredacted version. You are still required to submit Form G.

c. **IF** you are unable to combine/include all required forms, documents, and requested materials in a single Proposal file (unredacted or redacted), you may upload separate document files to BOX. All file names of uploaded documents must contain Proposer’s name as the first word in the file name, examples: “Proposer’s name + reports,” “Proposer’s name + forms,” “Proposer’s name + Assumptions and Exceptions.” All such files must be in Microsoft Word/Microsoft Excel, or Adobe Acrobat 9.0 (or above) format. If a document file includes confidential/proprietary information, include the word “confidential” in the file name along with the descriptive information noted above. Be sure to include the document name and details of the confidentiality, e.g., document name, page and/or section, in Form G – Designation of Confidential and Proprietary Information.

## 2.7 Instructions for Submitting Proposals

### 2.7.1 Submitting Cost Proposal Documents to Segal

a. Cost Proposal documents must be submitted to Segal using the Segal secure workspace. See Section 9.0 Cost Proposal.

### 2.7.2 Submitting Non-Cost Proposal Documents to the Department

a. Upload all non-Cost Proposal documents (i.e., all documents other than the Cost Proposal documents listed in [Section 9.1](#_9.1_Submission_of) Submission of Required Documents that must be uploaded to Segal’s secure workspace) via BOX by the due date and time specified in [Section 1.9](#_1.9_Calendar_of) Calendar of Events – Proposals Due. Documents must be submitted to the BOX upload site linked [here](https://etf.box.com/s/s8sop8vquchxkuerc1g3tu2ub2ncsoqn). See Section 2.7.3 below for details on how to upload documents to BOX.

b. It is recommended that Proposers begin the process of uploading the non-cost Proposal documents via Box and test their system well in advance of the due date and time listed in Section 1.9 Calendar of Events – Proposals Due to ensure submission can be accomplished by the due date. (If you submit a test document, include the word “TEST” in your file name.)

**2.7.3 Uploading Non-Cost Proposal documents to BOX**

**Non-cost Proposal documents must be uploaded to the following BOX URL:**

<https://etf.box.com/s/s8sop8vquchxkuerc1g3tu2ub2ncsoqn>

**Important Requirements for uploading documents to Box:**

a. Do not upload zipped folders or files to BOX.

b. Do not upload document folders to BOX.

c. Acceptable file types for upload to BOX include .pdf, .doc, or .xls.

1. Do not lock or password protect any Proposal files.
2. Include the Proposer’s organization name and the appropriate RFP number(s) at the beginning of each file name.
3. Files must be free of all malware, ransomware, viruses, spyware, worms, Trojans, or anything else that is designed to perform malicious operations on a computer.

g. If you experience problems uploding files to Box, please consult with your IT department first; consider “white-listing” Box or turning off your VPN to allow uploads. If you continue to experience issues, send an email to ETFsmbProcurement@etf.wi.gov.

### 2.7.4 Instructions for Submitting Assumptions and Exceptions

a. Regardless of any proposed assumption or exception, the Proposal as presented must include all services requested in the RFP being responded to.

b. If you cannot agree to a term or condition as written in this RFP or its attachments, you must make a specific requested revision to the language of the provision by striking out words or inserting language to the text of the provision. Any new text and/or deletion of original text must be clearly color coded or highlighted. Proposers must avoid complete deletion and substitution of entire provisions, unless the deleted provision is rejected in its entirety and substituted with substantively changed provisions. Wholesale substitutions of provisions must not be made in lieu of strategic edits required to reflect Proposer modifications. See Section 2.7.5 below regarding assumptions and exceptions to Appendix 11 – Department Terms and Conditions.

c. Immediately after a proposed revision, you must add a concise explanation concerning the reason or rationale for the revision. Such explanations must be separate and distinct from the marked-up text and be bracketed, formatted in *italics,* and preceded with the term “[*Explanation: ….*].”

d. Submission of any standard Proposer contracts as a substitute for language in Appendix 11 – Department Terms and Conditions is not a sufficient response to this requirement and may result in rejection of the Proposal. An objection to terms or conditions without including proposed alternative language will be deemed to be an acceptance of the language as applicable.

e. If the Proposer has any assumptions or exceptions to information in the Cost Proposal workbook(s) provided by Segal (see [Section 9](#_9_Cost_Proposal) Cost), provide those where indicated in the Cost Proposal template.

f. All provisions on which no changes are noted will be assumed to be accepted by the Proposer as written and will not be subject to further negotiation or change of any kind unless otherwise proposed by the Department.

g. The Department reserves the right to negotiate contractual terms and conditions when it is in the best interest of the State to do so.

h. Exceptions to any RFP terms and conditions may be considered by the Department during Contract negotiations if it is beneficial to the Department.

i. The Department may or may not consider any of the Proposer’s suggested revisions. The Department reserves the right to reject any proposed assumptions or exceptions.

j. Clearly label each assumption and exception with one of the following labels, as applicable:

* + Appendix 11 – Department Terms and Conditions Assumptions and Exceptions
	+ RFP/Appendix (excluding Cost Proposal) Assumptions and Exceptions
	+ Cost Proposal assumptions and exceptions must be clearly indicated and included with your Cost Proposal submission to Segal.

### 2.7.5 IMPORTANT: Supplemental Information – Department Terms and Conditions

1. The Department may not allow any assumptions or exceptions by the Proposer to any of the sections of Appendix 11 – Department Terms and Conditions that are listed in Table 10 below. Any Proposal with an assumption or exception to language in the sections listed in Table 10 may be rejected unless the Proposer, upon the Department’s request, recants each such assumption or exception in writing.
2. If, during contract negotiations, there are minor issues that need to be addressed due to the Proposer’s inability to meet specific provisions in the sections of the Department Terms and Conditions listed in Table 10 below, the Department may choose to negotiate these issues with the Proposer as the Department sees fit.
3. If there is a difference in interpretation of the Department Terms and Conditions between the Proposer and the Department, the Department may be willing to address those matters during contract negotiations and make clarifications.
4. Be advised that the Department is unlikely to agree to make substantial changes to the language in the sections of the Department Terms and Conditions that are listed in Table 10 below.

***Table 10. No Assumptions or Exceptions Allowed***

**Appendix 11 – Department Terms and Conditions**

|  |
| --- |
| **Section** |
| 3.0 Legal Relations |
| 12.0 Discount for Late Delivery |
| 14.0 Contract Dispute Resolution |
| 15.0 Controlling Law |
| 17.0 Termination of the Contract |
| 18.0 Termination for Cause |
| 18.1 Breach by Pattern or Practice |
| 19.0 Remedies of the Department |
| 24.0 Confidential Information, Privacy and HIPAA Business Associate Agreement |
| 25.0 Indemnification |
| 30.0 Information Security Agreement |
| 41.0 Assignment |

## 2.8 Withdrawal of Proposals

Proposals will be irrevocable until the Contract(s) is awarded unless the Proposal is withdrawn. Proposers may withdraw a Proposal in writing at any time up to the date and time listed in [Section 1.9 Calendar of Events](#_1.9_Calendar_of), for the Proposal Due Date or upon expiration of three (3) Calendar Days after the Proposal Due Date and time, if received by the Department. To accomplish this, the written request must be signed by an authorized representative of the Proposer’s company and submitted to the contact listed in [Section 1.1 Procuring and Contracting Agency](#_1.1__Procuring). If a previously submitted Proposal is withdrawn before the Proposal Due Date, the Proposer may submit another Proposal at any time up to the Proposal Due Date and time.

# 3 Proposal Selection and Award Process

## 3.1 Preliminary Evaluation

1. Proposals will initially be reviewed to determine if Form B – Attestations/Confirmations are met, to the extent the Department can make that determination, and if all required Proposal components are received. All components of the Proposal must be submitted prior to the deadline listed in [Section 1.9 Calendar of Events](#_1.9_Calendar_of). Failure on the part of the Proposer to:
* submit a complete non-cost Proposal on time and following the instructions for completing the Proposal specified in this RFP; or
* provide all required Cost Proposal documents on time; or
* be able to meet the specifications in this RFP and the appropriate appendices,

may result in rejection of the Proposal regardless of when the Department makes such discovery. In the event that all Proposers do not meet one or more of the RFP requirements, the Department reserves the right to continue the evaluation of Proposals and to select the Proposal(s) that most closely meet(s) the requirements specified in this RFP. Also see [Section 2.7.5](#_2.7.5__IMPORTANT:) regarding possible rejection of a Proposal for making assumptions/exceptions to certain sections of Appendix 11 – Department Terms and Conditions.

1. Failure to respond to each of the requirements / questions in this RFP (for the RFP(s) being responded to) may be the basis for rejecting a Proposal.
2. All Proposals must be in English.

## 3.2 Clarification Process

The Department may request Proposers to clarify ambiguities or answer questions related to information presented in their Proposal. Clarifications may occur throughout the Proposal evaluation process. Clarification requests will include appropriate references to this RFP and the Proposal. Proposer responses must be submitted to the Department in writing in the manner and timeframe specified by the Department. Failure to provide responses as instructed may result in rejection of a Proposal.

## 3.3 Evaluation Criteria

1. Proposals that pass the preliminary evaluation may be reviewed by an evaluation committee. The evaluation committee may review written Proposals, additional clarifications, oral presentations, or demonstrations of the Proposer’s proposed products(s) and/or service(s) (top scoring Proposers only), site visits, and other information to score Proposals. The Department may request reports on a Proposer’s financial stability (this includes the Department’s request for Proposers to furnish audited financial statements), and if financial stability is not substantiated, may reject a Proposer’s Proposal. The Department may review results of past awards to the Proposer by the State.
2. Proposers are required to provide a copy of their organization’s most recent SOC 2 Type 2 audit report with a letter of attestation (see Section 7.2.3 below and Appendix 11 – Department Terms and Conditions, Sections 6.0 and 30.0) with their Proposal. However, if a Proposer does not currently have a SOC 2 Type 2 report and letter of attestation, the Proposer must, within their Proposal, provide the Department with assurances that they have started a SOC 2 Type 2 audit (include auditor name and projected date of audit completion) and will provide such audit report to the Department **before May 1, 2025**. The Department may reject a Proposal if the report and letter of attestation are not provided, if the assurances are not provided, or if the report provided does not assure the Department that the Proposer is able to provide the services requested in this RFP for the life of the Contract to the Department’s satisfaction.
3. The RFP evaluation committee may contact the references of selected Proposers to determine the quality of services provided and work performed by the Proposer, customer satisfaction, etc. Proposers should use **Form F – Vendor References** to provide references**.** The Department will act as its own reference (therefore do not list the Department as a reference). At least one reference should be an entity with at least 50,000 eligible participants for whom your organization provides services like those described in this RFP. Reference checks may be used by evaluation committee members to clarify and substantiate information in the Proposals, learn about the Proposer’s past performance and ability to perform the services described in this RFP and in the Proposal, and may be considered when scoring Proposer responses to the general and technical questionnaires in this RFP.
4. The evaluation committee's scoring will be tabulated, and Proposals will be ranked based on the numerical scores received. The evaluation committee reserves the right to stop reviewing a Proposal at any point during the evaluation process and remove the Proposal from further consideration when the Proposal is not reasonably apt to receive an award.

## 3.4 Proposer Presentations, Demonstrations, Site Visits

**This section is not scored. (0 points)**

**Any presentations, demonstrations or site visits will inform evaluation committee members’ scoring of the General and/or Technical Questionnaires.**

1. At the direction of the evaluation committee and the discretion of the Department, Proposers reasonably apt to receive an award (top scoring Proposers) based on the evaluation of their Proposals and the scores of their General and Technical Questionnaires (Sections 6, 7) and review of their Section 8 Network Submission Requirements submissions may be required to participate in oral presentations or demonstrations, interviews and/or site visits to supplement the Proposals. This may include presentations to supplement or clarify information in the Proposal or demonstrations of Proposer’s key tools, web portal, and reporting capabilities, and interviews with key Department staff, evaluation committee members, and Board members. Proposer presentations and/or demonstrations may be used by evaluation committee members to validate or supplement Proposal information; committee members may change their scores to the Proposer’s responses to items in Sections 6 and 7 based on Proposer presentations/demonstrations.
2. The Department will reasonably attempt to schedule each Proposer presentation or demonstration at a time that is agreeable to the Proposer, however, such presentations or demonstrations must occur within a window of time specified by the Department. Presentations will be held either virtually via MS Teams or in Madison, Wisconsin. Failure of a Proposer to provide a presentation or demonstration or permit a site visit on the date scheduled may result in rejection of the Proposer’s Proposal.
3. By submitting a Proposal in response to this RFP, the Proposer grants rights to the Department to contact or arrange a site visit with any or all of the Proposer’s clients, associates, Subcontractors, and/or references.
4. Proposers invited by the evaluation committee and Department to provide a presentation or demonstration will be given a list of agenda items/talking points the Proposer must address to ensure an objective comparison by the evaluation committee of Proposers’ proposed services.
5. If a presentation or demonstration is required, the Department prefers to have the designated primary contact, program managers, implementation managers, or other key assigned project staff participate in the presentation or demonstration and facilitate discussions. The Department’s objective is to ascertain the designated primary contacts’ familiarity with the Department’s mission and expectations, and ability to explain, communicate, converse, and interact with Department staff. While respecting the role of sales and marketing staff in the sales process, the Department is most interested in interacting with the staff the Department will be interacting with daily to manage the Contract(s), if the Proposer wins an award.

