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| ETF_logo_large | **STATE OF WISCONSIN**  **Department of Employee Trust Funds**  **A. John Voelker**  SECRETARY | 4822 Madison Yards Way  Madison, WI 53705-9100  P. O. Box 7931  Madison, WI 53707-7931  http://etf.wi.gov |

Date: April 26, 2024

To: All Potential Proposers to RFPs ETD0050-51

RE: Addendum No. 1 to Request for Proposals (RFPs) ETD0050-51

Third Party Administration of IYC Medicare Advantage and Medicare Plus Programs

Vendor Q&A

This Addendum is available on ETF’s web site at <https://etf.wi.gov/node/35426>

**Acknowledgement of receipt of this Addendum No. 1:**

**Proposers must acknowledge receipt of this Addendum No. 1 by providing the required information in the table below and including this Page 1 with their Proposal cover letter.**

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| --- | --- |
| Company Name: |  |
| Authorized Person (Printed/Typed Name and Title): |  |
| Date: |  |

**1. The following questions from Proposers and answers from the Department are hereby added to RFPs ETD0050-51:**

| Q # | RFP / Appendix # and Section # | RFP Page | Question/Rationale | Department Answer |
| --- | --- | --- | --- | --- |
| Q1 | General Question |  | We understand ETF offers both a Medicare Advantage and Medicare Plus (Supplement or Medigap) plans. Is it preferred that ETF have the same vendor/carrier for both plans or please confirm if ETF will consider an award of vendor/carrier X for Medicare Advantage and vendor/carrier Y for Medicare Plus. | ETF will consider awards under each RFP (Medicare Advantage and Medicare Plus); awards may be to different vendors. Per RFP Section 1: *“Vendors may submit a Proposal for one or both of the RFPs.”* |
| Q2 | General Question |  | Related to the above, is ETF considering multiple MAPD PPO carriers available to retirees or is the strategy to only have 1 MAPD PPO carrier offered? | ETF is considering multiple Medicare Advantage and Medicare Plus vendors. Navitus Health Solutions will offer the EGWP plan. |
| Q3 | General Question |  | Please indicate whether retirees are allowed to come back on the plan if they have previously opted out of the employer sponsored plan. | The rules for reenrollment for retirees if they terminate coverage varies, based upon their status at retirement. Certain retirees are eligible to reenroll if they cancel coverage. ETF determines eligibility. |
| Q4 | General Question |  | Please indicate if the population is a closed group with no newly retired members eligible to join. | Newly retired members are eligible to join the population. It is not a closed group. |
| Q5 | General Question |  | Please provide the premiums paid for the MAPD PPO and HMO plans in 2023 and 2024. | MA Passive PPO (medical only) individual rates for State and Local:  2024: $75.58  2023: $60.58 |
| Q6 | General Question |  | Does ETF have any onsite dedicated staff provided by the current carrier? | Yes, there is one onsite dedicated staff person. |
| Q7 | Section 8, Network Submission Requirements | 72 | Please clarify if you would like the Network Questions returned in the Technical response or the Cost Proposal response. | Responses to the network questions provided by Segal should be sent with vendors’ cost proposal responses (and sent to Segal). |
| Q8 | Section 7, Technical Questionnaire, 7.16 ETD0051 Medicare Plus Plan | 69 | For bidders only responding to MA or only to Medicare Plus Plan, please confirm is it acceptable to respond "Not applicable" to the questions specific to the plan not being proposed. | RFP sections applicable to both MA and M+, sections applicable to just MA, and sections applicable to just M+ are specified in the RFP. If you are only responding to one RFP we don’t expect you to reply “not applicable” to questions in the sections that don’t apply to the RFP you are providing a response for. |
| Q9 | WI ETF MA Financial Summary |  | It is noted the claims are reflective of incurred dates, please indicate the “paid through” date. | Not applicable. As indicated, in the file, *WI ETF MA Financial Summary*, in the individual secure workspace(s), Medical is based on service dates. Medical Claims include: All FFS and capitated provider claims including Part B Rx claims - with IBNR. |
