STATE OF DELAWARE
Department of Human Resources

Request for Proposal for Medical and Prescription Insurance Audit Services

Draft Scope of Services

September 23, 2024

Scope of Services

The SEBC desires to contract with an independent organization(s) specializing in auditing contract compliance for medical and prescription drug plans for clients of similar size as the State of Delaware's Group Health Insurance Plan (GHIP), which provides medical and prescription drug coverage to approximately 104,600 active State employees, non-State participating group employees and non-Medicare retirees and their eligible dependents, and approximately 30,100 Medicare retirees and their eligible dependents.

- The medical insurance component of the GHIP is self-insured and is administered by two third-party administrators (TPAs), Aetna and Highmark Delaware, and includes a third-party network of surgeons of excellence (also referred to as centers of excellence) administered by Employer Direct Healthcare ("SurgeryPlus program") that is available to plan participants enrolled in the State's non-Medicare medical plan options. Interested vendors must have experience with auditing Blue Cross Blue Shield plan contracts (ideally, with Highmark Delaware) along with experience auditing Aetna plan contracts. Experience auditing plan sponsor contracts associated with Employer Direct Healthcare is not required; the State is interested in exploring vendor capabilities and relevant experience with auditing claims that are associated with Centers of Excellence and/or that feature bundled payment arrangements and requests that any proposals that include these capabilities provide separate pricing for auditing those capabilities separate from the pricing provided for audits of Aetna and Highmark Delaware. Audit services would include reviews of both non-Medicare and Medicare medical plan options offered to benefits eligible employees.

- The prescription drug benefit component of the GHIP is self-insured. Pharmacy Benefit Manager (PBM) services are carved out and administered by CVS Health (CVS). Interested vendors must have experience with CVS. Audit services would include review of the State's commercial plan (for active employees and retirees not eligible for Medicare) and the Employer Group Waiver Program ("EGWP", for retirees eligible for Medicare).

Vendors may bid on either audit service or both (i.e., medical insurance contract compliance audits and/or prescription drug insurance contract compliance audits, or both). As noted above, proposals for medical insurance contract compliance audits that include proposed audit services for the SurgeryPlus program should provide pricing for that program separate from the pricing provided for audits of Aetna and Highmark Delaware.

The SEBC is interested in receiving proposals from organizations whose medical and prescription drug claim audit services focus on retrospective reviews of plan experience, which is consistent with the audit

services that the SEBC is receiving from its incumbent contract compliance auditor. Additionally, the SEBC is also interested in receiving proposals from organizations that have contract compliance review services that can support ongoing and real-time reviews of administrative claims and fees for the GHIP medical and pharmacy benefit programs.

The organization(s) must have prior experience directly related to the services requested in this RFP and must be able to demonstrate clearly their ability to perform the required scope of services within the timeline requested. Consulting (Willis Towers Watson) and analytic firms (Merative) that currently provide services to the State of Delaware GHIP are not eligible to bid.

The selected organization(s) shall be required to provide the following services, at a minimum:

- offer state of the art administrative services for contract compliance audits that occur either in real-time on an ongoing basis or retrospectively;
- provide excellent account management services to the Statewide Benefits Office (SBO), including timely reporting and support with addressing audit findings with the carriers;
- have a strong reputation and historical experience in the contract compliance audits conducted either in real-time on an ongoing basis or retrospectively;
- have strong capabilities to proactively identify and recover overpaid claims;
- provide a competitive financial proposal;
- provide performance guarantees; and
- be responsive to changes in the program and requests of the SEBC and the SBO.

Medical Contract Compliance Review Services

[Note for the SEBC: If the Committee decides to modify the requested contract term from a 3-year contract with two optional one-year renewal periods, then the following introductory paragraphs will be modified.]

The selected organization(s) shall provide contract compliance review services, with two aspects, for six one-year periods:

1. Non-Medicare Medical Plans (For active employees and retirees not eligible for Medicare; four plan options offered: PPO, HMO, CDH Gold with an HRA, and First State Basic which resembles a PPO)
    a. July 1, 2025 – June 30, 2026 (FY26), which would audit the FY25 medical plan year
    b. July 1, 2026 – June 30, 2027 (FY27), which would audit the FY26 medical plan year
    c. July 1, 2027 – June 30, 2028 (FY28), which would audit the FY27 medical plan year

2. Medicare Supplement Plan (For retirees eligible for Medicare)

a. January 1, 2025 – December 31, 2025 (Plan Year 2025), which would audit the medical plan year corresponding to Calendar Year 2024

b. January 1, 2026 – December 31, 2026 (Plan Year 2026), which would audit the medical plan year corresponding to Calendar Year 2025

c. January 1, 2027 – December 31, 2027 (Plan Year 2027), which would audit the medical plan year corresponding to Calendar Year 2026

The State will have the option of extending the contract with the selected organization(s) for two additional one-year periods, i.e., July 1, 2028 – June 30, 2029 (FY29) and July 1, 2029 – June 30, 2030 (FY30) for the non-Medicare medical plans, and January 1, 2028 – December 31, 2028 (Plan Year 2028) and January 1, 2029 – December 31, 2029 (Plan Year 2029) for the Medicare Supplement plan. The medical plan years that would be audited during each of those additional periods would correspond to the next plan year in accordance with the description above.