## 3.5 Proposal Scoring

Proposals submitted for each of the RFPs (ETD0050 and ETD0051) will be scored based upon the proven ability of the Proposer to satisfy the requirements specified herein in an efficient, cost-effective manner, taking into account quality of services proposed. If a vendor submits a Proposal for ETD0050 and ETD0051, Proposals will be scored individually for ETD0050 and ETD0051. Proposals will be scored using the following point system:

Table 11. Evaluation Criteria

| **RFP Section** | **Description** | **Maximum Points that can be awarded** | **%** |
| --- | --- | --- | --- |
| 6 | General Questionnaire (complete only once, applies to both RFPs) | 300 | 30% |
| 7 | Technical Questionnaire (complete the sections appropriate for the RFP being responded to)  | 500 (for each RFP) | 50% |
| 9 | Cost Proposal (complete for the RFP being responded to) | 200(for each RFP) | 20% |
|  | **Total** | **1,000**(per RFP) | **100%** |
| **Top Proposers Only** | **Description** | **Total Points** | **%** |
|  | Proposer Presentation / Demonstration | Not scored but used by the evaluation committee to clarify proposals |

1. For clarity: If a Proposer submits a Proposal for both RFPs, scores will be tallied separately for each RFP as follows:

For **RFP ETD0050 IYC Medicare Advantage Plan total possible score: 1,000 points**

Score of Section 6: 300 points maximum

Score of Sections 7.6 – 7.15: 500 points maximum

Cost Score: 200 points maximum

For **RFP ETD0051 Medicare Plus Plan total possible score: 1,000 points**

Score of Section 6: 300 points

Score of Section 7.6 – 7.8 and 7.16: 500 points maximum

Cost Score: 200 points maximum

1. Proposers whose Proposals are accepted for final consideration will be required to participate in Proposer presentations and/or web-portal demonstrations if requested by the Department (see [Section 1.9](#_1.9_Calendar_of) Calendar of Events); see [Section 3.4](#_3.4_Proposer_Presentations,) Proposer Presentations, Demonstrations, Site Visits. Proposer presentations/demonstrations to evaluation committee members will be accomplished through video means.
2. Evaluation committee members may alter their scores of a Proposal based on the information they learn from the Proposer in their presentation/demonstration.
3. Proposals with Network Access Tool submissions that do not meet the access standards specified in [Section 8.1](#_8.1__Network) will not be passed on to the Board for consideration for contract award.
4. The evaluation and selection of a Contractor(s) will be based on the information received in the submitted Proposal(s) plus the following optional review methods, at the Department’s or evaluation committee’s discretion: reference checks, presentations, demonstrations, interviews, responses to requests for additional information or clarification, any on-site visits, and/or best and final offers (BAFOs), where requested. Such methods may be used to clarify and substantiate information in the Proposals.

e. At the discretion of the Department, Proposers reasonably apt to receive an award after the initial review of Proposals may be required to provide a copy of their organization’s audited financial statements for the two (2) most recent fiscal years including the audit opinion, balance sheet, statement of operations and notes to the financial statements. If a Proposer receives a request for these documents from the Department, the Proposer must furnish such documents to the Department within five (5) Business Days of the Proposer’s receipt of the Department’s request. If such documents are confidential, the Proposer must submit a revised Form G – Designation of Confidential and Proprietary Information with the documents. The Department may reject a Proposal if the requested documentation is not provided or if the documentation provided does not assure the Department that the Proposer is able to provide the services requested in this RFP for the life of the Contract to the Department’s satisfaction.

## 3.6 Method to Score Cost Proposals

Scoring of the Cost Proposals will be performed by the Board’s consulting actuary.

Cost scores for each RFP (ETD0050 and ETD0051) will be tallied separately.

### 3.6.1 IYC Medicare Advantage

a. For nationwide service area Proposals, the lowest Cost Proposal for the Uniform Benefit design will receive the maximum number of points available for the cost category, for each plan design option you are offering in your Proposal. Cost Proposals from other nationwide service area Proposers for the Uniform Benefit design will receive prorated scores based on the proportion that the costs of the Proposals vary from the lowest Cost Proposal, separately for each plan design. The scores for the cost category will be calculated with a mathematical formula.

b. For regional service area Proposals, costs will be compared to non-Medicare Advantage offerings already available to Participants in the area.

### 3.6.2 Medicare Plus

The lowest Cost Proposal for the overall benefit design will receive the maximum number of points available for the cost category. Other Cost Proposals will receive prorated scores based on the proportion that the costs of the Proposals vary from the lowest Cost Proposal. The scores for the cost category will be calculated with a mathematical formula.

## 3.7 Best and Final Offer (BAFO)

a. The Department reserves the right to solicit one or more BAFOs and conduct Proposer discussions, request more competitive pricing, clarify Proposals, and contact references of finalists should it be advantageous for the Department to do so. The Department is the sole determinant of what is most advantageous.

b. If a BAFO is solicited, it will contain the specific information on what is being requested, as well as submission requirements, and a timeline with due date for submission. Any BAFO responses received by the Department (or Segal as directed) after the stated due date may not be accepted. Proposers that are asked to submit a BAFO may refuse to do so by submitting a written response indicating their Cost Proposal remains as originally submitted. Refusing to submit a BAFO, if asked, will not disqualify the Proposer from further consideration.

## 3.8 Contract Award

The evaluation committee may conduct Proposer discussions, clarify Proposals, contact the references of Proposers, and request a Best and Final Offer (BAFO) from Proposers. Information regarding the Proposals will be presented to the Board. One or more Proposals may be presented to the Board for award based on the results of the general, technical, cost evaluations, and references. If the evaluation committee conducted oral presentations or demonstrations, the award will be based on the results of the presentations or demonstrations, as well. The Proposal(s) determined to best meet the goals of the State’s benefits program may be selected by the Board for further action, including oral presentations or demonstrations to the Board, and the Board’s discussion held in closed session regarding the award among other considerations in determining the award decision. The Board has the fiduciary responsibility and authority to make the final contract award decision. Under Wis. Stat. § 40.03 (6) there is no requirement for the Board to award a contract to the Proposer who scored the most points. The Board reserves the right not to award a Contract.

### 3.8.1 For IYC Medicare Advantage Plan Proposals

If Contract negotiations with the Proposer(s) selected for the nationwide service area cannot be concluded successfully, the Board may negotiate a Contract with another Proposer(s). If Contract negotiations with a Proposer selected for a regional service area cannot be concluded successfully, that Proposer's plan will not be available in that service area, and the Board may negotiate a Contract with another Proposer(s). Contract negotiations for IYC Medicare Advantage will include the proposed benefit designs outlined in this RFP and any new/revised benefit designs (if any) approved by the Board between the date this RFP was released and negotiations.

### 3.8.2 For Medicare Plus Proposals

If Contract negotiations with the Proposer selected cannot be concluded successfully, the Board may negotiate a Contract with another Proposer(s). Contract negotiations for Medicare Plus will include the proposed benefit designs outlined in this RFP and any new/revised benefit designs (if any) approved by the Board between the date this RFP was released and negotiations.

## 3.9 Right to Reject Proposals and Negotiate Contract Terms

a. This RFP does not commit the Board to award a Contract or pay any cost incurred in the preparation of a Proposal in response to the RFP. The Board retains the right to accept or reject any or all Proposals or accept or reject any part of a Proposal deemed to be in the best interest of the Board. The Board will be the sole judge as to compliance with the instructions contained in this RFP.

b. The Department, on behalf of the Board, will negotiate the terms of the Contract, including the award amount and the Contract length, with the selected Proposer(s) prior to entering into a Contract. The Department reserves the right to add contract terms and conditions to the Contract during contract negotiations and subsequent renewals.

## 3.10 Notification of Intent to Award

All Proposers who respond to this RFP will be notified in writing of the Board’s intent to award one or more contracts as a result of this RFP. All decisions and actions under this RFP are solely under the authority of the Board.

## 3.11 Appeals Process

1. Protests (appeals) of the Board’s intent to award a contract must be made in writing and according to the Board’s Vendor Procurement Appeals Policy located [here](file:///S%3A%5CFinance%5CProcurement%5CContract-R%5CContract%5CETD%5CETD0050-51%20-%20Medicare%20Advantage%20%26%20Medicare%20Plus%5C1.%20Development%5CRFP%20docs%20DRAFTS%5CAppeals%20Policy%20from%20web%201.19.2024.pdf), starting at the bottom of page 12.
2. A Proposer who wants to appeal the award must first email a written notice indicating that the Proposer intends to appeal the award decision to [ETFsmbProcurement@etf.wi.gov](https://secure-web.cisco.com/18XmQICqchrDvTdTbkJwv52UHhTJlRpTHvQjvsh90yyrLSNjPSSUjPfdRpo_FVNg_PnYOQiI_0KGsFGumoo5ULGh9GnSVPr29tCbfXb_sfu-Rfu0sUoQOcaxuLU-uJXdEioLY-CH7poGR6srcIJnjn4T_E4ja7d5EcYbbBXhVMgfo21HHP9shqMtba0EnmPRpGQw3mckXjXTxtLJ1RSJ_-Rwd-uLobeYwqbr2-YrSoyyJ2EcLRtWVOPN4nNS_3JumTJRRWNLTO7lY3Op4l7TYRlikI1qyCnc40Kd_xKVr28Pj8TPiOZ4HeOBfqk9eSQUKoh5pN1uV_yW8Fl70Z0JQUA/https%3A//r20.rs6.net/tn.jsp) ***AND*** to [ETFsmbProcurementAppeals@etf.wi.gov](https://secure-web.cisco.com/1lxk9HZL5s_18LpzpKxrYzLQnyu8TQ663rGp1PeCTVkv2dUIIhYvJQo9iWJ947-FzPrFLWpebxcXXaCymyCfgeRWZFTKVn_PZDeSqFNyjD3J3hk5xZmF-rG8nEjQyqfohhz8-5BqS2h4Iu-2fNayQ_V_VjLtKbCDDKXdrx1O9qd16I08hhr0ljuxURClkGCj9xK5YfzDt8GV0Odb494LqLAZcn1QcLYRMbi7aIiQ4Lic2KZ0OSYhNnp_5a3pnCES15ZPqzXNw5tObTF60yxiREmbssCvj2hoh3135TstlaPcSofugZZ2acECzkh_EF3egKYCFQgEJiHT7bL21Kp90Mw/https%3A//r20.rs6.net/tn.jsp). The notice of intent to appeal the decision must be received no later than five (5) Business Days after the notice of intent to award the contract is issued.
3. Following the notice of intent to appeal, the Proposer’s formal written appeal must be emailed to ETFsmbProcurement@etf.wi.gov ***AND*** [ETFsmbProcurementAppeals@etf.wi.gov](https://etf.wi.gov/resource/etf-insurance-complaint-form), addressed to the Board, c/o the Secretary of the Department, within ten (10) Business Days after the notice of intent to award the contract is issued. Appeal rights are lost if no formal appeal is timely received. The formal appeal must state the RFP number, detailed factual grounds for the objection to the contract award, and must identify any sections of the Wisconsin Statutes and Wisconsin Administrative Code that are alleged to have been violated. Proposers can appeal only once per award.
4. The subjective judgment of evaluation committee members is not appealable. Following Board action, a written decision will be sent to the appellant. The decision of the Board regarding any appeal is final.

# 4 Proposer Attestations/confirmations

**This section is not scored. (0 points)**

**Use Form B – Attestations/Confirmations to respond.**

Form B must be completed and submitted with the Proposal. A response to each item in Form B is required. If the Proposer cannot attest to or confirm each item listed in Form B, the Proposer must so specify and provide the reason for the disagreement in the Assumptions and Exceptions section of their Proposal (see instructions in [Section 2.7.4](#_2.7.4_Instructions_for) above).

Failure of a Proposer to attest/confirm one or more of the items listed in Form B – Attestations/Confirmations may disqualify the Proposer.

# 5 Program Specifications and Requirements

**This section is NOT scored. (0 points)**

1. If a Proposer cannot agree to specifications and requirements in this RFP, the Proposer must so specify and provide the reason for the disagreement in the Assumptions and Exceptions section of their Proposal (see instructions in [Section 2.7.4](#_2.7.4_Instructions_for) above). Failure of a Proposer to agree to one or more of the specifications and requirements in this RFP may disqualify the Proposer.

b. Exhibit 1 – State of Wisconsin Group Health Insurance Program - Medicare Advantage and Medicare Plus Program Agreement will be updated by the Department on an annual basis to reflect program changes approved by the Board and include State and federal mandated changes; therefore, the Department and the Contractor(s) will negotiate an Amendment to the Contract(s) to modify Exhibit 1 each year the Contract is in force.

# 6 General Questionnaire

**This section is scored. (300 total points)**

1. The purpose of this Section 6 is to provide the evaluation committee, the Department, and the Board with a basis for determining your organization’s (the Proposer’s) capability to undertake the Contract(s). This Section 6 applies to both RFPs (ETD0050 and ETD0051) and is worth a maximum of 300 points. If you submit a Proposal for both RFPs, the score received for Section 6 will be used for both Proposals.
2. You (the Proposer) must provide point-by-point responses to each and every statement, request, and question in Section 6. Restate the heading of each section being responded to and each question or statement in the section in bold and provide a detailed written response (in non-bolded text). Do not combine questions or responses. Provide only one answer to one question at a time. However, **if your answer differs for Medicare Advantage versus Medicare Plus, explain the difference.**
3. Your responses must follow the same numbering system, use the same headings, and address each point or sub-point listed in each section. Include the documents requested in Section 6 (if any) immediately after the request for the document(s).Label each document provided with the question it corresponds to (e.g., Response to 6.1.2).
4. Responses should reflect your (the Proposer's) understanding of the requirements and specifications herein, the procedures used to ensure the requirements will be met, and your organization’s qualifications and experience in providing the required Services. See 5.a. above.
5. You must provide sufficient detail for the evaluation committee, the Department, and the Board to understand how your organization will comply with each requirement. See 5.a. above. If you believe your organization’s qualifications go beyond the minimum requirements or add value, you should indicate those capabilities in the appropriate section of your Proposal.
6. Information described in your Proposal regarding programming and capabilities must be available to all eligible Participants unless otherwise noted in your Proposal.
7. Fees related to any services included in your Proposal must be noted in the Cost Proposal workbook(s) you provide to Segal only. Do not include cost/pricing information in any part of the non-cost Proposal.
8. The evaluation committee may stop reviewing a Proposal if the Proposal format does not follow these instructions. Do not combine questions. Provide only one answer to one question/requirement at a time.

## 6.1 Company Information

**6.1.1** Provide a description of your organization, including all of the following:

a. Legal name of the company

b. Mailing address

c. State in which the company is domiciled

d. Year in which your organization was established

e. Primary line(s) of business and description of experience in primary line(s) of business

f. Number of employees

g. Address of the following: your organization headquarters, account manager, customer service, claims processing, IT support and security, implementation team, and other key staff

h. Using Form C – Subcontractor Information, provide the same information above for any Subcontractors that will provide services as part of your Proposal. Provide the name and location of each Subcontractor and services for which they are (or will be) contracted to provide Services under the Contract. If no Subcontractors will be used, indicate that on Form C.