| Q10 | WI ETF MA Financial Summary |  | Please provide the information below regarding the Part/A Avg Risk scores:   * + What time period does the risk score represent?   + Were the months prior to the mid-year adjustments/payments (typically Jan-Jun/July) restated for the actual mid-year adjustment received?   + Were the actual paid mid-year CMS adjustments/payments removed from the Risk Scores in any way?   + Were the actual paid final CMS adjustments/payments included in the Risk Scores provided?   + Have any additional adjustments been made to the risk score data provided such that they would not reflect the paid risk scores as of the date the data was provided? If so, please describe and quantify those adjustments in detail. | For the file, *WI ETF MA Financial Summary*, in the individual secure workspace(s), the average risk scores reflect final settlements for 2021/2022, and mid-year scores for 2023. No additional adjustments have been applied. |
| Q11 | WI ETF MA MMR File |  | Please provide the information below regarding the data included in this file:   * + Does the provided risk score include any actual or estimated amounts for the CMS mid-year payment?   + Does the provided risk score include any actual or estimated amounts for the CMS final payment?   + Have any additional adjustments been made to the risk score data provided such that they would not reflect the paid risk scores as of the date the data was provided? If so, please describe and quantify those adjustments in detail. | For the file, *WI ETF MA MMR File*, in the individual secure workspace(s), the risk scores in MMR reflect the latest mid-year and adjustment as of January 2024. No additional adjustments have been applied. |
| Q12 | Exhibit 1 - Program Agreement | Entire document | Given the complexities of the Medicare Advantage (MA) product, will WI ETF accept negotiating a standard Medicare Advantage Agreement with the chosen carrier (template may be provided by MA carrier) in place of the Program Agreement to alleviate extensive exceptions and align with strict CMS requirements and regulations, as well as, administration of a fully-insured versus self-funded offering, for which the current agreement does not align? | No. The Department offers Uniform Benefits. Benefit exceptions are only made if a benefit is mandated by CMS and not covered under Uniform Benefits. Then it is permissible. Further, for supplemental benefits that are optional, the Board has taken action to permit these. This plan is to be fully insured. The Department requires all vendors to use the Department’s Program Agreement. |
| Q13 | Exhibit 1 - Program Agreement III.H.3.i. (Customer Service) | Page 36 | *“i. At the DEPARTMENT’S request, the CONTRACTOR must provide the policies and procedures related to the operation of the CONTRACTOR’S customer service department.* ***The DEPARTMENT reserves the right to require changes to the policies and procedures that directly impact PARTICIPANTS.”***  Please confirm, under a fully-insured offering the Medicare Advantage (MA) carrier is expected to own the risk and administer the DEPARTMENT's chosen plan on the DEPARTMENT's behalf, and as such the following provision restricting the carrier's operational control and other similar, are only applicable to a self-insured offering where the DEPARTMENT would own the plan oversight and risk? | The Medicare Advantage carrier is expected to own the risk and administer the Department's chosen plan on the Department's behalf. Regarding the reference to a self-insured offering, currently the Department does not operate within a self-insured offering through the Group Health Insurance Program except for the Pharmacy Benefit Manager.  The referenced provision applies to the fully-insured plan offering. Specific changes may be negotiated with the selected vendor. |
| Q14 | Exhibit 1 - Program Agreement III.H.9.d.i. (Bonding, Reinsurance and Insolvency) | Page 38 | *“d. In the event a CONTRACTOR becomes or is at risk for becoming insolvent, experiences a “Significant Event,” a significant loss of primary PROVIDERS and/or HOSPITALS, or no longer meets the minimum provider access standards defined under Wis. Stat. § 609.22 and Wis. Admin. Code INS 9.32, and included in Section III.F.1. Provider Access Standards, or if the BOARD so directs due to a “Significant Event,” the BOARD may do any of the following, including any combination of the following:*  *i. Terminate the CONTRACT upon any notice it deems appropriate, including no notice.”*  Please confirm under all circumstances, notice to terminate the contract must be received in writing no less than 30 days prior to termination in order to meet CMS required member notice of at least 21 days in advance if the member’s plan is terminating. (§50.7, Chapter 2, Medicare Managed Care Manual). | This provision may be negotiated with the selected vendor. |
