

# The State of Delaware

Request-For-Proposal for Medical Insurance Third Party Administrator

## Executive Summary

The intention of this RFP is to conduct a search for a medical third party administrator for the State of Delaware, on behalf of the Office of Management and Budget (OMB). The State’s current third party administrators include Aetna and Highmark Delaware. The procurement will provide an in-depth review into the prospective bidder’s ability to partner and align with the State’s goals and objectives. The main sections of the RFP will include:

- I. RFP Introduction
- II. RFP Background
- III. Minimum Requirements
- IV. Detailed Questionnaire, consisting of five sub-sections:
  - A. Bidder Profile
  - B. Medical Plan Administration
  - C. Health Care Delivery
  - D. Member Support, Tools and Resources
  - E. Health Management
- V. Network Adequacy
- VI. Financial Proposal
- VII. Attachments
- VIII. Appendices

### Section I. RFP Introduction

<b>Responsible Parties:</b>	OMB, Willis Towers Watson
<b>Status Notes:</b>	Draft 1: In process of development with OMB, including scoring criteria

The primary purpose of this section is to outline the procedures and conditions under which all prospective bidders will be expected to operate throughout the duration of their participation in this RFP. This will include a brief statement of purpose for the RFP, a brief description of the requested scope of services and a listing of the key dates most important to the RFP (e.g., contract effective date, due date for confirmation of intent to bid, due date for proposal submission). **Emphasis will be placed upon the focus of this RFP which is on the emergence of alternative network delivery models and driving an improvement in overall “total cost of care.”** This section will also include an outline of the proposal evaluation process, the scoring criteria upon which each bidder’s proposal will be evaluated, requirements for each bidder’s proposal response, and other important terms and conditions such as the confidentiality of documents and instructions for proposal submissions. As the bidders may submit a proposal for a distinct plan, such as a Medicare Advantage plan, this section will also include instructions on the RFP sections that must be completed for these bids.

## Section II. RFP Background

<b>Responsible Parties:</b>	OMB, Willis Towers Watson
<b>Status Notes:</b>	Draft 1: First draft of background included herein

The RFP Background section provides an overview of the committees and agencies within the State of Delaware tasked with management and/or oversight of the Group Health Insurance Program (GHIP). It will also provide a detailed overview of the State’s experience with its incumbent medical vendors (i.e., length of time with each vendor, administrative services and health management programs provided by each vendor), along with an overview of the covered population (i.e., number of covered lives; types of covered members such as State employee, retiree, Participating Group member; medical plans offered and their major design provisions). In addition, to provide the bidders with the necessary context to shape their proposals to the State, this section will focus on historical trends and cost drivers for the GHIP, along with a summary of the major regulatory provisions set forth by the Delaware Code dictating specific requirements within which the GHIP must operate. It will also include a summary of the final report to the State Employees Health Plan Task Force, including the short- and long-term actions for consideration, as well as findings and recommendations that dovetail with the services requested by this RFP. Finally, this section outlines the expectation that the winning bidder(s) will coordinate efforts to transform health care for GHIP participants with the work that the Delaware Center for Health Innovation (DCHI) is overseeing with respect to Delaware’s State Health Care Innovation Plan; a brief overview of this plan and the State Innovation Model (SIM) testing grant is also included.

## Section III. Minimum Requirements

<b>Responsible Parties:</b>	OMB – Legal terms of the contract Willis Towers Watson – Program-specific minimum requirements
<b>Status Notes:</b>	Draft 1: In process of development

This section will contain an outline of the minimum qualifications required of any bidder in order to be considered eligible for consideration by the State. A bidder must be deemed qualified to provide services in all of the categories or services within the scope of this proposal, and the judgement of whether a particular bidder is qualified will be rendered through the bidder’s ability to meet all of the minimum qualifications specified in this section. A bidder’s failure to meet any of the minimum requirements may result in disqualification of that bidder’s proposal. Among these requirements include administrative requirements (such as the ability to administer the State’s current plan designs), account management and staffing requirements (such as the ability to provide prior notification to the State of any critical team member changes), data security requirements, and financial requirements.