The selected organization(s) shall conduct contract compliance reviews of medical claims processed by the Plan's medical TPAs in accordance with the provisions and requirements under this RFP. The reviews should include but not be limited to the following that would occur either in real-time on an ongoing basis or retrospectively, depending upon the capabilities of the selected organization(s):

- **Electronic Review of All Claims (100%)** processed within the contract compliance review period should explore system capabilities and the accuracy of plan set-up. Queries should include, but are not limited to:
  - Potential duplication of payments or overpayments, including instances where duplicate payments are made by the medical carrier to the same provider as well as instances where duplicate payments are made by both the medical carrier and Employer Direct Healthcare to the same provider for services that were provided through the SurgeryPlus program;
  - Member eligibility (based on vendor's data file layouts);
  - Reimbursement of expenses excluded or limited by plan design;
  - Appropriate patient cost-shares (i.e., copayment, deductible, coinsurance);
  - Consistency in coordination of benefits, including subrogation and workers' compensation;
  - Validation of payments for services that are carved out from the medical carriers, such as bariatric surgeries, to confirm that the medical carriers are not paying for carved out services that are provided by other third-party administrators, such as Employer Direct Healthcare; and
  - Special programs such as limits and coinsurances on In-Vitro Fertilization.
- A **Target Claims Selection** (sample size for each vendor) is expected to validate the electronic query results. This is expected regardless of whether the contract compliance review happens in real-time on an ongoing basis or retrospectively.
- **Claim Sample** – Vendor proposals should clearly indicate the onsite claim review process. For example, is each sample reviewed for a single attribute or entirely from receipt through each step of processing for the following:
  - Provider submissions included necessary documentation to support the claim;
  - Claims were paid in strict accordance with Plan provisions;

- Established administrative procedures were followed and within industry guidelines;
- Claims were paid only for eligible individuals;
- Claims that required reviews, including pre-certification and utilization review for example, received appropriate evaluation;
- Third party recovery procedures, including coordination of benefits with Medicare and other group plans, were followed in accordance with plan provisions and standard insurance industry protocols;
- Amounts paid were within contracted or non-contracted allowances;
- Benefits were paid under the proper benefit classification, diagnostic, and procedure codes;
- Benefit limitations, deductibles, copays, coinsurance, and out-of-pocket maximums were properly applied;
- Requests for additional information were appropriate and did not result in unnecessary processing delays;
- Arithmetic calculations were correct, and payments were made to the proper party; and
- Duplicate claims have been properly denied.

❖ **Operational Review** to explore the day-to-day administrative policies, procedures, and internal quality control measures critical to minimizing financial loss and maintaining participant satisfaction levels. Review of the vendor's SOC reports is to be supplemented with a questionnaire specific to administration of the State's Plan, to be completed at least once during each plan year (i.e., it is not expected that this operational review will take please continuously if the selected organization(s) are reviewing claims in real-time on an ongoing basis). Topics include, but are not limited to:

- Divisions of staff and administrative functions assigned to the State Plan, with identification of any outsourced services;
- Eligibility receipt, timely update, reconciliation procedures, and system interfaces;
- Detection of other coverages (i.e., coordination with group and Medicare benefits, third-party centers of excellence vendors, workers' compensation, third party liability);
- System edits for detection of coding errors (i.e., unbundled or up-coded medical services, inconsistent drug codes) and alerts for claims requiring manual review and processing;
- Procedures employed to identify potential fraud and abuse (i.e., over utilization of physical therapy, over utilization of certain medical procedures/surgeries, etc.);
- Coordination with departments related to claim administration (i.e., medical review, preauthorization, case management); and
- Maintenance of provider files and fee schedules with distinction between contracted and non-network providers for medical claims, and application of appropriate generic vs. brand and formulary vs. non-formulary drugs.

❖ **Financial Comparison** of amount paid on the data file to amounts invoiced and paid by the State.