| Q15 | Exhibit 1 - Program Agreement III.L.2.a. (STATE and Federal Mandates) | Page 47 | *“2. Reporting on compliance will, at minimum, provide evidence that the CONTRACTOR has met the requirements of the compliance activities. Additional information may be required by the DEPARTMENT based upon the type of compliance activity being reported.*  *a. Specifically pertaining to the transparency requirements set forth in the Consolidated Appropriations Act of 2021, the CONTRACTOR must attest annually that transparency-related requirements have been met beginning with each compliance year specified by the Act and rules as they are finalized by Federal authorities. The CONTRACTOR must also make compliance reports required by the Act specific to Mental Health Parity available to the DEPARTMENT upon request, and in the event that reporting is required by the federal government. The CONTRACTOR must also notify the DEPARTMENT if any aspect of the DEPARTMENT’S HEALTH BENEFIT PROGRAM design or administrative requirements create risks to compliance.”*  Please confirm that as the majority of the Consolidated Appropriations ACT (CAA), 2021, is not applicable to Medicare Advantage (MA) plans, this provision may be deleted. | This provision can be deleted from the Program Agreement as the transparency requirements in the Consolidated Appropriations ACT are silent on Medicare requirements. |
| Q16 | Exhibit 1 - Program Agreement IV.A.1. (Performance Standards and Penalties) | Page 48 | Please provide the referenced template to be used to track performance. | See the linked template for the quarterly reporting of the customer service performance standards. |
| Q17 | RFP 1.9 Table 9 (Calendar of Events - May 1, 2025 due date for SOC 2 Type 2 Report) | Page 21 | Can WI ETF please confirm if there will be a waiver available to allow for use of the HITRUST Common Security Framework in lieu of the SOC 2 Type 2 report? | The Group Insurance Board indicated at its November 2023 meeting a preference for the SOC 2 Type 2 report starting on January 1, 2026. ETF is working to develop a risk framework and policies to apply this guidance, which will be shared with the Board and vendors as soon as is practicable and prior to the due date for the RFP responses. |
| Q18 | RFP 3.3.b. (Evaluation Criteria) |  | A SOC 2 Type 2 audit is currently on our organizational roadmap but may not be completed prior to the stated May 1, 2025 deadline. Would the Department consider our HITRUST certification in place of the SOC 2 Type 2 audit report and/or letter of attestation? | The Group Insurance Board indicated at its November 2023 meeting a preference for the SOC 2 Type 2 report starting on January 1, 2026. ETF is working to develop a risk framework and policies to apply this guidance, which will be shared with the Board and vendors as soon as is practicable and prior to the due date for the RFP responses. |
| Q19 | Table 3 | Page 10 | Can you provide more details on the skilled nursing benefit? Specially on the coverage for the non-Medicare approved facilities. | The linked [chart](https://etf.wi.gov/its-your-choice/2024/state-employee-and-retiree-health-plan-supplemental-benefits/health-insurance-retirees-medicare/breakdown-your-costs-medicare-plan-design) may be helpful. See the two rows for Skilled Nursing Facility (SNF). Medicare Plus will pay up to 30 calendar Days at a non-Medicare approved SNF due to Wis. Stat. [632.895(3)](https://docs.legis.wisconsin.gov/document/statutes/632.895(3)). |
| Q20 | WI ETF MA Financial Summary | Financial Summary tab | a. Does the claim/financial data that was submitted combine PPO and HMO products?  b. If so, can the claim data be separated?  c. Also, could we get a census to indicate out of the 17,000 how the enrollment is distributed between the two products? | There is only a MA PPO product currently. |
| Q21 | RFP Section 1.3.6 Table 5 | Page 13 | a. On average, how many new lives enroll in the Medicare Plus plan each year?  b. What percentage go to the Medicare Plus plan vs Medicare Advantage plan? | The data file, *WI ETF Med+ Financial Summary*, in the individual secure workspace(s), provides monthly enrollment by plan. |
| Q22 |  |  | Are current medical only rates for the Medicare Plus plan available? [https://etf.wi.gov/publications/24et-2108/download?inline=](https://secure-web.cisco.com/1ST-XC54OA1hicDXendpHMSIcxruQcflBOOz5kM875uO15uMApcSY5cJEiPbboQ23_47Utq8_TCwQ4vqyYL9Upyp0YM2acREv_edWuucy0_x_B6cNe8KRkZZIjok7r_N8TQoi9KYjbxdZ1ToYcoTPuDKCGrAcJ0-dHTERphC-ccK3iMHMeoQmA57AkZ750Z4aJJmwDFfY-iymD0PM2MP2ckilf0Ew9iQO1XjvcLE7H2dPhTJAcWQjhjOD5tO2Q5PsOCX6vBz7iJgRBhXSEsCq3X5CeFg7NfyVdC_OLQHuYzpg-Bz3mDbvCE36o_ztLL3g/https%3A%2F%2Fshared.outlook.inky.com%2Flink%3Fdomain%3Detf.wi.gov%26t%3Dh.eJxVzE0OwiAQQOGrNKy1_LRY2sToVYCOdiJCA6NdGO-uuHP7XvK92CMHNjVsIVrLxDnQpd2wvaYnXx8uoLeEKRaueqC9ksLwOW0xJDufMAaMcGS7ht0qEaxLeX_BXIh7CAFLiucMhBngV1uf7rwXw0GPxkjtTNfp0Q8OrPBaKqGV6zyXg1TyIHsjWjlUHCpetgUsfUEHEQvZXLF653r_4vsDCpRDeQ.MEYCIQCF46qjXZVv1yVj093Yqfoiw9tiwLC7zQwAflE21aXFYAIhAM4YtzfgIDqPWl4oWG4gKV9pGcIjX68kwmmX2Qj_86Ra) | Medicare Plus (medical only) individual rates:  2024: $238.74 State,  $253.64 Local  2023: $230.92 State,  $245.32 Local |