**6.1.2** Describe fully your organization’s corporate or other business entity structure, including company ownership information.

a. Attach an organizational chart showing principal officers, directors, managers, and staff members who will be associated with providing services related to this RFP.

b. Indicate if your organization is a subsidiary or affiliate of another company, and if yes, list the name(s) of the affiliated companies or parent company.

c. Provide full disclosure of any direct or indirect ownership or control by any administrative service agency and/or financial institution and describe the relationship in detail.

**6.1.3** Describe any acquisitions and/or mergers or other material developments regarding your organization (e.g., changes in ownership, personnel, business, etc.) pending now or that occurred in the past five (5) years. Disclose any potential mergers or acquisitions that have been recently discussed by senior officials and could potentially take place within three (3) years after the Contract is executed. If this is confidential information, designate the information as such in Form G – Designation of Confidential and Proprietary Information. (The Department understands if Proposers cannot share certain information due to SEC rules and/or the existence of non-disclosure agreements that may be in place with Proposer regarding certain acquisitions and mergers.)

**6.1.4** List any relevant websites for your company and its offerings.

**6.1.5** Is your company involved in any current or pending litigation? If yes, explain.

**6.1.6** What are the most recent ratings for your company? Enter for all ratings agencies that apply)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Rating** | **Date** | **If your rating has changed within the past 12 months for any of the rating agencies, explain why.** |
| A.M. Best |  |  |  |
| Fitch |  |  |  |
| Moody’s |  |  |  |
| Standard and Poor’s |  |  |  |

**6.1.7** Submit evidence of your organization’s current licensure under the State of Wisconsin’s Office of the Commissioner of Insurance for group Medicare Advantage and group Medicare (Supplement or Medigap) plans, as applicable.

## 6.2 Staff Qualifications

**6.2.1** Describe the qualifications of the dedicated account manager you will assign to the Contract(s) and provide their resume. In your description, include all of the following:

a. The skills and attributes of the account manager that will ensure Contract requirements will be met

b. Information about the account manager’s professional qualifications

1. A detailed description of the types of group accounts that work with Medicare that your account manager has been, or currently is, managing. Include the total number of group Medicare plans along with the number of years of experience in managing these types of accounts
2. Number of other accounts, and their size, which the account manager will be overseeing when also assigned to manage the State and Local GHIP Medicare program
3. A specific example of how the account manager has resolved a general administrative problem identified by a client

**6.2.2** Provide a list of the key, qualified staff who will assist in fulfilling the Contract requirements. Specify if they are for implementation and/or subsequent account management. At a minimum, include the back-up to the account manager and at least one staff person in enrollment, actuarial science, customer service, claims, medical management, provider relations, IT security with a focus on SOC2, and other key areas. For each staff person, list all of the following (Note: a dedicated account manager is required):

* 1. Name, job title, and location (city, state)
	2. Primary responsibilities
	3. Years of related experience
	4. Indicate whether the named person would be assigned only to the Department or if they would support/continue to support multiple accounts.

**6.2.3** Provide an organizational chart that shows the reporting structure for the key implementation and subsequent account management staff.

## 6.3 Customer Service

**6.3.1** Explain how your company plans to meet the customer service requirements as specified in Exhibit 1 – State of Wisconsin Group Health Insurance Program - Medicare Advantage and Medicare Plus Program Agreement Sections III.H.3. Customer Service, IV.G.3. Customer Service Inquiry System Certification, and IV.I.2. Customer Service.

**6.3.2** Provide examples of reports that demonstrate how your organization would meet the requirements specified in Exhibit 1 – State of Wisconsin Group Health Insurance Program - Medicare Advantage and Medicare Plus Program Agreement Section IV.I.2. Customer Service.

**6.3.3** Describe your organization’s policies and procedures for handling participant contacts (e.g., calls, emails, etc.) during times of peak volume (e.g., Open Enrollment Period, new plan year). Describe how your organization handles after-hour participant contacts.

**6.3.4** Patients demonstrate a wide range of understanding and ability with regard to understanding their benefits, using their health coverage, choosing providers, and engaging with care. Describe your organization’s efforts to address health literacy issues and promote informed decision‐making skills and active patient participation in their healthcare. Responses should address all of the following topics:

1. Health literacy policies and practices
2. Evaluation of effectiveness of oral, printed, and web communications (including billing statements, benefit and enrollment materials, and information on provider network)
3. Initiatives to increase patient engagement

Provide at least one (1) example for a., b., and c. above.

**6.3.5** The Medicare population is more likely to have different customer service needs than a commercial population. Describe your understanding of the different needs of this population. Describe how your organization’s customer service staff are trained to meet the needs of the Medicare population and how your technology, policies, and procedures are specifically designed to meet those needs.

**6.3.6** Describe how your organization meets the communication needs of your visually and hearing-impaired Medicare members and those for whom English is a second language. Specifically address how your customer service staff are trained to meet their needs and how you make your written and electronic materials, including your website available to meet their needs.

**6.3.7** Confirm you will provide one full-time employee to work with Department staff to resolve Participants’ escalated eligibility, enrollment, premium, and claim issues and to assist with communications and training and resolve operational issues by being a liaison with the main office. Confirm this person will be solely dedicated to the Department.

**6.3.8** Will you provide a “pre-enrollment” telephone information line during Open Enrollment as well as a telephone information line throughout the year? Describe the information that would be made available to members via the pre-enrollment line.

**6.3.9** Are specific customer service staff trained and assigned to calls according to the need of the caller (i.e., provider directories vs. claims payment issues)? Do all customer service representatives reside in the US?

**6.3.10** How are calls "after hours" of operation handled?

**6.3.11** Provide the geographic location of the customer service unit(s) that will be servicing Participants. Will this service be outsourced? If so, provide the name (and location) of the Subcontractor that will do this work for you.

**6.3.12** Describe the escalation process for customer service satisfaction and complaints.

**6.3.13** Complete the following table:

|  |  |
| --- | --- |
| **Provider Directories** | **Response** |
| Are hard copy provider directories available to your membership? If so, describe how often they are mailed and whether they are sent to new members only. |  |
| Are the provider directories also available online? |  |
| If so, how often are the online directories updated? |  |

**6.3.14** Indicate whether your member website captures the following and indicate any additional tools or functionalities under “Other” below:

|  |  |
| --- | --- |
| **Member Website Capabilities** | **Response** |
| 1. Provider directory and provider search (physician, hospital, and ancillary providers) for Providers that accept Medicare assignment)
 |  |
| 1. Ability to review claims payment status online
 |  |
| 1. Ability to review a history of claims payments, including deductible status, and out-of-pocket maximum status
 |  |
| 1. Ability to see a summary of the Department’s plan design and review the Medicare Plus Certificate of Coverage or Medicare Advantage Evidence of Coverage
 |  |
| 1. Ability to print ID cards and request replacement cards
 |  |
| 1. Ability to contact customer service online
 |  |
| 1. Star Ratings (Medicare Advantage only)
 |  |
| 1. Information about diseases and conditions
 |  |
| 1. Contact information for Department, its other vendors, and links to their websites
 |  |
| 1. Online access to forms
 |  |
| 1. Ability to review/select incentives (i.e., gift cards) when they are available to the member (Medicare Advantage only)
 |  |
| 1. Cost information by procedure type
 |  |
| 1. Access to wellness resources
 |  |
| 1. Other
 |  |

**6.3.15** Confirm your member website is maintained for HIPAA, ADA, and CMS compliance.

**6.3.16** Describe your mobile application and how it is designed to serve a Medicare population.

**6.3.17** Describe your organization's member satisfaction surveys and provide the most recent results.

## 6.4 Implementation

**6.4.1** Submit a detailed implementation plan identifying the tasks necessary to implement the Services, such as staff roles, programming changes, Subcontractors involved, timeline, transition requirements with the incumbent vendor(s), data and timing requirements from current vendors to ensure transition of care and prior-authorization data is appropriately transferred, etc. Note implementation requirements in Exhibit 1 – State of Wisconsin Group Health Insurance Program - Medicare Advantage and Medicare Plus Program Agreement.

**6.4.2** Provide a detailed explanation of how your organization will be available to support Department staff during implementation.

**6.4.3** Indicate whether you plan to implement any major computer system upgrades or conversions, major staff relocations, or telephone system changes during 2025 or the first six months of 2026. If any are planned, identify the specific measures you will be taking to ensure that such changes will not affect the implementation of the Contract. What assurances can you provide that no unanticipated changes will develop between submission of your Proposal and Contract implementation that could impact the implementation?

**6.4.4** Describe how your organization will conduct testing to ensure claims will process correctly on the ‘go-live' date of January 1, 2026.

**6.4.5** How long will your implementation team stay involved after the ‘go-live' date of January 1, 2026 for troubleshooting before a handoff to your Account Management team?

## 6.5 Enrollment and Communication

The Board expects the awarded Proposer(s) to provide a significant multi-faceted effort to educate Participants about: the enrollment process leading up to and during the Open Enrollment Period, Medicare plans in general, Proposer’s organization, the benefits and providers available under the specific plan(s) being offered, and the various methods Participants can use to get more information.

**6.5.1** Submit a detailed communication and enrollment plan for Participants that includes a timeline starting prior to the Open Enrollment Period through enrollment and payment of premiums.

**6.5.2** Provide examples of participant communication materials that explain the enrollment process, covered benefits and cost-sharing, available providers, and methods for obtaining more information. Include any materials CMS requires you to send to members during enrollment, a sample subscriber identification card, explanation of benefits statement, and a billing invoice for participants that are direct billed.

**6.5.3** Describe your ability to co-brand Participant communication materials, including web, print and any other electronic/digital materials. Describe any limits, including frequency, colors, logo size, and format, co-branding with the Department.

# 7 Technical Questionnaires

**This section is scored. (a maximum of 500 points for each RFP)**

The purpose of this section is to provide the evaluation committee, the Department, and the Board with a basis for determining your organization’s (the Proposer’s) capability to undertake a Contract.

**All Proposers must complete Sections 7.1 – 7.8 below.**

**If submitting a Proposal for RFP ETD0050 IYC Medicare Advantage Plan, Proposers must also complete Sections 7.9 – 7.15.**

**If submitting a Proposal for RFP ETD0051 Medicare Plus Plan, Proposers must also complete Section 7.16.**

**Scoring of the Technical Questionnaires will be as follows:**

**Sections 7.1 – 7.5** apply to both RFPs, ETD0050 and ETD0051, and are not scored but are reviewed closely by Department staff to determine if the Proposer has applicable information technology and security measures in place. Should Department staff have follow-up questions or require clarification to any answers provided for these Sections, the Department will reach out to the Proposer. Should a Proposer’s responses to the questions and requirements in Sections 7.1 – 7.5, or any assumptions and exceptions related to the technology, data, and security requirements in the RFPs not satisfy the Department’s information technology and security rules and practices, the Proposal may be disqualified. Section 3.2 Clarification Process applies.

**Sections 7.6 – 7.15 for RFP ETD0050 IYC Medicare Advantage Plan:** maximum of 500 points

**Sections 7.6 – 7.8, and 7.16 for RFP ETD0051 Medicare Plus Plan:** maximum of 500 points

You (the Proposer) must provide point-by-point responses to each and every statement, request, and question in Section 7 applicable to the RFP being responded to. Restate the heading of each section being responded to and each question or statement in the section in bold and provide a detailed written response (in non-bolded text). Do not combine questions or responses. Provide only one answer to one question at a time.

Your responses must follow the same numbering system, use the same headings, and address each point or sub-point listed in each section. Include the documents requested in Section 7 immediately after the request for the document(s).Label each document provided with the question it corresponds to (e.g., Response to 7.1.2).

Responses should reflect your (the Proposer's) understanding of the requirements and specifications herein, the procedures used to ensure the requirements will be met, and your organization’s qualifications and experience in providing the required Services.

You must provide sufficient detail for the evaluation committee, the Department, and the Board to understand how your organization will comply with the specifications and requirements in this RFP and its attachments. See 5.a. above. If you believe that your organization’s qualifications go beyond the minimum requirements or add value, you should indicate those capabilities in the appropriate section of your Proposal.

Information described in your Proposal regarding programming and capabilities must be available to all eligible State and Local retirees, their dependents and survivors.

**Fees related to any services included in your Proposal must be noted in the Cost Proposal workbook(s) you provide to Segal only. Do not include cost/pricing information in any part of the non-cost Proposal.**

**The evaluation committee may stop reviewing a Proposal if the Proposal format does not follow these instructions or combines questions.**

## Information Technology

**7.1.1** Describe how and where your organization will host the Services.

1. If your organization is headquartered in the United States, provide the state of incorporation.
2. If your organization is headquartered outside the United States, provide the country of incorporation.
3. For your organization and all Subcontractors you intend to use to provide Services, provide the location of all cloud infrastructure where Department data and data provided/received pursuant to the Contract(s) will be stored, processed, and transmitted that are located outside of the contiguous United States (this excludes Hawaii, Alaska, and US Territories).
4. For your organization and all Subcontractors you intend to use to provide Services, provide all locations outside of the contiguous United States where your employees and Subcontractors will have access to Department data.

**7.1.2** Provide your organization’s policies or other documentation that demonstrate compliance with the storage of data that is protected by federal, state, or private-sector regulations.

**7.1.3** Provide your organization’s published policy that indicates employees’ and subcontractors’ access to program participant data is the “minimum necessary” level.

**7.1.4** Describe capabilities of your organization’s systems (related to the provision of Services) related to querying and reporting functions.

**7.1.5** Describe how data imports and exports are handled/provided by your organization’s systems.

**7.1.6** Describe the service level agreement and hours of availability of your organization’s website/web portal including when it is unavailable due to planned maintenance and how unplanned maintenance is managed and communicated to users.

**7.1.7** Describe how the website and web portal your organization would make available for the Program are accessible for disabled users including where the website and web portal are (and are not) Section 508 compliant. Describe specifics on how you meet or will meet WCAG 2.0 Level AA; include any accessibility audit results for your organization.