❖ **Written Report of Findings** presented in draft form to the respective administrator for review and comment. Their responses are to be incorporated into the final draft provided for the State's review. This written evaluation will be completed at least once during each plan year, with certain

components to be reported on a more frequent basis if the selected organization(s) will be reviewing claims in real-time on an ongoing basis, and will include:

- Objectives of the contract compliance review;
- Procedures taken to complete the contract compliance review;
- Number of claims examined and total paid amount of the claims;
- Number and dollar value of claims with financial errors and procedural errors expressed as a percentage of the total claims reviewed;
- Comparison of contract compliance review results to performance guarantees and industry standards;
- A description of the error categories found during the review with attention to systemic or human cause and required corrective measures;
- Recommendations to improve overall administration and/or claims processing accuracy;
- Evaluation of the vendor's policies and administration for managing claims costs to ensure that procedures support maximized savings;
- Identify error patterns or trends, identify causes, assess effects, and provide recommendations for corrections;
- Provide a table of payment errors with a clear description of the sampled error and/or other errors detected through review of the patient's history; the report should clearly identify those errors that were subject to internal review but bypassed detection;
- Include an action plan for overpayment validation of overpayments with the medical TPAs, recovery of overpaid amounts, including coordination with the medical TPAs for notification to providers/subscribers of overpaid amounts and to ensure claims history is updated as a result of the recovery of overpayments, and development of a process with the medical TPAs to report on proof that overpayments have been returned to the State; and
- Summary comments and recommendations for each plan regarding improving plan design to ensure that the State receives high quality services in a cost effective, timely manner.

❖ **Post-Audit Support** for resolving open issues with the TPAs, for at least 8 hours of support time per TPA. Vendors will be asked to quote on the incremental cost for the State to increase the number of hours for post-audit support.

Prescription Drug Contract Compliance Review Services

[Note for the SEBC: If the Committee decides to modify the requested contract term from a 3-year contract with two optional one-year renewal periods, then the following introductory paragraphs will be modified.]

The selected organization(s) shall provide contract compliance review services, with two aspects, for six one-year periods as follows:

1. Commercial Plan (Active employees and retirees not eligible for Medicare)
   a. July 1, 2025 – June 30, 2026 (FY26), which would audit the FY25 plan year

b. July 1, 2026 – June 30, 2027 (FY27), which would audit the FY26 plan year

c. July 1, 2027 – June 30, 2028 (FY28), which would audit the FY27 plan year

2. Employer Group Waiver Program (Retirees eligible for Medicare)

   a. January 1, 2025 – December 31, 2025 (Plan Year 2025), which would audit the plan year corresponding to Calendar Year 2024

   b. January 1, 2026 – December 31, 2026 (Plan Year 2026), which would audit the plan year corresponding to Calendar Year 2025

   c. January 1, 2027 – December 31, 2027 (Plan Year 2027), which would audit the plan year corresponding to Calendar Year 2026

The State will have the option of extending the contract with the selected organization(s) for two additional one-year periods, i.e., July 1, 2028 – June 30, 2029 (FY29) and July 1, 2029 – June 30, 2030 (FY30) for the Commercial Plan, and January 1, 2028 – December 31, 2028 (Plan Year 2028) and January 1, 2029 – December 31, 2029 (Plan Year 2029) for the Employer Group Waiver Program. The prescription drug plan years that would be audited during each of those additional periods would correspond to the next plan year in accordance with the description above.

The selected organization(s) shall conduct contract compliance reviews of pharmacy claims processed by the Plan's PBM in accordance with the provisions and requirements under this RFP. While the State's current contract with the Plan's PBM is reflective of a transparent arrangement requiring 100% pass-through of all retail network discounts and dispensing fees, the State reserves the right to change the basis of its PBM contract (e.g., move from a transparent arrangement to a cost-plus arrangement) at any point during the term of its contract with the selected organization(s). In the event such a change takes place, the State's expectation is that the scope of services may be updated to reflect any services typically associated with contract compliance reviews of other types of PBM pricing arrangements that would not otherwise be covered in the current scope of services. Additionally, the State's PBM is subject to additional mandates of House Bill 219[1] of the 151st General Assembly, which includes the requirement that brand drugs adjudicated in the State of Delaware are processed at the National Average Drug Acquisition Cost (NADAC) as well as other requirements.

The contract compliance reviews should include but not be limited to the following for the State's current PBM pricing arrangement:

- **Electronic Contract Compliance Review of all Prescription Transactions (100%)** (including specialty drugs) is expected to include the following review components and will occur either in real-time on an ongoing basis or retrospectively, depending upon the capabilities of the selected organization(s).
  - Independent verification that the appropriate prescription drug claims, specifically claims for brand drugs adjudicated in the State of Delaware, are being processed using NADAC pricing and that the NADAC price was accurate for the given time period;
  - Independent verification of average wholesale price (AWP), where applicable;

[1] Additional information about House Bill 219 of the 151st General Assembly is available at the following link: https://legis.delaware.gov/BillDetail?LegislationId=78800.