| Q23 |  |  | Please confirm the claims provided are for the Medicare Plus population only. | Confirmed. |
| Q24 |  |  | Is 3 years of claims history available? | Additional claims data will not be provided at this time. |
| Q25 |  |  | Is a Large Claims report available for the claims provided? | A large claims report is not available. |
| Q26 |  |  | Are the claims in the report incurred or paid?   * + *The provided Claims report shows the following:* * Enrollment- Month and year * Medical – month and year of based on service dates and plan paid amount.   Can you confirm these claims do not include pharmacy claims, admin fees or any additional charges? | As indicated in the file, *WI ETF MA Financial Summary*, in the individual secure workspace(s), Medical is based on service dates. Medical Claims include: all FFS and capitated provider claims including Part B Rx claims - with IBNR. |
| Q27 | WI ETF MA Financial Summary | Financial Summary tab | Do the risk scores include the 2022 mid-year adjustment or Final Settlement? For | For 2022, the risk scores include Final Settlement. |
| Q28 | WI ETF MA Financial Summary | Financial Summary tab | There was almost a 20% increase in enrollment from 12/2022 to 1/2023 (one month). What is the explanation for that sudden and sharp enrollment increase? | The Medicare Advantage plan has continuously grown in membership since inception. Since January is the start of a new plan year and is reflective of updated plan elections, it is common to see the most change in enrollment during this month. The enrollment growth rate in January for 2023 is consistent with past years. |
| Q29 | RFP 1.9 (Calendar of Events) | 21 | Please confirm.  Is the current SOC 2 Type 2 scope with today’s group health insurance program requirement? | Yes. |
| Q30 | RFP 1 (General Information) | 4 | Please confirm.  a. Is this RFP specific to Medicare Advantage medical services only?  b. Does it include prescription/drug coverage? | a. RFP Section 1 states: 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.  RFP sections applicable to both MA and M+, sections applicable to just MA, and sections applicable to just M+ are specified in the RFP.  b. The RFP does not include prescription/drug coverage, see RFP Section 1.3.4. which states: Pharmacy Benefits are not part of this RFP. |
| Q31 | RFP 1.3.1  (Health Insurance Program Background) | 12 | *“…..This self-insured benefit is available to all GHIP members including members enrolled in the Medicare Advantage plan……….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.”*  Must all bids exclude pharmacy benefits (i.e. meaning pharmacy will automatically be administered thru the State’s chosen PBM)? | Correct. |
| Q32 | RFP 6.5.2 (Enrollment and Communication) | 42 | *“Provide examples of participant communication materials that explain…..and a billing invoice for participants that are direct billed.”*  *a. Will Direct Billing retirees be a requirement of the program and if so, will there continue to be an expectation of pass through premiums (i.e. dental, pharmacy)?*  *b. If Direct Billing will be a requirement, will this only include direct billing the retiree the medical premium?* | a. Yes, direct billing will be a requirement, as it is today. That is, the health plan bills the member for health, pharmacy benefits, Department administrative fees and if selected, Uniform Dental coverage. The plan retains the medical portion and some of the fees. The Department claws back the other items.  b. This is yet to be determined. The current practice is to bill the retiree for the entire premium; this may change when BenefitFocus is implemented. |
| Q33 | Exhibit 1 –Program Agreement, IV.F.6.  SUBSCRIBER Notification of Changes Review | 56 | *“The CONTRACTOR must submit the written notice that it will be issuing to PARTICIPANTS enrolled in its benefit plan(s) prior to the annual OPEN ENROLLMENT period identifying those PROVIDERS that will not be IN-NETWORK for the upcoming benefit period and including any language directed by the DEPARTMENT summarizing any BENEFIT or other HEALTH BENEFIT PROGRAM changes. The CONTRACTOR must issue the written notice after DEPARTMENT approval. (See Section III.E.1. OPEN ENROLLMENT Informational / Marketing Materials.)”