## Section IV. Detailed Questionnaire

<b>Responsible Parties:</b>	Willis Towers Watson
<b>Status Notes:</b>	Draft 1: First draft of questionnaire included herein

### Sub-section A. Bidder Profile

The Bidder Profile sub-section provides the bidders with an opportunity to present information about their organization and the proposed account management team for the State of Delaware. The bidders will also be asked to provide an overview of the clinical resources they are proposing to support the health management of GHIP members. Importantly, the bidders will also be asked to describe the degree to which they will need

support from or access to the State of Delaware staff during implementation and throughout the ongoing service delivery process.

### Sub-section B. Medical Plan Administration

In this section, the bidders will present a detailed picture of their capabilities to administer all aspects of the State's GHIP, both as it exists today and in various alternative health care delivery models that have been emerging in the marketplace.

This section is further divided into the following areas:

1. **Medical Plan Implementation** – The bidders will be asked to describe the process for implementing the services they are proposing to provide to the State. Included here is a request for a detailed implementation timeline with key milestones and team member roles and responsibilities.
2. **Eligibility Data Processing** – This section will require the bidders to describe their processes and procedures for maintaining eligibility information for GHIP participants, and distributing that information to other GHIP vendors and the Truven data warehouse.
3. **Medical Plan Claims Administration** – This section provides the bidders with an opportunity to describe the claims administration process that it is proposing for the State. This would include questions on the bidders' internal quality assurance and audit processes to ensure claims are being processed accurately.
4. **Health Reimbursement Account (HRA) Administration** – This section will allow the bidders to describe how they would administer the HRA associated with the State's consumer directed health plan. Questions in this section will also cover the member experience under each bidder's HRA.
5. **Health Savings Account (HSA) Administration** – While the State of Delaware does not currently offer a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), this type of plan offering has continued to grow in popularity among plan sponsors throughout the public and private sector and may be of interest to the State at some point in the future. Therefore, this section of the RFP aims to collect information from bidders on their capabilities for administering HSAs, including the member experience using each bidder's HSA product.
6. **Behavioral Health Benefit Administration** – This section will delve into the bidders' ability to provide behavioral health benefits to the State.
7. **Affordable Care Act (ACA)** – This section allows the bidders to describe their ability to administer plans in compliance with the Affordable Care Act (ACA).
8. **Provider Support: Administrative and Clinical Efficiencies** – This section will allow the bidders to describe ways that they have supplied participating providers with information about the bidders' claims processes and clinical guidelines to simplify providers' interactions with the bidders.
9. **Provider Network** – This section allows the bidders to describe the configuration of the "traditional" PPO/POS and HMO/EPO network(s) being proposed for the State.
10. **Network Financial Information** – Bidders will be asked in this section to describe the basis for their negotiated rates and out-of-network payment levels for the bidders' book of business as well as specific procedures that will provide another point of comparison for the State to evaluate the competitiveness of the bidders' pricing.
11. **Network Accreditation and Plan Performance Reporting** – One of the hallmarks of an effective health system is its ability to provide high quality care. In this section, bidders will describe the ways that the networks being proposed for the State have achieved certain nationally-recognized accreditations and/or certifications for high quality in medical care.

12. **Access to Care/Providers** – This section requests that each bidder describe the efforts taken to expand and maintain their provider network to meet the expected demand for not only the State, but also the broader community as access to care in general continues to be an issue of national importance.
13. **Provider Credentialing** – Bidders will be asked to respond to questions regarding how their providers are credentialed and vetted before, during and after the contracting process that designates those providers as participating in the bidders' networks.
14. **Provider Management** – Bidders will be asked to disclose the terms and conditions included in their contracts with in-network providers. This section will be important for the State to understand as it could directly affect the care experiences that GHIP members would face if covered under each bidder.
15. **Medical Plan Performance Auditing** – This section outlines how the bidders evaluate the performance and manage the quality of their proposed services to the State.
16. **Medical Plan Reporting** – The bidders will be asked to provide details on their capabilities for reporting on the performance (utilization, clinical, financial) of the health plan.
17. **Medical Plan Banking Arrangements** – This section asks the bidders' to describe their preferred banking arrangements for performance of the proposed services.