**7.1.8** Describe your organization’s development process for the website/web portal offered to the Department as part of the Services, including how security and quality assurance are built into the development process and how releases are managed.

**7.1.9** Provide all application programming interface (API) documentation that exists for your organization’s system including but not limited to, descriptions of the APIs, what business functionality they expose, how they are used, and how they are secured.

**7.1.10** Describe the on-going resources your organization will devote to research and development of your system. Include the length of time the system has been in production.

**7.1.11** Provide a roadmap for all platform/application enhancements that are planned for your organization’s system in the next three years.

**7.1.12** Describe how your platform/application and internal IT systems have changed/improved over the previous 3 to 5 years (response should demonstrate how agile and flexible your organization is with regard to staying current with technology and IT best practices).

**7.1.13** Describe how and when your organization will ensure that your system software is in compliance with applicable local, state, and federal statutes and regulations. Also, describe the process and timeline associated with your organization’s proposed system changes to accommodate applicable local, state, and federal statutes and regulations.

**7.1.14** The Department is in the process of implementing Benefitfocus’ Benefitplace eligibility and enrollment software. The Contractor(s) awarded a contract under RFPs ETD0050-51 will be required to submit data to and receive data from the Department and/or Benefitfocus. The Contractor(s) will be required to have the ability to provide and receive repeatable, automatable data interchange with the Department and/or Benefitfocus at no additional cost. In your Proposal, provide a statement that your organization can or cannot (as appropriate) provide data sharing services.

a. Is your organization part of the Benefitfocus Benefit Catalog Vendor program? If so, provide your Benefitfocus vendor or partner identification number.

b. Describe your organization’s experience integrating with the Benefitfocus SaaS platform (if applicable) and other SaaS platforms your organization integrates with.

**7.1.15** Describe how your organization supports mobile applications and their usage and how your web applications are supported on mobile devices.

**7.1.16** Describe any authentication mechanisms, identity stores, and user types that will be used as part of your detailed implementation plan.

**7.1.17** Describe your integration strategies to existing public (State of Wisconsin) and / or private information technology systems as part of your detailed implementation plan.

## 7.2 Computer and Data Processing Facilities, Data Policies

**7.2.1** Provide an overview of your organization’s business continuity/disaster recovery plan (BC/DRP). The Contractor will be required to provide evidence it tests and updates its business continuity plans regularly to ensure that they are up to date and effective.

**7.2.2** Provide an overview of your organization’s Incident Response Plan (IRP).

**7.2.3** Provide a copy of your organization’s most recent SOC 2 Type 2 report along with a letter of attestation indicating your organization’s receipt of management’s assertion of control compliance from your organization’s subcontractors. (See Appendix 11 – Department Terms and Conditions, Sections 6.2 and 30.0). If your organization currently does not have a SOC 2 Type 2 audit report and letter of attestation, your organization should take steps to have a SOC 2 Type 2 audit completed so if your organization is selected as a finalist, your organization can meet the requirement of providing the report to the Department **no later than May 1, 2025**. If you do not currently have a SOC 2 Type 2 report and letter of attestation, you must provide the Department with assurances in your Proposal that your organization has started the audit (include auditor name and projected date of audit completion) and will provide the audit report and letter of attestation to the Department before May 1, 2025. If the report is submitted after you submit your Proposal, include an updated Form G if the report(s) is confidential. **If a Proposer does not intend to obtain a SOC 2 Type 2 audit or provide a SOC 2 Type 2 report and letter of attestation to the Department, the Proposer will be disqualified.**

**7.2.4** Provide a summary of the results of your organization’s most recent penetration test.

**7.2.5** Describe your organization’s annual risk assessment performed in accordance with accepted principles. If annual risk assessment is not performed, explain why.

**7.2.6** Provide your organization’s policies/guidelines related to security/privacy (e.g., annual training, confidentiality agreement, privacy policy).

**7.2.7** Describe in detail the measures your organization uses to protect the security and privacy of program data, records, forms, participant information, and data processing operations.

**7.2.8** Describe internal controls that are in place to reduce loss of program data, records, forms, participant information, and data processing operations that may occur through fraud, negligence, incompetence, or system errors. Include information about the physical security measures used to control access to your organization’s systems.

**7.2.9** Provide your organization’s data retention procedures/policies for client data evidencing that retention is in accordance with federal and state laws and regulations.

**7.2.10** Describe your organizations disaster recovery procedure if the cloud solution is not available, including processes to bring up the cloud solution and restore connectivity?

**7.2.11** Describe what software applications and supporting platform your organization will use to secure Department and Participant-related records and data. Provide information on how information is secured in transit and at rest.

**7.2.12** Describe in detail the computer and data processing facilities your organization currently uses (owned or otherwise used) and would make available for administering the Program. Include a description of any mainframe, distributive servers, cloud services, and network structures that you will use for providing the Services.

**7.2.13** What additional computer/data processing resources would your organization acquire in order to provide the Services, if any?

**7.2.14** Describe your organization’s policy for preventing data loss in the collection, use, storage, and disclosure of personal data.

**7.2.15** Describe how the web portal would transition to use single sign-on functionality to facilitate ease of use by Participants if that became available.

**7.2.16** Does your organization have a cloud exit strategy to export a client’s data that is processed, transmitted, or stored by your organization? If yes, provide the exit strategy. The Contractor will be required to provide a formal cloud exit strategy during the term of the Contract.

**7.2.17** List all current IT and IT security certificates your organization holds. Provide current copies of all IT and IT security certifications.

## 7.3 Information Security

**7.3.1** Does your organization maintain an up-to-date inventory of all user accounts?

**7.3.2** Does your organization have controls in place to prevent the installation or execution of unauthorized software on all assets?

**7.3.3** Has your organization restricted administrative/elevated rights to only those technology personnel with the need to maintain the organization's systems based upon the principle of least privilege and supported through technical controls?

**7.3.4** Does your organization utilize an identity and access management (IAM) tool?

**7.3.5** Has your organization implemented multifactor authentication (MFA) wherever possible?

**7.3.6** Does your organization logically segregate a client’s data from other clients’ data?

**7.3.7** Indicate if your organization has or has not implemented each of the following endpoint protections:

* Anti-virus software with real-time signature upgrades
* Anti-malware software with Heuristic capabilities
* Host firewalls
* Web filtering capabilities enabled

**7.3.8** Does your organization follow an established framework for asset hardening? If yes, are the configurations maintained and enforced using an automated tool?

**7.3.9** Does your organization maintain an inventory of all assets that includes responsible owners that is updated at least weekly?

**7.3.10** Will your product/service require any on-premises deployment?

**7.3.11** Will your system need to integrate with any other public cloud solution?

**7.3.12** Will backups of client data be captured and maintained at intervals established based on client need?

**7.3.13** Will backups be available at client request?

**7.3.14** Are backups tested at least semi-annually?

**7.3.15** Can client data be deleted upon request?

**7.3.16** Does your organization have methods in place to detect and prevent the loss of client data?

**7.3.17** Will your organization or your Subcontractor(s) keep all Department data and data provided/received pursuant to the Contract(s) within, and only accessible from, the contiguous United States?

**7.3.18** Are formal policies and standards communicated to your staff at least annually?

**7.3.19** Does your organization utilize a centralized log management system that alerts appropriate staff when an incident occurs?

**7.3.20** Is your system capable of providing audit logs? If yes, what format are they provided in?

**7.3.21** Is your system capable of providing audit logs to be sent to a client’s central logging system? If yes, explain what methods are used?

**7.3.22** Does your organization send audit logs to a centralized logging tool?

**7.3.23** Does your organization only utilize non-deprecated encryption methods wherever possible?

**7.3.24** Does your organization support IP and geo-location restrictions?

**7.3.25** Does your organization perform security posture checks?

**7.3.26** Are patches for hardware and software applied within thirty Calendar Days of being released when technically possible?

**7.3.27** Does your organization have an emergency patch management process?

**7.3.28** Does your organization follow formal change control processes and procedures in alignment with an established framework?

**7.3.29** Does your organization outsource any software development? If yes, does outsourced software follow formal change control processes and procedures that require supervision and monitoring?

**7.3.30** Does your organization follow an industry standard when designing, developing, and implementing applications and components? If yes, what standard does your organization use?

**7.3.31** Does the organization use a web application scanning tool for deployed web applications?

**7.3.32** Does the organization follow a regular cadence for web application scanning?

**7.3.33** Does your organization conduct vulnerability scanning at least weekly?

**7.3.34** Are vulnerabilities prioritized based upon the common vulnerability scoring system?

**7.3.35** Are critical vulnerabilities remediated within at least thirty Calendar Days?

**7.3.36** Provide confirmation that your organization conducts annual risk assessments in accordance with the HIPAA Security Rule.

**7.3.37** Describe how you will keep digital banking information unreadable while at rest, in compliance with National Automated Clearing House Association (NACHA) requirements.

**7.3.38** Does your organization utilize any artificial intelligence (AI) tools? If so, which tools and for what purpose.

## 7.4 Data Privacy

**7.4.1** Provide documentation that demonstrates your organization’s compliance with the HIPAA Privacy Rule.

**7.4.2** Describe how your organization ensures compliance with the HIPAA Privacy Rule’s minimum necessary standard, including how role-based access relates to this process.

**7.4.3** Provide a copy of your organization’s auditing policy as it relates to ensuring the proper use and disclosure of protected health information (PHI).

**7.4.4** Describe how your organization monitors, controls, and prevents the use of identifying information (personally-identifiable information (PII) and PHI) in generative artificial intelligence (AI) applications, such as ChatGPT.

**7.4.5** Provide the number of unauthorized disclosures of PHI your organization has experienced in the last two (2) years, including the number of individuals and incidents involved.

**7.4.6** Describe how your organization responded to the unauthorized disclosures listed above (if any). Provide a copy of your organization’s policy related to responding to unauthorized disclosure of PHI.

**7.4.7** Has your organization had, or has your organization ever been involved with a business partner who has had, a privacy breach or investigation in the last three (3) years? If so, provide a brief description, including if and how you responded to your clients who were affected by the breach.

**7.4.8** Describe the processes you have in place to ensure that PHI and PII in external e-mails are properly secured to prevent unauthorized access.

## 7.5 Audit

**7.5.1** Describe your experience relative to a Contractor’s audit responsibilities below:

a.  **Items Open to Audit.** All Contractor books, records, ledgers, and journals relating to the Program will be made available for inspection and audit by Department internal audit staff or their designees, the State of Wisconsin Legislative Audit Bureau, or designated agents, attorneys, and accountants, at any time during normal working hours. Records requested shall be provided by the Contractor electronically in a format acceptable to the Department.

b. **Program or Contract Audits.** The Department may require benefit program or Contract audits. The audits will be completed by the Department, or the firm contracted by the Department, to complete the contract audits. These audits will be in addition to the annual Legislative Audit Bureau audits and periodic audits by Department staff. The audits will be based upon Department specifications and follow generally accepted auditing standards, when applicable. A report of findings and recommendations will be delivered to the Contractor and the Department within the guidelines established by the Department. The Department will use the findings and recommendations of each such report as part of its ongoing monitoring of the Program and the Contractor.

**7.5.2**  Describe how your organization, tracks, and stores all billing information, incentive payments (if applicable), performance guarantees, and supporting documentation. What is your turnaround time for being able to provide requested information for an audit? What personnel resources do you make available to ensure audits are conducted timely and accurately?

## 7.6 Claims Processing

Note: If you are proposing both Medicare Advantage and Medicare Plus and your response to a question differs by product, clearly describe the differences in your response. If you are proposing both a nationwide Medicare Advantage PPO and a regional Medicare Advantage HMO(s) and your response to the question differs by product, clearly describe the differences in your response.

**7.6.1**  Using most recent year-end data, complete the table below for the claim office that will have payment responsibility for this account:

|  |  |  |
| --- | --- | --- |
|  | **Target** | **Actual 2023 year end results** |
| 1. Total annual claim volume per year (in total number of claims)
 |  |  |
| 1. Average claims processed per processor per Business Day
 |  |  |
| 1. Claims turnaround time (percent of clean claim transactions processed within 14 Calendar Days following receipt of claim)
 |  |  |
| 1. Average number of Business Days to process a clean claim from date received to date check/EOB issued
 |  |  |
| 1. Financial accuracy (percentage of claim dollars paid without error, relative to total claim dollars paid)
 |  |  |
| 1. Processing accuracy (percentage of claims processed without error, relative to the total number of claims processed)
 |  |  |
| 1. What percent of all non-clean claims submitted are processed (from date received to date check/EOB issued) within 10 Business Days?
 |  |  |
| 1. What percent of all non-clean claims submitted are processed (from date received to date check/EOB issued) within 30 Business Days?
 |  |  |

**7.6.2**  Confirm that the claims processing system is integrated with the eligibility and customer service system.

**7.6.3** Describe the claims payment process for medical “clean claims” from date of receipt to full adjudication of checks to providers or patients. If the process is different for network and non-network claims, discuss separately.

**7.6.4** Describe the claims payment process for medical “non-clean claims” from date of receipt to full adjudication of checks to providers or patients. If the process is different for network and non-network claims, discuss separately.

**7.6.5.** Describe how claims are reviewed for medical necessity including, but not limited to, for post-acute/rehabilitative care. What type of algorithms, technology, and tools are used to assist in determinations? Do you use any Artificial Intelligence tools to make such determinations? What clinical criteria do you use to make such determinations? How do these tools factor into the overall decision-making process?

**7.6.6** a. Provide a list of services that require prior authorization. Are they used for reasons other than determining if care is medically necessary as described in the Certificate of Coverage (ET-2180) section 4.D. Medical Necessity? If yes, describe.

b. Do all prior authorizations on the list provided in 7.6.6.a. above comply with CMS national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare statutes and regulations as interpreted by CMS? If not, how many are based on internal, proprietary, or external clinical criteria?

c. Are prior authorizations valid for the duration of the approved course of treatment? If not, describe limits.

d. Describe how prior authorizations are reviewed, for example, by a Utilization Management Committee. What type of technology is used to assist in determinations?

e. Describe if and how your prior authorization process has changed over the past three years.