- Comparison of actual aggregate claim discounts, dispensing fees, and rebates to contractual guarantees;
- Comparison of actual claim adjudication to plan design and benefit rules;
- Member cost share;
- Member eligibility (based on vendor's data file layout);
- Duplicate claims;
- Coverage rules;
- Verification that claims are processing according to the terms and conditions of the PrudentRx program (Commercial Plan only); and
- Identification of contractual term improvement opportunities.

❖ **Operational Review** to explore the day-to-day administrative policies, procedures, and internal quality control measures critical to minimizing financial loss and maintaining participant satisfaction levels. Review of the vendor's SOC reports is to be supplemented with a questionnaire specific to administration of the State's Plan, to be completed at least once during each plan year (i.e., it is not expected that this operational review will take please continuously if the selected organization(s) are reviewing claims in real-time on an ongoing basis). Topics include, but are not limited to:

- Divisions of staff and administrative functions assigned to the State Plan, with identification of any outsourced services;
- Eligibility receipt, timely update, reconciliation procedures, and system interfaces;
- Detection of other coverages (i.e., coordination with group and Medicare benefits, workers' compensation, third party liability);
- System edits for detection of coding errors (i.e., unbundled or up-coded medical services, inconsistent drug codes) and alerts for claims requiring manual review and processing;
- Procedures employed to identify potential fraud and abuse (i.e., prescription refills filled too soon, higher than expected utilization/cost of compounds medication, etc.);
- Coordination with departments related to claim administration (i.e., medical review, preauthorization, case management);
- Maintenance of provider files and fee schedules with distinction between contracted and non-network providers for medical claims, and application of appropriate generic vs. brand and formulary vs. non-formulary drugs;
- Demonstration of policies and procedures in place to comply with the mandates of House Bill 219 of the 151st General Assembly; and
- Special programs such as In-Vitro Fertilization limits and coinsurance and diabetic programs.

❖ **Financial Comparison** of amount paid on the data file to amounts invoiced and paid by the State, in sufficient detail to verify the use of NADAC pricing for brand drugs processed in the State of Delaware and the impact of drug copay accumulator programs such as CVS PrudentRx for the Commercial Plan.

❖ **Rebate Review** should include all payments from manufacturers or other third parties to the PBM as they relate to the State's plan and will occur either in real-time on an ongoing basis or retrospectively,

depending upon the capabilities of the selected organization(s). The manufacturer payment and rebate comparison should include a comprehensive review that includes:

- Identification of all rebate-eligible claims and identification of categories properly excluded from rebates, according to the PBM contract;
- Verification of earned rebates by quarter by National Drug Code (NDC);
- Comparison of earned rebates file to manufacturer rebate submission file;
- Onsite review of applicable manufacturer contracts to verify all rebate amounts due are properly paid to the State; and
- Comparison of PBM receipts from manufacturers to earned rebate file.

- **MAC List Review** of the top fifty (50) drugs utilized (number dispensed during the review period) by the Plan to determine if MAC pricing is optimal for generic prescription drugs. While the State's PBM is required by Delaware Code to use NADAC pricing for drugs dispensed at pharmacies in Delaware, a MAC list review will still be within the scope of this audit in the event that the State's PBM continues to use MAC lists for out-of-state pharmacies and/or for the PBM's mail order pharmacy. This review will be completed at least once during each plan year.
- **Written Report of Findings** presented in draft form to the respective administrator for review and comment; their responses are to be incorporated into the final draft provided for the State's review. This written evaluation will be completed at least once during each plan year, with certain components to be reported on a more frequent basis if the selected organization(s) will be reviewing claims in real-time on an ongoing basis, and will include:
  - Objectives of the contract compliance review;
  - Procedures taken to complete the review;
  - Number of claims examined and total paid amount of the claims;
  - Number and dollar value of claims with financial errors and procedural errors expressed as a percentage of the total claims reviewed;
  - Comparison of results to performance guarantees and industry standards;
  - A description of the error categories found during the review with attention to systemic or human cause and required corrective measures;
  - Recommendations to improve overall administration and/or claims processing accuracy;
  - Identification of contractual term improvement opportunities; and
  - Summary comments and recommendations for each plan regarding improving plan design to ensure that the State receives high quality services in a cost effective, timely manner.
- **Post-Audit Support** for resolving open issues with the TPAs, for at least 8 hours of support time per TPA. Vendors will be asked to quote on the incremental cost for the State to increase the number of hours for post-audit support.