### Sub-section C. Health Care Delivery

This section will uncover each bidder's experience with alternative health care delivery models that are emerging in the marketplace.

This section is further divided into the following areas:

1. **Onsite Health Centers** – In this section, bidders will be asked to describe how the services they're proposing for the State could coordinate and integrate with the services provided by a primary care onsite or near-site health center operated by the State. While the State has not been formally tasked with entering into a contract with an onsite or near-site health center provider, this is an initiative that has been discussed in the past, hence the importance of including questions on this topic in this RFP.
2. **Telehealth – Partnering with an External Vendor** – This section will allow bidders to present how their proposed solutions would integrate with and complement the health care services accessible through a third-party telemedicine provider.
3. **Emerging Health Care Delivery Models** – Bidders will provide additional details on their overall value-based contracting strategy as well as the evolution their abilities and experience necessary for providing the State with other emerging models of health care delivery.
4. **Accountable Care Organizations** – If the bidder is affiliated with a health system or provider group to deliver an Accountable Care Organization (ACO) solution and is proposing to provide GHIP members with access to it, then the bidder will also be asked to address a series of questions pertaining to that ACO.
5. **Patient-Centered Medical Homes (PCMHs)** – Bidders will outline the details behind their PCMH strategy and how PCMHs would integrate with onsite health centers.
6. **Centers of Excellence (COEs)** – In this section, bidders will be asked to respond to questions about any Centers of Excellence that may be part of their proposal to the State. Centers of Excellence are facilities that have been identified as delivering high quality services and superior outcomes for specific procedures or conditions, and may be established through separate contracting arrangements for a pre-determined set of services (e.g., bundled payments) with a facility that may already be participating within the bidder's provider network.

7. **High Performance Networks (HPNs)** – This section poses specific questions on the composition of any high performance network(s) that may be a part of bidders’ proposals to the State.
8. **Network Financial Information** – Bidders will be asked in this section to describe the risk sharing arrangements in place with any ACO solutions proposed for the State.

### Sub-section D. Member Support, Tools and Resources

This section provides bidders with an opportunity to describe the variety of services and support systems that are available to address member questions, trouble-shoot and resolve issues with claims, and access information necessary to be informed health care consumers.

This section is further divided into the following areas:

1. **Medical Plan Member Services Administration** – This section provides the bidders with an opportunity to present their solution for telephonic and online support for GHIP participants.
2. **Medical Plan Member Self-Service: Technology and Tools** – Bidders will be asked to provide an overview of their tools and resources available to members for on-demand access to various services and features of the bidder’s proposed health plan. This section will include a request for sample log-in information to a demo version of the bidders’ tools, where available.
3. **Provider Data Transparency: Pricing and Quality** – Part of being a wise health care consumer is having access to data on provider cost and quality ratings. This section of the RFP will delve into the details behind each bidder’s provider transparency tool, including data sources, definitions and availability of certain types of information about providers (i.e., after hours care, languages spoken, ability to conduct virtual visits).

### Sub-section E. Health Management

This section is intended for the bidders to outline their approach to managing and monitoring the health of the GHIP participants, which will improve GHIP participant health outcomes and help the State and GHIP participants manage their health care costs.