**7.6.7** Provide the following information regarding internal claims audit(s):

|  |
| --- |
| **Internal Claims Audits:** |
| 1. What are the current standards for internal claim audits?
 |
| 1. How often are claim processors audited?
 |
| 1. When an error is found, what is the time period for correction of the claim?
 |
| 1. Are reports monthly, quarterly, semi-annual, etc.?
 |
| 1. What claims do you consider for high dollar audits?
 |
| 1. Are high dollar audit claims handled internally?
 |
| 1. How are criteria determined for internal audits?  What triggers do you utilize?
 |
| 1. What percent of claims are audited internally?
 |
| 1. What is the ratio of quality reviewers to claim processors?
 |

**7.6.8** Describe your process to ensure that benefits or program changes that have the potential to create member disruption and provider payment issues are made timely and accurately. Such changes include mandated CMS updates of service codes, fee schedules, etc.

**7.6.9** Will you share the results of the medical internal audit testing with the Department and its designee? Describe your process to address errors and adjustments found from the internal audit and quality assurance review. How are adjustments issued and what impact does it have, if any, on the implementation timing?

**7.6.10** Describe your process to honor existing medical prior authorizations and pre-certifications. Describe how you will use information from the preceding plan carrier to obtain new medical prior authorizations and pre-certifications so the members' care is not disrupted.

## 7.7 Reporting to the Department

Note: If you are proposing both Medicare Advantage and Medicare Plus and your response to a question differs by product, clearly describe the differences in your response. If you are proposing both a nationwide Medicare Advantage PPO and a regional Medicare Advantage HMO(s) and your response to the question differs by product, clearly describe the differences in your response.

**7.7.1**  Standard Utilization and Cost Reports:

a. Confirm you will create and generate standard utilization and cost reports.

b. Provide a list of your standard reports.

c. Include a description of each report and the frequency of the report.

**7.7.2** For the Department’s Data Warehouse:

a. Confirm that you will provide claim line detail for all medical claims, including but not limited to financial and diagnosis information. All required fields can be found in Appendix 4a Claims Data Specifications – Medical. Note these data specifications may be subject to change depending upon data that may be needed for the analysis.

1. Confirm that you will report the plan paid allowed amount and net pay, not the Medicare allowed amount and net pay. Also see Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement Section III.D.

c. Confirm that your organization will provide this data to the Department’s data warehouse in a mutually agreed upon format by the tenth (10th) Calendar Day of the month following the subject month.

d. Confirm that claims line detail for ALL claims that you will provide to the Department’s data warehouse will include member level detail using SSNs and ETF-assigned 8-digit Participant IDs.

**7.7.3** Confirm your organization will monitor and provide reporting to the Department on contractual Performance Standards as specified in Exhibit 1 – State of Wisconsin Group Health Insurance Program - Medicare Advantage and Medicare Plus Program Agreement, Section IV.

**7.7.4** Describe your standard web portal and customer service utilization reports (i.e., number of hits and calls and the nature of the members' inquiries) and provide examples.

**7.7.5**  Confirm you will provide a denied claims report, including number of denials by reason, as requested by the Department. Provide a sample denied claims report.

**7.7.6** Confirm that you are able to customize reports for the Department and this is included in your quoted premium(s). If there is an additional charge for ad hoc reporting, provide the average cost per report and the average preparation time in your Cost Proposal workbook(s), Non-Claims Component, Other section.

**7.7.7** For external reviews, confirm that you will provide the Department the notifications required per Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement Section III.I.6. External Review.

**7.7.8**  Confirm that you will provide the annual appeals/grievances and independent review reports to the Department. If you have concerns with the structure of the report (Appendix 14, Grievance Report Plan Template), explain how you would structure the report / provide the information differently.

**7.7.9** Confirm you will provide and present the reports specified in Exhibit 1 – State of Wisconsin Group Health Insurance Program - Medicare Advantage and Medicare Plus Program Agreement to the Department.

**7.7.10** Confirm that, prior to distribution, you will review and verify for accuracy the reports referred to in 7.7.9 above and any other reports that may be developed as part of the Contract throughout the term of the Contract.

**7.7.11** Confirm that you will provide the Department, upon the Department’s request, sufficient information regarding claims and enrollment so that an audit for accuracy and a comparison to actual experience can be completed.

## 7.8 Eligibility

Note: If you are proposing both Medicare Advantage and Medicare Plus and your response to the question differs by product, clearly describe the differences in your response. If you are proposing both a nationwide Medicare Advantage PPO and a regional Medicare Advantage HMO(s) and your response to the question differs by product, clearly describe the differences in your response.

**7.8.1** Describe your enrollment system (including how long it has been in place and whether there are plans to use a new system within the next three years), hardware and software, and detail how updates are made regarding eligibility.

**7.8.2** Confirm that you will update eligibility data within 2 Business Days from receipt of data.

**7.8.3** Confirm that you will electronically accept and process the Department’s (or the Department’s Insurance Administration System vendor’s) HIPAA 834 file within 2 Business Days. See Appendix 1 - 834 Overview & Companion Guide.

**7.8.4** Confirm that your organization will not enroll or cancel GHIP Participants on its own unless there is a conflict from CMS.

**7.8.5** If a conflict from CMS is found, confirm that the conflict information will be reported back to the Department within 2 Business Days.

**7.8.6** Confirm that your organization will store member-level detail using SSNs, Department-assigned 8-digit Participant IDs and will include it on any member-level reporting to the Department.

**7.8.7** Confirm that your organization will generate a reconciliation file monthly or on demand and that this file will contain, at a minimum, the member's SSN, Department-assigned 8-digit Participant IDs, demographics, GHIP and Medicare enrollment dates, and cancel dates. Confirm that your organization will work with the Department on a monthly basis (or other time frame as determined by the Department) to reconcile enrollment data.

**7.8.8** Describe the processing procedures to ensure files are received and processed timely. What safeguards are in place to detect missing files?

**7.8.9** Explain your process of working error reports generated from the file loads.

**7.8.10** Confirm your system can accommodate a confidential mailing address as required by Title II of HIPAA.

## 7.9 ETD0050 Medicare Advantage Plan Experience

1. Note: **If** you are proposing both a nationwide Medicare Advantage PPO and a regional Medicare Advantage HMO(s) and your response to the question differs by product, clearly describe the differences in your response.
2. Proposers must be able to provide all services under Uniform Benefits, the current standard benefits package available to Medicare-enrolled Participants described in Table 2 – 2025 Medicare Advantage Traditional and Deductible Benefit Designs and further described in the Certificate of Coverage (ET-2180) and Schedules of Benefits of Exhibit 1 State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement or as approved by the Board prior to January 1, 2026.
3. The nationwide service area plans should function as a passive PPO that provides the same level of benefits for Participants when they see a provider outside the network that accepts Medicare. Both the nationwide and regional plans must meet all CMS requirements, and any benefits not delineated in the plan design must be covered at least at the minimum requirement set by CMS. Proposers may not deviate downward from these plan designs in any manner other than to meet CMS requirements.

**7.9.1** Describe your organization's experience participating in Medicare with a third-party EGWP option for Part C benefits. Include the number of years that your organization has participated in Medicare and a brief history of key developments over this time, such as when your first group Medicare plan was offered. Also include insight on the direction of your program over the next five years.

**7.9.2** Provide statistics regarding your Medicare Advantage business for your entire book of business. Break out your Medicare Advantage individual book of business and your Medicare Advantage employer group book of business. Further, break out your public sector book of business. Provide both number of enrolled members for individual and group and number of employer group clients for 2020 - 2024.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Individual Members** | **Total Group Members** | **Total Number of Employer Groups** | **Public Sector Members** | **Number of Public Sector Groups** | **Number of Public Sector Groups with 50,000+ Members** |
| 2020 |  |  |  |  |  |  |
| 2021  |  |  |  |  |  |  |
| 2022  |  |  |  |  |  |  |
| 2023  |  |  |  |  |  |  |
| 2024  |  |  |  |  |  |  |

**7.9.3** Provide a list of your 10 largest nationwide Medicare Advantage PPO group health plan clients. Largest is denoted by size of membership.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Largest** **Clients** | **Name of Client** | **Is the client in the Public Sector, Corporate or Taft – Hartley / Multiemployer market?** | **Total Membership** | **Start** **Date** | **End** **Date** |
| **1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |
| **4** |  |  |  |  |  |
| **5** |  |  |  |  |  |
| **6** |  |  |  |  |  |
| **7** |  |  |  |  |  |
| **8** |  |  |  |  |  |
| **9** |  |  |  |  |  |
| **10** |  |  |  |  |  |

**7.9.4** Provide a list of your 10 largest regional Medicare Advantage HMO group health plan clients. Largest is denoted by size of membership.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Largest** **Clients** | **Name of Client** | **Is the client in the Public Sector, Corporate or Taft – Hartley / Multiemployer market?** | **Total Membership** | **Start** **Date** | **End** **Date** |
| **1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |
| **4** |  |  |  |  |  |
| **5** |  |  |  |  |  |
| **6** |  |  |  |  |  |
| **7** |  |  |  |  |  |
| **8** |  |  |  |  |  |
| **9** |  |  |  |  |  |
| **10** |  |  |  |  |  |

**7.9.5** How many new group Medicare Advantage (MA) members did your organization add effective January 1, 2023 and January 1, 2024?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Nationwide MA PPO - Effective January 1, 2023 | Nationwide MA PPO - Effective January 1, 2024 | Regional MA HMO - Effective January 1, 2023 | Regional MA HMO - Effective January 1, 2024 |
| New group MA members |  |  |  |  |
| New MA groups |  |  |  |  |

**7.9.6** What percentage of your 2023 total group nationwide Medicare Advantage PPO and regional Medicare Advantage HMO membership renewed for the 2024 plan year?

**7.9.7** Describe what happens to enrolled participants’ medical coverage within the plan you are offering for medical coverage when the participant:

a. Has Medicare Part A but does not have Medicare Part B coverage.

b. Drops Part B coverage after enrolling in your plan.

c. Enrolls in another Medicare Advantage plan after enrolling in your plan.

How do you ensure such individuals do not have a gap in coverage?

 In your answers, describe how your organization verifies Medicare enrollment and describe all communications you would send to the Participant and to the Department regarding enrollment.

**7.9.8** Describe your organization’s understanding of, and how you can support, the Department’s handling of split-family (Medicare Some) contracts where some family members are Medicare enrolled and some family members are not.

**7.9.9** Provide documentation that shows your organization is approved by the U.S. Centers for Medicare & Medicaid Services (CMS) to provide employer group Medicare Part C plans in Wisconsin, or that you are in the process of applying to CMS to provide such programs starting in the 2026 plan year. If not approved to provide services statewide in Wisconsin, identify the specific counties in which you are CMS-approved or have applied for approval.

**7.9.10** Confirm you will handle all initial internal and external appeals in accordance with CMS requirements and guidelines. Describe how you will comply with this requirement.

**7.9.11** Confirm you will handle all grievances in accordance with CMS requirements and guidelines. Describe how you will comply with this requirement.

**7.9.12** Complete the table below using your 2023 nationwide Medicare Advantage PPO and regional Medicare Advantage HMO group book of business statistics on appeals and grievances.

|  |  |  |
| --- | --- | --- |
|  | **Nationwide MA PPO** | **Regional MA HMO** |
| **Total 2023 Member Medical Appeals** |  |  |
| Total Dismissed |  |  |
| Total Overturned |  |  |
| Total Upheld |  |  |
| **Total 2023 Provider Medical Appeals** |  |  |
| Total Dismissed |  |  |
| Total Overturned |  |  |
| Total Upheld |  |  |
| **Total 2023 Member Grievances** |  |  |

## 7.10 ETD0050 Medicare Advantage Star Ratings and Risk Adjustment Strategies

Note: If you are proposing both a nationwide Medicare Advantage PPO and a regional Medicare Advantage HMO(s) and your response to the question differs by product, clearly describe the differences in your response.

**7.10.1** Identify theCMS Part C audits your organization has been involved in, within the last five (5) years, including findings and any enforcement actions applied. Indicate if any fines were levied as a result of the outcome of the audit.

**7.10.2** Indicate if your organization has been identified as “poor performing” or an “outlier” by CMS as part of a past performance review in the last five (5) years. If so, explain why and indicate whether CMS denied any part of your organization’s application to expand Medicare Advantage services as a result.

**7.10.3** What is the nationwide Medicare Advantage PPO group contract number on which the Department’s account will reside? What is the regional Medicare Advantage PPO group contract number(s) on which the Department’s account will reside?

**7.10.4** Describe specific provisions in your provider contracts used to incent providers to contribute towards improvement in your ratings in the CMS Star Ratings. Indicate whether such incentives are awarded at the system, clinic, or practitioner level. Identify the percent of providers under such contract incentives.

**7.10.5** In the tables below, provide your CMS Five-Star Quality Rating for the 2022, 2023 and 2024 nationwide Medicare Advantage PPO and regional Medicare Advantage HMO plans you will be offering, and comment on the ratings (or lack of ratings, if applicable).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CMS Five-Star Quality Rating – Nationwide MA PPO** | **2022** | **2023** | **2024** | **Comments** |
| Staying Healthy: Screenings, Tests and Vaccines |  |  |  |  |
| Managing Chronic (Long-Term) Conditions |  |  |  |  |
| Member Experience with Health Plan |  |  |  |  |
| Member Complaints and Changes in the Health Plan's Performance |  |  |  |  |
| Health Plan Customer Service |  |  |  |  |
| Total Five-Star Quality Rating |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CMS Five-Star Quality Rating – Regional MA HMO(s)** | **2022** | **2023** | **2024** | **Comments** |
| Staying Healthy: Screenings, Tests and Vaccines |  |  |  |  |
| Managing Chronic (Long-Term) Conditions |  |  |  |  |
| Member Experience with Health Plan |  |  |  |  |
| Member Complaints and Changes in the Health Plan's Performance |  |  |  |  |
| Health Plan Customer Service |  |  |  |  |
| Total Five-Star Quality Rating |  |  |  |  |

**7.10.6** Describe your organization’s Star Maximization program in detail, including a description of the data and tools you use to drive your strategy and how it has changed over time. Specifically address changes your organization made after CMS issued its finalized Risk Adjustment Data Validation (RADV) rule and prior authorization rule due to findings of inappropriate denials.

