**Department of Employee** **Trust** **Funds**

P.O. Box 7931

Madison, WI 53707-7931

**Form B**

**Attestations/Confirmations**

**RFP ETD0050: Medicare Advantage**

**RFP ETD0051: Medicare Plus**

Failure to confirm compliance with one or more of the requirements/qualifications below may disqualify the Proposer.

**Instructions:**

1. Check “Agree” or “Disagree” to each item as appropriate.
2. Complete the “ACKNOWLEDGE AND ACCEPT” section.
3. Include any clarifications, assumptions, and exceptions to the attestations/confirmations below in the Assumptions/Exceptions section of your Proposal.
4. Return this Form per RFP Section 2.5.

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| --- | --- | --- | --- |
| **Agree** | **Disagree** | **Sec.** | **Attestation/Confirmation** |
|[ ] [ ]  **4.1** | If awarded a Contract, the Services provided by the Proposer to the Department under the Contract will be performed within the United States. |
|[ ] [ ]  **4.2** | If Proposer’s system is hosted in the cloud, Proposer agrees all data provided to the Proposer (Contractor) by the State, Department, Participants, Department-contracted third-parties for Contract purposes will be stored in the contiguous United States. |
|[ ] [ ]  **4.3** | Proposer agrees that all work products developed by Proposer for the Department (e.g., all written reports, drafts, presentations, and meeting materials, etc., required under the Contract) will become the property of the Department. |
|[ ] [ ]  **4.4** | With regard to the services that Proposer is offering to the Department, Proposer currently has and will have no conflict of interest with regard to any other work performed by the Proposer on behalf of the State of Wisconsin. |
|[ ] [ ]  **4.5** | The Proposer is not currently suspended or debarred from performing federal or State government work. Proposer will notify the Department if Proposer becomes suspended or debarred from performing federal or State government work during the RFP process and during the Contract term should Proposer receive a Contract award.  |
|[ ] [ ]  **4.6** | During the past five (5) years, the Proposer has not been in bankruptcy or receivership or been involved with any litigation alleging breach of contract, fraud, breach of fiduciary duty or other willful or negligent misconduct. (If the Proposer provides a response of “Disagree,” Proposer must provide details of any pertinent judgment, criminal conviction, investigation, or litigation pending against the Proposer.) Proposer will notify the Department if Proposer enters into bankruptcy or receivership or becomes involved with any litigation alleging breach of contract, fraud, breach of fiduciary duty or other willful or negligent misconduct during the RFP process and during the Contract term should Proposer receive a Contract award. |
|[ ] [ ]  **4.7** | Proposer confirms that its recommended services comply with industry best practices as well as applicable federal and state law, including the Affordable Care Act (ACA), Americans with Disabilities Act (ADA), Genetic Information and Nondiscrimination Act (GINA) and Health Insurance Portability and Accountability Act (HIPAA) guidelines.  |

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|[ ] [ ]  **4.8** | Proposer confirms it is able to meet the requirements listed in the RFP, including the requirements in the appendices applicable to the RFP(s) for which the Proposer is submitting a Proposal and will meet such requirements should the Proposer receive a Contract award.  |
| [ ] ☐ |[ ]  **4.9** | The Department is in the process of implementing an Insurance Administration System for benefits eligibility, enrollment, and management; the selected Proposer(s)/Contractor(s) will be required to submit and/or receive data to/from the Department and/or the IAS at no additional charge. Proposer, if awarded the Contract, must have the ability to provide and receive repeatable, automatable data interchange with the Department and/or the IAS, the cost of which shall be included in the Proposer’s Cost Proposal Workbook.  |

**Medicare Advantage and Supplement/Medigap Confirmations:**

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| --- | --- | --- | --- |
| **Agree** | **Disagree** | **Sec.** | **Attestation/Confirmation** |
|[ ] [ ]  **4.10** | Confirm you will possess and maintain all licenses, certifications, or registrations required by State and federal laws, rules, and regulations for the services to be provided under any resulting contract. For Medicare Advantage proposers, confirm you will be properly authorized by CMS to provide services as required in the Contract.  |
|[ ] [ ]  **4.11** | Confirm you are willing to cover members entering your plan that have been diagnosed with End Stage Renal Disease (ESRD). |
|[ ] [ ]  **4.12** | Confirm that you agree that Retirees and dependents who are disabled and on Medicare, but who are under age 65, are eligible for the plan(s) you are proposing.  |
|[ ] [ ]  **4.13** | Confirm your pricing is based on the Department’s actual claims data provided to Proposers in connection with the RFP. |
|[ ] [ ]  **4.14** | Confirm you will provide all requested data the Department needs to validate a Medical Loss Ratio (MLR) by the Department or its designee. For Medicare Advantage, the validation will include a review of the Quality Improving Activities (QIA) as defined by CMS. |
|[ ] [ ]  **4.15** | Confirm you will provide Explanation of Benefits to Participants in instances where the claim is not fully paid. |
|[ ] [ ]  **4.16** | Confirm you will notify the Department when you first identify significant issues that cause member disruption. |
|[ ] [ ]  **4.17** | Confirm you will notify the Department when you first identify significant issues that cause provider disruption. |
|[ ] [ ]  **4.18** | Confirm you will provide a Department-specific web site for Participants so that Participants can access plan specific information, including provider directories (or look-up functions), as well as plan documents that are sent to all members.  |
|[ ] [ ]  **4.19** | Confirm you will have a program in place to prevent and detect internal and external fraud and fraudulent practices. The program must have the ability to screen for potential fraud and systematically review provider claims. Confirm you will report the fraud findings and any corrective measures to the Department where necessary. |

**Medicare Plus (Supplement/Medigap) Only Confirmations:**

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| **Agree** | **Disagree** | **Sec.** | **Attestation/Confirmation** |
|[ ] [ ]  **4.20** | Confirm you will provide utilization review services for portions of the plan requiring such services (generally, the plan pays in excess of Medicare and uses Medicare managed care protocols). |

**Medicare Advantage Only Confirmations:**

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| --- | --- | --- | --- |
| **Agree** | **Disagree** | **Sec.** | **Attestation/Confirmation** |
|[ ] [ ]  **4.21** | Confirm that in the event the star rating for the plan you are offering (providing as part of the Contract) **decreases**, you agree to honor the Contract pricing set at the higher star rating.  |
|[ ] [ ]  **4.22** | Confirm that in the event the star rating for the plan you are offering (providing as part of the Contract) **increases**, you agree to decrease the Contract pricing by a percentage that coincides with the new, higher Star rating.  |
|[ ] [ ]  **4.23** | Medicare Advantage Nationwide PPO Proposers only: Confirm you will provide the requested Nationwide MA PPO plan design(s) identically in all states. |

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| **ACKNOWLEDGE AND ACCEPT:** |
| This form has been reviewed by me and shall become part of the final Contract. I am a duly authorized representative of my company and have the authority to legally bind my company. I hereby acknowledge and accept responsibility for the accuracy of the responses given above. I further accept that my company’s Proposal *may* be rejected on the grounds that any item listed above is marked as “Disagree.” Also, I acknowledge I have specified and provided a reason for any answer marked as “Disagree” in the Assumptions and Exceptions section of my company’s Proposal. |
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| Proposer Company Name: | Click or tap here to enter text. |
|  |  |
| Name & Title of Authorized Representative: | Click or tap here to enter text. |
|  |  |
| Authorized Representative Signature: |  |
|  |  |
| Signature Date: | Click or tap here to enter text. |