*  Need to understand how they define PROVIDER. Does this include one provider closing/merging a location or several locations but other locations remain open? | This provision applies to Medicare Advantage HMO bids.  Per the Certificate of Coverage, Provider means a doctor, Hospital, clinic, or any other person or entity licensed by the State of Wisconsin, or other applicable jurisdiction, to provide one or more Benefits.  For Regional MA Providers, yes, such notice to Participants would include when one Provider closes/merges with another location or several locations but other locations remain open.  For nationwide passive PPO Medicare Advantage plans, written notices may be required to inform Participants about out-of-network Providers who have issues, for example, in billing the Contractor. This notice would be to inform the PARTICIPANT of the issue and steps to resolve it.  This provision is waived for Medicare Plus plans, since all Providers are eligible for payment. Some Providers, such as those who opt-out of Medicare or who are out-of-country, can be subject to UCR and hold harmless. |
| Q34 | Exhibit 1 –Program Agreement, IV.G.9. Over-Age Disabled Child Eligibility Verification Report and Certification | 59 | **9. Over-Age Disabled Child Eligibility Verification Report and Certification**  Confirm that this Performance Standard wouldn’t apply to Medicare Advantage contractor. | The Medicare Advantage Contractor is expected to perform certification of over-age disabled dependents. |
| Q35 | Exhibit 1 – Program Agreement, IV.J.1. Claims Data Transfer to Data Warehouse  IV.J.2. Provider Data Transfer to Data Warehouse | Ex 1, page 61 | **1. Claims Data Transfer to Data Warehouse**  **2. Provider Data Transfer to Data Warehouse**  Confirm that these are required by a Medicare Contractor, seems like a Commercial requirement. | Yes, both claims and provider data submissions are required to be provided by the Medicare vendor to ETF’s claims data warehouse for all the ETF’s Medicare members.  Regarding provider data submission, Medicare vendors tend to have a very large provider network, therefore ETF will accept provider data of the providers that submitted a claim on ETF’s Medicare members, instead of the vendor’s entire network. This response applies to Medicare Plus as well. |
| Q36 | Appendix 2 (Drug Claims Functional Specification) | n/a | The 2024 Functional Specification Drug (Appendix 2) indicates the specification is designed to produce a prescription drug claims file for plan participants. RFP Section 1.3.4 indicates that the Pharmacy benefits are not part of the RFP. Please provide clarity on the purpose of the file specification. | The Department will provide data specifications to Contractors to fully incorporate available pharmacy claims data into data reporting, which includes, but is not limited to: HEDIS data; Wisconsin Health Information Organization (WHIO) claims data; information requested on the disease management program survey; and Catastrophic claims data. The Department’s data warehouse uses this data/information in consultation with the Pharmacy Benefit Manager. |
| Q37 | RFP 7.1.10  (Information Technology) | 45 | Please elaborate what you mean by *"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."* Are you referring to support of applications that will be used to administer ETF business? Not sure what you mean by R&D. | Yes. The answer is applicable to the systems you will be using to administer the benefits under the Contract.  What we’re looking for here is:   1. How do you plan for and determine future system updates? 2. What are the resources used to accomplish that? 3. Do you have any investment in research and development and at what level? |
| Q38 | RFP 7.1.11  (Information Technology) | 45 | Is this for any in-flight or potentially planned platform or application changes? | Both.  Does your organization have a plan (i.e., road map) for when and what your system is expected to provide that it does not provide now (e.g., new functions, enhancements, etc.) over a period of time, (e.g., next two years)? |
| Q39 | RFP 7.1.13  (Information Technology) | 45 | *“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.”*  a. Can you provide an example on what you mean by *"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"?*  b. What type of compliance are you referring to in terms of applicable applications?  c. Are you talking about HIPAA required security applications/controls? | This would be for software you would be using to administer Medicare Advantage and/or Medicare Plus for the State.  There are State, federal, etc. laws and statutes that must be met when administering and providing benefits for Medicare. These could be for HIPAA, CMS, or other. For example, Medicare is in the process of requiring Medicare Advantage insurers to report race, ethnicity, and other collected data. How do you ensure you are meeting the requirements? |