**7.10.7** Describe your approaches to risk adjustment for your medical program, if appropriate. Include in your response any innovative programs you use to improve the accuracy of your risk scores. Be sure to include in your response how you address scores for individuals aging into Medicare. Include in your response any increase in scores you have been able to achieve.

**7.10.8** Describe your process for reconciling member risk scores with risk scores on file with CMS, tracking member risk scores, and tracking the financial impact of risk-adjusted scores.

**7.10.9** Describe any initiatives your organization has to educate providers on the importance of complete medical record documentation to support the data used for risk adjustment.

**7.10.10** Describe the controls that are in place to ensure the following related to the data submitted to CMS:

* + - 1. All required data is sent for each data collection period;
			2. Only valid risk adjustment codes are submitted;
			3. Only valid provider types are submitted; and
			4. Ineligible duplicate transactions are not submitted.

**7.10.11** What does your organization do to audit the quality and completeness of provider claims data?

**7.10.12** Confirm that you will continue your risk adjustment activities until at least the Contract termination date.

**7.10.13** Describe how long you will continue your risk adjustment strategies once the Contract has terminated?

**7.10.14** Describe your processes and strategies for improving encounter data now and in the future.

**7.10.15** What processes do you have in place to ensure accurate coding and billing is submitted to CMS? What fraud, waste and abuse measures do you have in place to prevent “upcoding” or miscoding?

## 7.11 ETD0050 Medicare Advantage Provider Management and Reimbursement

1. Note: If you are proposing both a nationwide Medicare Advantage PPO and a regional Medicare Advantage HMO(s) and your response to the question differs by product, clearly describe the differences in your response.
2. The Proposer must provide strong network management that not only provides the necessary network oversight, but that also demonstrates leadership in network development, innovation, collaboration, and overall patient quality of care. Because Medicare Advantage plans service a particular population, Proposers are also expected to provide networks that meet the needs and expectations of this population, including having a sufficient choice of providers, and particular types of providers.

**7.11.1** Describe efforts to leverage data and technology and/or collaborate with providers on initiatives and pilot programs to address current population health issues.

a. Include in the description any collaboration and data sharing with external vendors (e.g., pharmacy benefit manager(s), data warehouse vendor(s), etc.).

b. Include how you track and evaluate the success of the programs.

c. Provide a specific example in which a troubling trend was identified, the action taken, and the results of the action taken; include the results of any such actions to date.

d. If the initiative or pilot was part of a CMS pilot or demonstration, provide a copy of any reports provided to CMS on the outcomes of the initiative or pilot, if available.

**7.11.2** Describe the methods (e.g., data and technology, communications, etc.) to steer care toward providers that achieve the best outcomes in terms of quality and cost.

**7.11.3** Provide a detailed explanation of the process to track, compare, and give feedback to providers regarding practice patterns relative to their peers and best practices for the categories listed below. Include frequency, communication method(s), and the types of providers (e.g., specialty, certain provider groups versus all providers, etc.) to which the process applies. If applicable, include:

a. Prescription drug prescribing patterns;

b. Rates of diagnostic procedures ordered (e.g., lab, imaging, etc.);

c. Rates of high cost procedures;

d. Rates of infection (e.g., pneumonia, urinary tract infections, cellulitis and other skin infections); and

e. Repeat procedures within given timeframes.

**7.11.4** Provide a detailed description of your model for engaging primary care providers to improve patients’ quality of care, including a description of any innovative payment methods used.

a. How do you measure success with your model?

b. Describe any planned initiative to improve your model.

c. Include specific outcomes associated with your model (e.g., increase in appropriate preventive screenings/vaccinations/visits, patient satisfaction, etc.).

**7.11.5** Provide a detailed description of your model for ensuring adequate access to specialists that focus on the needs of the Medicare-enrolled population, including geriatricians, palliative care, and behavioral health as well as home health providers.

a. How do you measure success with your model?

b. Describe any planned initiatives to improve your model.

c. Describe any innovative payment models used to improve costs and outcomes for Participants seen by these specialists.

**7.11.6** Indicate the percentage of providers in your network that accept Medicare assignment. For providers who do not accept assignment, describe your method for ensuring that Participants are not responsible for any balance billing.

**7.11.7** Identify the percentage of claims that are reimbursed out-of-network.

a. Describe your out-of-network reimbursement methodology (e.g., percentage of Medicare, percentile of Usual and Customary), including for providers who have Opted Out of Medicare. For the methodology used, provide the appropriate percentage or percentile used and the most recent year on which the rates are based.

b. For urgent and emergent out-of-network claims, how do you ensure that Participants are not responsible for balance billing from providers?

**7.11.8** Identify the percentage of your Medicare Advantage contracts paid under the reimbursement methods listed in 1. through 11. in question 7.11.9. Describe using a. through e. below:

1. the reimbursement method in detail;
2. the length of time the reimbursement method has been in force;
3. the impact on the quality and efficiency of care delivered;
4. how it is anticipated to impact plan costs; and
5. the criteria to determine payment and/or evaluate success.

**7.11.9** Specify any of the methods below that you currently have in place or are planning to have in place prior to January 1, 2026. Indicate if you believe any of these payment arrangements are not allowed under a Medicare Advantage program.

1. Tiered/narrow provider networks;
2. Bundled payments;
3. Reference value/pricing;
4. Pay for performance (describe specific performance measure(s) used);
5. Patient Centered Medical Homes (PCMH);
6. Risk sharing;
7. Capitation (partial or global);
8. Centers of Excellence (COE);
9. Retrospective episode-based reimbursement;
10. Shared savings/incentives for health outcomes; and
11. Other.

**7.11.10** Indicate in which of the 50 states and U.S. territories your organization is licensed to offer employer-sponsored, network-based Medicare Advantage solutions. If your responses to the question below differ for the plan options you are quoting, specify that in your response.

**7.11.11** Describe your organization's Medicare Advantage network growth and development plans. Describe your organization's approach for selecting and recruiting providers to participate in your Medicare Advantage networks.

**7.11.12** **Only complete 7.11.12 if you are proposing a regional Medicare Advantage HMO plan(s).**

Complete the following:

a. Indicate the counties in which you will offer your regional Medicare Advantage HMO plan(s). Note the state the counties are in. What you indicate will constitute the service area of your Medicare Advantage HMO plan(s).

b. List any excluded zip codes within the covered regional Medicare Advantage HMO counties.

**7.11.13** Describe in detail your organization's approach to contracting with providers currently utilized by Participants. Include in your response how you outreach to providers, build, and maintain relationships, work through contractual issues, etc. to bring them into your network. If your responses to the question below differ for the plan options you are quoting, specify in your response.

**7.11.14** Describe how your organization will target and educate providers that are considered out-of-network. If their charges are allowable, how would you ensure Participants would not be responsible for balance billing from these providers?

**7.11.15** Provide details on the plan for transition of members engaged in treatment and how continuity of care can be assured when a member changes carriers. Discuss in detail how cases are transferred if a provider terminates the contractual relationship with Proposer during the plan year.

**7.11.16** Confirm your telemedicine benefit meets or exceeds the requirements specified in the Certificate of Coverage (ET-2180) and Schedules of Benefits.

**7.11.17** Describe any provider advocacy services or programs you offer between your organization and providers including education, communication and support for providers, including items such as the following:

* claim payment issues
* provider relations and outreach strategies
* types of providers included
* topic specific education
* changes such as new products or policies practice-based support

**7.11.18** Describe any processes, interactions, and resources you employ to support providers with payment services and policies including items such as the following:

* claims filing and processing
* coding
* clinical criteria and code editors
* coverage determinations
* prior authorizations
* rejected claims or claims denial outreach
* medical necessity denials verses admin denials
* other carrier policies
* escalated issues and quick/accurate issue resolutions
* review of trends for targeted and ongoing education

**7.11.19** Describe your organization’s approach for credentialing providers =to participate in your network (your recruitment strategy).

## 7.12 ETD0050 Medicare Advantage Medical Management and Quality of Care

1. Note: If you are proposing both a nationwide Medicare Advantage PPO and a regional Medicare Advantage HMO(s) and your response to the question differs by product, clearly describe the differences in your response.
2. The Board is committed to the concept of effective cost containment for which documented savings can be provided and to improvement in the quality of care which improves the health of Participants. Each Proposal must contain a detailed description of the medical management programs you administer, which include case management, complex case management, and other initiatives to improve the quality of care.

**7.12.1** a. Describe all case and complex case management programs you currently administer, including:

1. How long the programs have been operating;
2. How your programs have been specifically tailored to meet the needs of the Medicare population;
3. The elements or triggers to identify and screen potential candidates (e.g., predictive modeling, risk stratification, etc.);
4. The enrollment and/or outreach process for potential candidates;
5. The activities and interventions provided to enrollees;
6. Where the case management primarily takes place (e.g., phone, clinic, home, etc.);
7. How the program is integrated with behavioral health management; and
8. The criteria used for discharging/graduating an enrollee from the program.

b. Provide one specific, de-identified, actual example for complex case management, including its documented outcome.

**7.12.2** For each program you described in 7.12.1.a. above, provide the following:

* 1. Percent of enrollment of those targeted for participation;
	2. Percent of completion;
	3. Impact on health status; and
	4. Return on investment (ROI) and how it was calculated.

**7.12.3** For each program you described in 7.12.1.a. above, indicate whether your programs are accredited by a nationally recognized body, such as Utilization Review Accreditation Commission (URAC) or the National Committee for Quality Assurance (NCQA). If accreditation is currently being sought, provide the status.

**7.12.4** How do you intend to amend your policies as a result of the 2024 Medicare Advantage Final Rule regarding Utilization Management Programs? What steps have you already taken to amend your policies?

**7.12.5** Describe any initiatives you have implemented specifically to communicate with participants about, and educate them on the use of, advance care plans. Describe the goals of the initiative, how long it has been in operation, how it has changed over time, provide any participation statistics and results to date.

**7.12.6** Describe any initiatives or programs you have implemented that are specifically related to supporting palliative care. Describe the goals of the initiative/program, and what Services are available, how patients are identified as eligible for the program, what training is provided to staff, and how long the program has been in operation and how it has changed over time. Provide any participation statistics and results to date.

**7.12.7** Describe in detail any CMS Medicare pilots or demonstrations your organization is currently participating in related to cost containment and/or quality of care involving providers or Participants in Wisconsin. Indicate whether Participants in the plan you are proposing would be eligible to participate in such pilots or demonstrations. Include the results of any such initiatives to date.

**7.12.8** Confirm that you will provide a designated clinical manager at no cost to the Department for medical programs for this population, who will have full knowledge of all clinical programs in effect as well as all clinical programs offered by your organization. Confirm that the clinical managers will have sufficient resources to handle the workload efficiently and effectively.

**7.12.9** Confirm you offer a comprehensive behavioral health network that includes a variation of providers such as psychiatrists (MDs), psychologists, therapists, counselors, social workers, DEA waiver providers, etc. Describe any efforts used to educate members of available behavioral health services. Also describe education efforts to medical providers and facilities of your behavioral health services so that members who could benefit from those services can be referred if presenting at a medical provider.

**7.12.10** Describe in detail your capabilities and processes regarding discharge planning. Include how many on-site (in facility) and remote case managers you propose at the various facilities statewide to serve Participants to minimize as much as possible any disruption during the discharge or transition of care process.

**7.12.11** Describe the support you provide to members that reside in lower income zip codes to access/link to community-based services including any tools to help members access and use virtual health care services.

## 7.13 ETD0050 IYC Medicare Advantage Population Health Management and Wellness

1. Note: If you are proposing both a nationwide Medicare Advantage PPO and a regional Medicare Advantage HMO(s) and your response to the question differs by product, clearly describe the differences in your response.
2. The Board seeks a Contractor(s) to assist in further engaging Participants in the management of their health. This includes education and outreach by the Contractor(s), with transparency tools to help Participants select quality and efficient care and engage in their health and well-being.

**7.13.1** Describe the tools you would make available to Participants to support healthcare decisions, such as self-management of at least one chronic condition, cost estimators, provider selection, quality comparisons, and shared decision-making tools. If you work with a Subcontractor to provide these tools, include Subcontractor information in your response. For each tool, provide the following information:

a. Identify the specific services included with the tool, if appropriate;

b. Provide the percentage of your members that have access to the tools and currently use them;

c. Explain how the effectiveness of the tools are evaluated;

d. For any comparison tool, provide the methodology used;

e. Describe how such tools are enabled for mobile devices and integrated with your other platforms (e.g., web-portal, provider locator, etc.);

f. Explain how the tools are promoted to Participants; and

g. Indicate whether Participants under the plan you are proposing would be eligible for the tools described.

**7.13.2** Describe any participant financial incentive programs you currently offer to encourage participants to get appropriate and timely care, steer patients to certain providers, or other desired behavior. Describe how these efforts improved health outcomes and how such programs are tailored to Medicare beneficiaries in particular. Indicate whether Participants under the plan you are proposing would be eligible for these incentive programs.

**7.13.3** Describe your wellness and disease management programs(s) that would be available to Participants under the plan you are proposing. Provide samples of educational materials available to Medicare participants. In your response, detail each of the following:

1. Available Participant incentives and rewards;
2. Programs available to Participants;
3. Engagement strategies;
4. Participation rates of your Medicare Advantage participants; and
5. Program evaluation methods to measure health outcomes.

Indicate if your Proposal includes the Silver Sneakers® or similar gym membership program and include this cost in your premium submission described in Section 9.

**7.13.4** The Department views all wellness incentives as a taxable fringe benefit. Describe how your organization can track the value of incentives issued to members and report to the Department at least annually on all incentives issued to GHIP members. Further describe how your organization would submit the Participant’s portion of FICA taxes to the Department.

**7.13.5** Describe any CMS demonstrations or pilot programs related to wellness, disease management or healthcare utilization your organization is currently participating in. In your description, provide the following:

1. The purpose;
2. When it started and when it is expected to end;
3. Who is eligible to participate;
4. Outcome of the demonstration or pilot to date, if available; and
5. Whether Participants in the plan you are proposing will be included in the program.

## 7.14 ETD0050 Medicare Advantage Data Integration and Collaboration

1. Note: If you are proposing both a nationwide Medicare Advantage PPO and a regional Medicare Advantage HMO(s) and your response to the question differs by product, clearly describe the differences in your response.