This section is further divided into the following areas:

1. **Health Management Program Administration** – In this section, bidders will describe the operations and clinical oversight of their health management programs. We will also inquire about the care and case management integration in place with any proposed ACOs.
2. **Alternative Health** – This section addresses the bidders’ ability to provide alternative health programs such as acupuncture and nutritional counseling for GHIP participants.
3. **Gaps in Care Technology** – Bidders will be asked to describe the technology used to monitor the health risks of the covered population and how the bidders would outreach to plan participants and their medical providers to notify them of health risks at any level (i.e., minor to life threatening).

### Section V. Network Adequacy

<b>Responsible Parties:</b>	Willis Towers Watson
<b>Status Notes:</b>	Draft 1: Templates for GeoAccess and provider disruption to be included within Draft 2

This section will allow the State to determine the adequacy of each bidder’s proposed network for GHIP participants.

This section is further divided into the following areas:

1. **GeoAccess** – Bidders will be asked to provide information about the number of current GHIP-eligible members with access to various types of medical providers (i.e., PCPs, specialists, hospitals) within specified access standards (i.e., “x” number of providers within “y” miles). This will allow the State to determine how many GHIP participants could end up without access to one or more types of providers within a certain number of miles.
2. **Provider Disruption** – Bidders will be asked to provide information on whether current GHIP providers are participating in the proposed networks for the State. This will allow the State to determine the extent to which members will need to change their current medical providers in order to stay in-network.

Both the GeoAccess and Provider Disruption analysis will be requested for traditional broad networks as well as any high-performance networks, narrow networks or ACOs proposed by the bidder.

### Section VI. Financial Proposal

<b>Responsible Parties:</b>	Willis Towers Watson
<b>Status Notes:</b>	Draft 1: Templates for financial proposal to be included within Draft 2

This section will require the bidders to present their administration fees and pricing for providing the State with the services included in their proposal. The section is subdivided into areas that request pricing for the State’s current health plans, plus any alternative plan configurations included in the bidders’ proposals. There will be separate appendices containing pricing worksheets for the bidders to complete that will outline all aspects of their financial proposals. In addition, the bidders will be asked to submit supplemental financial savings estimates for any proposed high-performance networks, ACOs, etc. they are proposing. Other sub-sections include one for the bidders to outline their financial assumptions and caveats, and another for the bidders to comment on their ability to accommodate a series of best-in-class performance guarantees proposed in this section of the RFP. Outside of the questionnaire and based upon location of State of Delaware members, Willis Towers Watson will perform an evaluation of the health care vendors’ network discounts for the non-Medicare population, using the Network Relative Performance Metrics (NetRPM) tool. Bidders will also be asked to provide their book-of-business discount information. Each bidder’s chief actuary will be required to sign off on the book-of-business discount information. In the event bids are received from a vendor that does not participate in NetRPM, the analysis will include the book-of-business discounts, in lieu of NetRPM for the entire bidding field, to ensure an apples-to-apples comparison of the discount relativities.

### Section VII. Attachments

<b>Responsible Parties:</b>	Willis Towers Watson
<b>Status Notes:</b>	Draft 1: In process of development

This section will include any additional data relevant to assisting the bidders in completing their proposals for the State, such as current plan designs, benefit plan documents (if required, beyond those publicly available on the State’s website), etc. It will also include a detailed census file with current GHIP participants and some additional details on the GHIP claims experience, which will be provided to bidders following receipt of each bidder’s intent to bid plus each bidder’s execution of a non-disclosure agreement.

**Section VIII. Appendices**

<b>Responsible Parties:</b>	Willis Towers Watson
<b>Status Notes:</b>	Draft 1: First draft of appendices included in the questionnaire

This section will contain pricing spreadsheets for the bidders to complete that outline all components of their financial proposals, for both “traditional” PPO/HMO-type plans as well as any proposed “alternative” health care delivery models (i.e., ACOs, patient-centered medical homes, etc.). This section will also include detailed worksheets for the bidders to report out on certain metrics approved by the Centers for Medicare & Medicaid Services that are performance measures for their proposed ACO arrangements, to the extent those are part of the bidders’ proposals to the State.