| Q40 | RFP 7.1.16  (Information Technology) | 45 | *“Describe any authentication mechanisms, identity stores, and user types that will be used as part of your detailed implementation plan.”*  a. Are you referring to a detailed implementation plan for any new system that is needed to support MA LOBs?  b. Do you have certain systems in scope for this? | For the systems you will be using to administer Medicare Advantage and/or Medicare Plus for the State what are the identity management systems that your solution supports? |
| Q41 | RFP 7.2.16  (Computer and Data Processing Facilities, Data Policies) | 47 | *“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.”*  a. Not sure what you mean by a cloud exit strategy to export a client’s data that is processed, transmitted, or stored by your organization. Are you referring to data removal/destruction processes for in scope data in the cloud?  b. Do you mean migrate data off the cloud to some other platform? | Provide your documented processes and procedures if DEPARTMENT terminates a business relationship with your company, e.g., if your solution is in the cloud, how does the DEPARTMENT move off your cloud platform? |
| Q42 | RFP 7.3.10  (Information Security) | 48 | *“Will your product/service require any on-premises deployment?”*  Would you like us to indicate if we would be adding any new on-Prem software to support the MA LOB? | No. We are asking if your solution will require any on-premises IT components at the DEPARTMENT’S location in Madison, WI. |
| Q43 | RFP 7.13.3 (ETD0050 IYC Medicare Advantage Population Health Management and Wellness) | 66 | What, if any, restrictions will ETF place on the Medicare specific enhanced wellness offerings? For example, if multiple health plans are awarded contracts will the wellness benefit be uniform across all plans? | The Department will evaluate the information provided in proposer responses and bring forward a recommendation to the Board on the wellness policy and approach, taking into consideration the offerings available through the Medicare Advantage health plan, the anticipated impact of said offerings, and the other wellness benefits available external to the Medicare Advantage health plan. |
| Q44 | Form F - Vendor References | n/a | Form F Vendor References indicates vendors are to provide at least one reference that is an entity with enrollment of at least 100,000 employees and one reference a public sector employer group of over 50,000 employees. Please provide direction on how to respond if the vendor does not serve an employer group this large. | 100,000 was incorrectly stated in Form F; that number has been changed to 50,000 (a revised Form F was uploaded on 4/5/2024 to [https://etf.wi.gov/node/35426 on April 5](https://etf.wi.gov/node/35426%20on%20April%205), 2024. The number of 50,000, stated in RFP section 3.3.c., is correct.  If you do not currently have a reference with 50,000 subscribers (or employees), provide references for your largest public employers. List how many subscribers are in each employer group. |
| Q45 | RFP 7.1.6, 7.1.7, 7.1.8 (Information Technology) | 44-45 | The RFP sections reference "website/web portal". Could you provide clarification on what needs to be reported on? For example, the public facing website and/or MyChart. | The RFP sections listed in the question reference the Proposer’s dedicated website and web-portal that the Proposer will host for Participants. See RFP State of Wisconsin Group Health Insurance Program -Medicare Advantage and Medicare Plus Program Agreement, Section III.E.3. CONTRACTOR Web Content and Web-Portal. |
| Q46 | RFP 6.1.6 | 38 | a. Are vendors limited to these ratings? b. May vendors include history of NCQA ratings and accreditation? | Yes, vendors may, and are encouraged to, include their NCQA ratings. |
| Q47 | RFP 6.3.16 | 41 | Please clarify what is meant by mobile application. We have several apps that serve Medicare our member population such as a primary member app, MyChart, various contracted vendor apps, etc. | Provide information on applications you will make available to Participants. Information on Provider apps is not necessary. |
| Q48 | RFP 6.5.3 (Enrollment and Communication) | 42 | Please explain what type of co-branding would be expected by the Department. Would all member materials need to be co-branded with ETF? | During Medicare’s open enrollment period, members may receive many Medicare Advantage mailings and can be confused about which apply to their Benefits under the Health Benefit Program. The Department has found that by including its logo and/or verbiage describing its relationship with the Medicare Advantage Contractor(s), members are more likely to read plan materials. This verbiage may be needed on most materials. |