**7.14.1** Describe your experience working collaboratively with your plan sponsor clients, providers, pharmacy benefit managers, wellness and data warehouse vendors and other health plans on strategic initiatives using data-driven insights to improve population health, clinical quality, and member engagement. Describe the attributes of such collaborations that are necessary for success. Describe any attributes of such collaborations that provide challenges or hinder progress. Provide a specific example of a particularly successful initiative that was the result of such a collaboration. Include in your description your team members that would work with the Department on such collaborations.

**7.14.2** Describe your ability to integrate information from electronic medical records (EMR) and electronic health records (EHR) into the data used for predictive modeling, risk stratification, and identification for medical management services.

a. Include the percentage of your providers’ EMRs/EHRs that are currently integrated into your data analytics systems.

b. Include a description to any barriers to integration and how your organization will overcome them within the first year of the Contract.

c. How is the integrated information used? Describe how it has improved the quality of care and the impact on costs.

**7.14.3** Describe the accessibility and compatibility of EMRs/EHRs across providers in your network and providers referred to, whether within your network or outside your network, in order to coordinate care for Participants. Describe any barriers and how your organization will overcome them within the first year of the Contract.

**7.14.4** Describe the accessibility to EMRs/EHRs from providers outside your network, which are required to coordinate care for Participants (e.g., via partnerships such as the Wisconsin Statewide Health Information Network). Describe any barriers and how your organization will overcome them within the first two years of the Contract.

**7.14.5** Describe your reports on CMS revenue, CMS risk scores, clinical programs, and legislative updates and provide examples.

**7.14.6** Confirm that your organization will cooperate with the Department’s data warehouse vendor to submit the required claims and provider data as required by the Department. See requirements in Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement Sections III.D.5 Data Warehouse File Requirements, III.D.6 Data Warehouse File Submission Quality, IV.J. Data Warehouse Deliverable Requirements, and IV.K. Data Warehouse Performance Standards.

**7.14.7** Describe the process regarding CMS eligibility issues for members that only have a P.O. Box address.

**7.14.8.** Describe your ability to manage CMS eligibility issues and how you propose to work with Department staff on these issues.

**7.14.9** Confirm that you will submit the Part C Medicare Membership Reports (MMR) monthly to the Department, including all fields as received from CMS. The monthly MMR must be submitted within thirty (30) Calendar Days following the end of the month reported on.

## ETD0050 Medicare Advantage Plan Design

1. Note: If you are proposing both a nationwide Medicare Advantage PPO and a regional Medicare Advantage HMO(s) and your response to the question differs by product, clearly describe the differences in your response.
2. The nationwide Medicare Advantage PPO should function as a passive PPO that provides the same level of benefits for retirees when they see a provider outside the network that accepts Medicare. Medicare Advantage PPO and regional Medicare Advantage HMO plan(s) you propose must meet all CMS requirements, and any benefits not delineated in the plan design must be covered at least at the minimum requirement set by CMS. Proposers may not deviate downward from these plan designs in any manner other than to meet CMS requirements. You may offer supplemental benefits and/or enhanced benefits as long as they are at no cost to the Department and Participants.

**7.15.1** If submitting a nationwide PPO service area proposal, confirm that your organization will be able to replicate Uniform Benefits, the current medical standard benefits package described in Table 2 – 2025 Medicare Advantage Traditional and Deductible Benefit Designs and in the Certificate of Coverage (ET-2180) and Schedules of Benefits of Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement, with the same benefits and services for in-network and out-of-network providers. If not, describe what benefits must be covered or excluded due to Medicare Advantage requirements, per CMS as well as any other deviations to the plan design.

**7.15.2** If submitting a regional Medicare Advantage HMO service area proposal, confirm that your organization will be able to replicate Uniform Benefits, the current standard benefits package described in Table 2 – 2025 Medicare Advantage Traditional and Deductible Benefit Designs, and further described in the Certificate of Coverage (ET-2180) and Schedules of Benefits of Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement. If not, describe what benefits must be covered or excluded due to Medicare Advantage requirements, per CMS as well as any other deviations to the plan design.

**7.15.3** Are there any Medicare Coverage Determination limitations that would impact benefit coverage levels for any benefit design elements? If yes, explain in detail.

**7.15.4** Describe any CMS mandated coverage that is not included in the Certificate of Coverage (ET-2180) or Schedules of Benefits of Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement.

**7.15.5** Describe any supplemental benefits and/or enhanced benefits available to Participants. Specify if they are offered at no cost. If you are offering these at a cost, include those in your Cost Proposal workbook where indicated.

**7.15.6** Describe how your proposed Medicare Advantage plan(s) covers emergency services incurred outside of the United States. Explain the process for submitting non-U.S. emergency claims.

**7.15.7**  Are there any challenges related to sustainability and cost control based on recent legislation? If your response varies based upon the plan option you are quoting, provide your response by plan option.

## 7.16 ETD0051 Medicare Plus Plan

**7.16.1** a. Provide the names of your two largest employer groups that offer Medicare supplement plans.

b. Complete the tables below illustrating your organization’s enrollment and clients as of June 1, 2024. For clients that are comprised of multiple employer groups, count them as one employer in your response.

**Group Medicare Supplement or Medigap Book of Business**

|  |  |  |
| --- | --- | --- |
| **Total # of Covered Members** | **# of Public Sector Employers** | **# of Private Sector Employers** |
| Less than 500 |  |  |
| > 500 < 2,000 |  |  |
| > 2,000 < 10,000 |  |  |
| > 10,000 |  |  |

**Individual Book of Business**

|  |  |  |
| --- | --- | --- |
|  | **Wisconsin Total Covered Members** | **United States Total Covered Members** |
| Medicare Plus (Supplement or Medigap) |  |  |

**7.16.2** Provide a list of your three largest (by size of membership) Medicare Supplement or Medigap group health plan clients.

**Largest Clients**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Name of Client** | **Public Sector or Private Sector** | **Total Membership** | **Start** **Date** | **End** **Date** |
| **1.** |  |  |  |  |  |
| **2.** |  |  |  |  |  |
| **3.** |  |  |  |  |  |

**7.16.3** How many new group Medicare Supplement or Medigap members did your organization add effective January 1, 2023 and January 1, 2024?

|  |  |  |
| --- | --- | --- |
|  | **Effective January 1, 2023** | **Effective January 1, 2024** |
| New group Medicare Supplement/Medigap ***members*** |  |  |
| New Medicare Supplement/Medigap ***groups*** |  |  |

**7.16.4** What percentage of your 2023 total group Medicare Supplement or Medigap membership renewed for the 2024 plan year?

**7.16.5** Describe what happens to enrolled participants’ medical coverage within the plan you are offering for medical coverage when the participant:

a. Has Medicare Part A but does not have Medicare Part B coverage.

b. Drops Part B coverage after enrolling in your plan.

c. Enrolls in Medicare late and/or fail to enroll when that participant turns 65 years of age.

In your answers, describe how your organization verifies Medicare enrollment and describe all communications you would send to the Participant and to the Department regarding enrollment.

**7.16.6** Describe your organization’s understanding of, and how you can support, the Department’s handling of split-family (Medicare Some) contracts where some family members are Medicare-enrolled and some family members are not.

**7.16.7** Explain how long your firm has maintained the ability to receive the electronic transmission of claims data from the Medicare Part A and B administrators.

**7.16.8** Describe the rating methodology used to develop the proposed and future rates and fees (assumed claims, trend, and target loss ratio).

**7.16.9** Confirm the Medicare Plus plan you are offering the Department can be rated on its own merit.

**7.16.10** Indicate whether the risk is held entirely by your organization or shared with a reinsurer or other risk bearing entity.

**7.16.11** Describe your policy regarding retroactive enrollments and cancellations.

**7.16.12** What percentage of your Medicare claims is processed manually?

**7.16.13** Has your firm ever been suspended by CMS from either offering or selling Medicare plans of any type?

**7.16.14** Explain the approach for determining the breadth of the provider network to be offered. Describe if and how you pay providers who do not accept Medicare assignment or have opted out of Medicare.

**7.16.15** Indicate the percentage of providers in your network that accept Medicare assignment. For providers who do not accept assignment, describe your method for ensuring that Participants will not be responsible for any balance billing.

**7.16.16** Identify the percentage of claims that are reimbursed out-of-network.

Describe your out-of-network reimbursement methodology (e.g., percentage of Medicare, percentile of Usual and Customary). For the methodology used, provide the appropriate percentage or percentile used and the most recent year on which the rates are based.

For urgent and emergent out-of-network claims, how will you ensure that Participants will not be responsible for balance billing from providers?

**7.16.17** Describe any initiatives you have implemented specifically to communicate with participants about, and educate them on the use of, advance care plans. Describe the goals of the initiative, how long it has been in operation, how it has changed over time, provide any participation statistics and results to date.

**7.16.18** Describe any initiatives or programs you have implemented that are specifically related to supporting palliative care. Describe the goals of the initiative/program, and what services are available, how patients are identified as eligible for the program, what training is provided to staff, and how long the program has been in operation and how it has changed over time. Provide any participation statistics and results to date.

**7.16.19** Describe your wellness and disease management programs(s) that you would make available to Participants under the plan you are proposing. Be sure to indicate if your Proposal includes the Silver Sneakers® or similar gym membership program and to include this cost in your premium submission described in Section 9. Provide samples of educational materials you currently make available to your Medicare participants. In your response, detail each of the following:

a. Current programs available to your Medicare participants;

b. Engagement strategies; and

c. Participation rates of your Medicare participants in the programs described above.

**7.16.20** The Department views all wellness incentives as a taxable fringe benefit. Describe how your organization will be able to track the value of incentives issued to Participants and report to the Department at least annually on all incentives issued to Participants. Further, describe how your organization would submit the Participant’s portion of FICA taxes to the Department.

**7.16.21** Describe your experience working collaboratively with your plan sponsor clients, providers, pharmacy benefit managers, wellness and data warehouse vendors and other health plans on strategic initiatives using data-driven insights to improve population health, clinical quality, and Participant engagement. Describe the attributes of such collaborations that are necessary for success. Describe any attributes of such collaborations that provide challenges or hinder progress. Provide a specific example of a particularly successful initiative that was the result of such a collaboration. Include in your description your team members that would work with the Department on such collaborations.

**7.16.22** Confirm that your organization will cooperate with the Department’s data warehouse vendor to submit the required claims and provider data as required by the Department. See requirements in Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement Sections III.D.5 Data Warehouse File Requirements, III.D.6 Data Warehouse File Submission Quality, IV.J. Data Warehouse Deliverable Requirements, and IV.K. Data Warehouse Performance Standards.

**7.16.23** Confirm you will be able to replicate the current plan design for the Medicare Plus Plan. If not, indicate any deviations.

**7.16.24** If you are offering additional supplemental benefits and/or enhanced benefits, describe them. Specify if they are offered at no cost. If you are offering these at an additional cost, include those in your Cost Proposal Workbook where indicated.

**7.16.25** Are there any CMS filing limitations that would impact benefit coverage levels for any benefit design elements? If yes, explain and include in your pricing.

**7.11.26** Describe how your plan covers services incurred outside of the U. S. that are permitted under the Medicare Plus Certificate of Coverage.

**7.11.27** Submit a sample Explanation of Benefits for a Medicare Supplement plan. How often are they provided to members?

# 8 Network Submission Requirements

**This section is not scored.**

***The Segal point of contact is:*** [***JSlutzky@segalco.com***](https://etf.wi.gov/its-your-choice/2022/22et-4113/download)***.***

The Board is interested in meeting Participant’s needs for cost-effective plans that meet their expectations for provider choice. The Department will accept Proposals for regional Medicare Advantage HMO networks, which are provided with regional service area submissions, or a nationwide passive PPO network, as approved by CMS, which are provided with nationwide service area Proposals. The Board will also accept Medicare Plus Proposals, which are provided with nationwide service area Proposals.

## 8.1 Network Access Tool (applies to IYC Medicare Advantage HMO Proposals)

**For IYC Medicare Advantage HMO Proposals only:** After you submit your signed Appendix 9 – Non-Disclosure Agreement among Vendor, the Department, and Board Actuary to the Department (NDA) (see [Section 2.3](#_2.3_Appendix_13)), Segal will provide the recipient(s) you specified in your NDA with a link to the **Network Access Tool**. Complete and submit the Network Access Tool. Your completed Network Access Tool must be submitted to the Segal secure workspace through Segal’s Secure File Transfer system by the due date and time listed in Section 1.9, Calendar of Events.

## 8.2 Accessibility Reports

**8.2.1** Nationwide Medicare Advantage passive PPO, regional Medicare Advantage HMO and Medicare Plus Proposers are required to submit to Segal an accessibility report (using OptumTM,GeoAccess®, GeoNetworks or comparable software) for each program being proposed, based upon the Proposer’s contracted network (e.g., do not include all providers that accept Medicare) **AND** the census file provided by Segal. Only providers under contract with the Proposer should be included. In other words, do not count all providers that accept Medicare if you meet the 51% Rule.