| Q49 | RFP 7.7.7 (Reporting to the Department) | 53-54 | Please clarify that the expectation would be for vendors to notify ETF every time a case is sent to IRE and for every decision received back. | Section III.I.6 of the Program Agreement requires Contractors to notify the Department in specified time frames of requests for external reviews and their outcome. Medicare Advantage Contractor(s) must follow CMS rules. To meet III.I.6., Contractor(s) should notify the Department of appeals that go to independent review (level 2), Administrative Law Judge (level 3), Medicare Appeals Council (level 4) and federal district court (level 5). |
| Q50 | RFP 7.9.10 and 7.9.11 (ETD0050 Medicare Advantage Plan Experience) | 58 | Sections 7.9.10 and 7.9.11 ask vendors to confirm appeals and grievances will be handled in accordance with CMS requirements and guidelines, however, in Exhibit 1 - 2025 Program Agreement with Medicare Provisions has deviations from CMS requirements. For example, Medicare Advantage appeals have multiple levels of appeal including IRE, Administrative Law Judge (ALJ) and Medicare Advisory Committee (MAC). Would the expectation be that ETF would be included as a step in the appeal process? | No, except Contractor(s) should notify the Department of appeals that go to independent review (level 2), Administrative Law Judge (level 3), Medicare Appeals Council (level 4) and federal district court (level 5). |
| Q51 | RFP 7.9.10 and 7.9.11 (ETD0050 Medicare Advantage Plan Experience) | 58 | Section 7.9.10 and 7.9.11 ask vendors to confirm appeals and grievances will be handled in accordance with CMS requirements and guidelines, however, in Exhibit 1 - 2025 Program Agreement with Medicare Provisions has deviations from CMS requirements. For example, Section III.I.5 of the Program Agreement reference's a grievance committee's determination but Medicare Advantage appeals are not reviewed by a grievance committee rather a Medical Director. Is ETF's expectation that the appeals are reviewed by a Grievance Committee? | No, the Department’s expectation is that Contractors follow CMS’ rules. |
| Q52 | RFP 7.9.10 and 7.9.11 (ETD0050 Medicare Advantage Plan Experience) | 58 | Section 7.9.10 and 7.9.11 ask vendors to confirm appeals and grievances will be handled in accordance with CMS requirements and guidelines, however, in Exhibit 1 - 2025 Program Agreement with Medicare Provisions has deviations from CMS requirements. For example, Section IV.D.19. of the Program Agreement indicates that vendor must allow 90 days to accept an appeal while CMS requirements state that enrollees have 60 days to file an appeal. Please provide clarity on what deviations from CMS rules vendors would need to follow in regard to the grievance and appeals rules. | The Department’s expectation is that Contractors follow CMS’ rules, for example, CMS’ 60-day requirement rather than the Department’s 90-day requirement. To meet Section III.I.6, of the Program Agreement, Contractors should notify the Department of appeals that go to independent review (level 2), Administrative Law Judge (level 3), Medicare Appeals Council (level 4) and federal district court (level 5). |
| Q53 |  |  | WI ETF Medicare Advantage Network Access Workbook seems to be aligned to RFP Section 8.1 Network Access Tool, which only applies to IYC Medicare Advantage HMO proposals. Can you confirm this workbook is part of the Network Access Tool referenced in this section and should not be completed if a vendor is proposing a nationwide PPO? | Confirming the Medicare Advantage Network Access workbook is not to be completed by those vendors proposing a nationwide PPO. |
| Q54 |  |  | Please provide the suburban and rural classifications on a member level in your census files. | A revised census with an added urban/non-urban classification column on a member level was sent to the secure workspace of all vendors who provided a fully executed NDA to the Department. |
| Q55 | GeoAccess Report |  | Should the 2,467 out-of-state retirees be excluded from the GeoAccess report? If not, please provide the access parameters for the out-of-state retirees | No. Do not exclude any retirees from the GeoAccess report(s). Please use the access standards provided in RFP Section 8 - Network Submission Requirements. The product for which you are submitting a Proposal will be considered in the evaluation of GeoAccess reports. |

**END**