**8.2.2** Nationwide Medicare Advantage passive PPO, regional Medicare Advantage HMO, and Medicare Plus Proposers are required to submit to Segal a summary report (using OptumTM, GeoAccess®, GeoNetworks, or comparable software) of Participants with and without access to network providers/facilities within the established mileage parameters listed below. The submitted accessibility reports (mapping and accessibility analysis) must demonstrate provider availability for EACH provider group type listed below.

|  |  |  |
| --- | --- | --- |
| **Provider Type** | **Urban** | **Non-Urban** |
| **Facilities** |  |  |
| *Hospitals* | *1 within 20-mile radius* | *1 within 35-mile radius* |
| *Ambulatory Surgical Centers* | *1 within 20-mile radius* | *1 within 35-mile radius* |
| *Urgent Care facilities* | *1 within 20-mile radius* | *1 within 35-mile radius* |
| *Imaging Centers* | *1 within 20-mile radius* | *1 within 35-mile radius* |
| *Inpatient Behavioral Health Facilities* | *1 within 20-mile radius* | *1 within 35-mile radius* |

|  |  |  |
| --- | --- | --- |
| **Professional Services** |   |   |
| ***Primary Care*** |  |  |
| *General/Family Practitioner (includes Internal Medicine, Family Medicine, and General Medicine)* | *2 within 10-mile radius* | *2 within 20-mile radius* |
| *OB/GYN (female Participants, age 12 and older)* | *2 within 10-mile radius* | *2 within 20-mile radius* |
| *Pediatrician (birth through age 18)* | *2 within 10-mile radius* | *2 within 20-mile radius* |
| ***Specialists*** |  |  |
| *Endocrinologist* | *2 within 20-mile radius* | *2 within 35-mile radius* |
| *Urologist* | *2 within 20-mile radius* | *2 within 35-mile radius* |
| *Cardiologist* | *2 within 20-mile radius* | *2 within 35-mile radius* |
| *Dermatologist* | *2 within 20-mile radius* | *2 within 35-mile radius* |
| *Allergist* | *2 within 20-mile radius* | *2 within 35-mile radius* |
| *Psychologist/Psychiatrist* | *2 within 20-mile radius* | *2 within 35-mile radius* |
| *General Surgeon* | *2 within 20-mile radius* | *2 within 35-mile radius* |
| *Hematologist/Oncologist* | *2 within 20-mile radius* | *2 within 35-mile radius* |
| *Chiropractor* | *2 within 20-mile radius* | *2 within 35-mile radius* |

## 8.3 Provider Utilization Experience (applies to Nationwide Medicare Advantage Passive PPO Service Area and Medicare Plus Proposals)

After you submit your signed Appendix 9 – Non-Disclosure Agreement among Vendor, the Department, and Board Actuary to the Department (see [Section 2.3](#_2.3_Appendix_13)), Segal will provide the recipient(s) you specified in your NDA with a link to an Excel file labeled **Provider Utilization**, which is a provider utilization file representative of the medical utilization experience for Medicare-eligible Participants. Using the file, complete and submit the following to Segal:

a. For **nationwide Medicare Advantage passive PPO Service Area** Proposals: For each provider listed, indicate if the medical provider is in the network (i.e., a participating provider) for the plan you are proposing.

b. For **Medicare Plus** Proposals: An Excel file labeled **Provider Utilization File** provided by Segal, is a provider utilization file representative of the medical utilization experience for Medicare-eligible Participants. For each provider listed, indicate if the medical provider is in the network (i.e., a participating provider) for the plan you are proposing. Return the file to Segal.

## 8.4 Network Questions

**8.4.1** For **nationwide Medicare Advantage passive PPO service area** Proposals:

a. Does your organization meet CMS's Medicare Advantage coordinated care network adequacy requirement for the Department’s Medicare-eligible retiree membership (the 51% rule)? Discuss how you are able to meet this requirement.

b. What is your percentage of network adequacy with regard to the 51% rule based on the Department’s membership?

**8.4.2** For **regional** **Medicare Advantage HMO service area** Proposals:

a. Complete the following table. Add as many columns as necessary for the number of regional Medicare Advantage HMOs you are proposing.

|  |  |  |
| --- | --- | --- |
|  | **MA HMO 1** | **MA HMO 2** |
| 1. Based upon the retiree census data (provided to Proposers by Segal), identify any areas in which you are filed to operate where your provider network and network pharmacies may not have adequate capacity to meet the potential demand. |  |  |
| 2. How is adequacy determined by your organization? |  |  |
| 3. What are your plans for expansion in these areas? |  |  |
| 4. Indicate any areas where your network access does not meet the CMS-standard access requirements. |  |  |

# 9 Cost Proposal

**This section is scored (a maximum of 200 points per RFP).**

***The Segal point of contact is:*** [***JSlutzky@segalco.com***](https://etf.wi.gov/its-your-choice/2022/22et-4113/download)***.***

## 9.1 Submission of required documents

***Segal-provided Section 9 Documents***

After you submit your Non-Disclosure Agreement (NDA) to the Department (see [Section 2.3](#_2.3_Appendix_13)), Segal will provide the recipient(s) you specified in your NDA with a secure link to Segal’s secure file transfer system to access the following documents:

* Cost Proposal workbook(s)
* Census
* Claims Summary Experience
* Network Access Tool *(applies to IYC Medicare Advantage HMO Proposal(s) only)*
* Provider Utilization File *(applies to nationwide Medicare Advantage passive PPO and Medicare Plus Proposals only)*

***Submission of Section 9 Documents***

Submit the following as appropriate for the Proposal(s) you are responding to:

* **Cost Proposal workbook(s)** *(applies to all Proposals):* by the due date and time listed in [Section 1.9](#_1.9_Calendar_of), Calendar of Events, you must submit a Cost Proposal workbook for the RFP(s) you intend to bid on to Segal through Segal’s Secure File Transfer system.
* **Network Access Tool** *(applies only to Medicare Advantage HMO Plan Proposals):* by the due date and time listed in Section 1.9, Calendar of Events, submit your completed Network Access Tool to Segal through Segal’s Secure File Transfer system. See [Section 8.1](#_8.1__Network) above.
* **Provider Utilization** *(applies to nationwide Medicare Advantage passive PPO service area and Medicare Plus Proposals):* by the due date and time listed in Section 1.9, Calendar of Events, submit your Provider Utilization reports to Segal through Segal’s Secure File Transfer system. See [Section 8.3](#_8.3_Provider_Utilization) above.
* **Accessibility Reports** *(applies to nationwide Medicare Advantage passive PPO, regional Medicare Advantage HMO, and Medicare Plus):* by the due date and time listed in Section 1.9, Calendar of Events, submit your completed Accessibility Reports to Segal through Segal’s Secure File Transfer system. See [Section 8.2](#_8.2__Accessibility) above.

## 9.2 IYC Medicare Advantage and Medicare Plus Premium Bids

1. Separate, Excel Cost Proposal workbooks will be provided to you for the Medicare Advantage and the Medicare Plus RFPs by Segal. You must submit pricing using the appropriate Cost Proposal workbook(s) only, based on the services, terms and conditions set forth in this RFP and in the Cost Proposal workbook. Failure to submit pricing as required may render your entire Proposal non-responsive and ineligible for a contract award. The provided Excel Cost Proposal workbooks must be used, no substitutions for submitting costs will be allowed.
2. Your Cost Proposal workbook(s) must include your premium bid for the first year of the Contract(s), rate guarantees for the second (2nd) through fifth (5th) year of the Contract, any implementation credits you propose (see [Section 9.3](#_9.3_Implementation_Credits) Implementation Credits), and your gain-sharing minimum loss ratio guarantee. Your premium bid must include rates for Uniform Benefits as described in Table 2 and/or Table 3 above as appropriate for the RFP you are responding to and the Certificate of Coverage ET-2180 for IYC Medicare Advantage and/or Certificate of Coverage ET-4113 for Medicare Plus of Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement and any Wellness programs, like fitness center memberships, you propose to offer Participants.
3. In your Cost Proposal workbook(s), provide the fully-insured per Participant monthly premium rates for 2026 (first year of the Contract: January 1, 2026 - December 31, 2026). If CMS requires a certain Medicare Advantage benefit level that is superior to what is required in this RFP, then the CMS benefit should be applied and noted. The premium rates you list in your Cost Proposal workbook(s) must include all required services described in this RFP.
4. The Department is seeking a partner to provide services as a viable long-term solution for its Medicare population. This requires pricing throughout the Contract term that recognizes the need for reasonable year over year increases in premiums. While the Department recognizes certain provisions of the Medicare Advantage pricing is dependent on CMS pricing terms released annually, the Department also believes organizations should be able to price for such fluctuations. Therefore, the Department requests Proposers to provide annual total premium rate guarantees for each succeeding year under the Contract, for Medicare Advantage and Medicare Plus.
5. The premium rates you include in your Cost Proposal workbook(s) shall serve as the basis for the compensation included in the resulting Contract(s). In the event the Star rating for the plan you are offering (providing as part of the Contract) decreases, Proposer is required to honor the Contract pricing set at the higher star rating. In the event the star rating for the plan you are offering (providing as part of the Contract) increases, Proposer is required to decrease the Contract pricing by a percentage that coincides with the new, higher Star rating.
6. Identify in your Cost Proposal workbook(s) any pricing implications of CMS filing limitations identified under 7.16.25 above.
7. After the first year of the Contract(s), subsequent annual premium rates must be based on the claims experience of Participants enrolled in each plan, verified demographics, other documented actuarial factors, and projected health care cost trends. Subsequent annual premium rates shall not exceed the Renewal Rate Cap Guarantees included in your Cost Proposal workbook(s) and will be negotiated annually. The rates will be reflected in a written amendment to the Contract executed by the parties to the Contract(s). See Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement Section III.C. Rate Setting.
8. This RFP requires that pricing be based on the Department’s actual Medicare-allowed claims as included in the Claims Summary Experience data provided by Segal as well as the Certificate of Coverage ET-2180 for Medicare Advantage and/or the Certificate of Coverage ET-4113 for Medicare Plus (as the case may be) of Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement. Medical Claims data is based on current financial and utilization data submitted by current health plans during annual renewal submissions. Proposals based upon manual rates will not be accepted. In your Proposal, confirm your agreement with this requirement.
9. In your Proposal, confirm your pricing is based on ETF’s current medical plan designs as appropriate for the RFP you are submitting a Proposal for, as described in Table 2 and Table 3 above, Medicare Plus Certificate of Coverage (ET-4113), Certificate of Coverage (ET-2180), Schedules of Benefits for the 2025 plan year: Local Traditional Plan for Medicare Retirees/COBRA; Local Retirees with Medicare Including LAHP (ET-2108sb) and Local Deductible Plan: Medicare Retirees and COBRA Continuants (ET-2158sb), and Exhibit 1 – State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement.
10. In your Proposal, confirm that pricing will not include any taxes unless accompanied by proof that the Department is subject to the tax. If necessary, Proposers may request the Department’s tax exempt number and federal tax ID information.
11. This RFP requires IYC Medicare Advantage and Medicare Plus Contractors participate in an annual premium rate bid process for each year of the Contract. Confirm that you are able to provide, and will provide if awarded a contract pursuant this RFP, the data included in Appendix 8 - Premium Rate Bid Tool on an annual basis. Note, the Premium Rate Bid Tool is subject to change annually depending on detail that may be needed for analysis.

## 9.3 Implementation Credits

Are you willing to provide a one-time implementation allowance to fund, as approved by the Department, implementation support, pre-implementation audits, readiness assessments, communication plans, outside printing costs, etc.? If you are willing to provide a one-time implementation allowance, enter the amount you are willing to provide in your Cost Proposal workbook(s).

## 9.4 Performance Guarantees

**9.4.1** Confirm your agreement with the performance guarantees listed in Exhibit 1- State of Wisconsin Group Health Insurance Program – Medicare Advantage and Medicare Plus Program Agreement.

9.4.2 Include any additional, proposed performance guarantees within your Proposal(s).

# 10 Contract Terms and Conditions

**This section is NOT scored.** **(0 points)**

## 10.1 Final Contract

1. The Department may execute one or more Contracts with the awarded Contractor(s). A Pro Forma Contract is included as Appendix 10 as an example. The Contract(s) and any subsequent renewal(s) will incorporate all terms and conditions included in this RFP, including all forms, exhibits, etc., made a part of this RFP, and Contractor’s Proposal. The Department will draft the Contract(s).
2. By entering into a Contract with the Department, the Contractor guarantees it has the resources to provide and perform the Services per the terms of the Contract. After the date the Contract is executed, if the Contractor requires additional resources to fulfill the terms of the Contract, the Contractor will bear all costs for such additional resources.

## 10.2 Payment Terms

* 1. If a Contractor is not already set up in the State’s payment system, Contractor must complete the State’s banking and payment forms to facilitate the Department’s payments to the Contractor. The Department will provide the forms to the Contractor.
	2. By the end of each month, the Department will transmit payment to the Contractor for that month’s premium based on the number of enrolled Subscribers per the Department’s records. The Department will deduct any premium for pharmacy benefits, dental premium if applicable, and other fees required by the Board.
	3. The Department will make payments to the Contractor via ACH.
	4. For all wellness incentives (a taxable fringe benefit) the Contractor provides to GHIP Participants, the Contractor must submit to the Department, at least annually, the Participant’s portion of FICA taxes.
	5. The Contractor must perform the Services and all obligations under the Contract(s). The total cost to the Board for the Contractor’s performance of the Services must not exceed the limitation set forth in the Contract (if a limit is set). The Board is not obligated to reimburse the Contractor for billing in excess of the limits set forth in the Contract, and the Contractor will not be obligated to continue performance of work under the Contract or to incur costs for additional requirements identified by the Board that are not specified in the Contract, unless and until an amendment to the Contract is approved by the Board and signed by the Contractor and the Board.
	6. The Contractor’s and any Subcontractors’ travel expenses (e.g., airfare, lodging, meals, other transportation costs, and insurance) and other miscellaneous expenses related to the provision of Services must be included in your premium bid. Travel expenses may not be billed to the Department.
	7. The Department will provide the Contractor with an invoice for any missed performance standards after the calendar quarter in which the performance standard was not met by the Contractor. Amounts owed for missed performance standards will be deducted from premiums owed to Contractor.
	8. Other payment terms and conditions are listed in Appendix 11 – Department Terms and Conditions.
	9. Final payment arrangements, if different than stated herein, will be finalized during Contract negotiations.

## 10.3 Cooperative Purchasing Clause

Other institutions, such as state, local and public agencies, occasionally express interest in participating in Department contracts. The Department would like the Contractor to extend the terms, conditions and prices of the Contract(s) that result(s) from this RFP to any such entity. Any institution that would contract with the Contractor for the Services provided under the Contract(s) will finalize their own contract with the Contractor and issue their own purchasing documents. The Contractor agrees that the Department bears no responsibility or liability for any agreement between the Contractor and the other entity that desires to exercise this option. Note your agreement or disagreement with this clause on Form E – Vendor Information.

## 10.4 Data Agreements

The Contractor will be required to sign agreements similar to Appendix 12 – Data Supplier Agreement (sample) and Appendix 13 – Non-Disclosure Agreement (Data Out) (sample), which are attached to this RFP as **samples** and must be negotiated among the parties named in those agreements and signed prior to implementation.