



State of West Virginia

Public Employees Insurance Agency

Medicare Advantage-Prescription Drug (MAPD)

Request for Proposal

December 21, 2006

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CHAPTER 1: INTRODUCTION

1.1 Program Background

The Public Employees Insurance Agency (PEIA) is responsible for administering health care benefits on behalf of approximately 35,000 Medicare retirees and dependents. The PEIA currently manages a traditional indemnity program for these covered Medicare primary members, coordinating their benefits with Medicare.

1.2 Clarification of Procurement Offering

The State of West Virginia is seeking proposals to provide a Medicare Advantage and Prescription Drug (MAPD) program to its Medicare primary policyholders. This request for proposal (RFP) will result in the State's retirees having sufficient access to Medicare providers across the country with the benefits as outlined in Appendix A available to them.

All MAPD proposals must be based on the benefits described in Appendix A with absolutely no variation permitted. It is understood that if CMS requires a certain benefit level that is superior to a benefit listed in Appendix A, then the CMS benefit should be applied. All benefits described in this Appendix A are subject to change. This RFP is written to allow for either a provider fee for service plan (PFFS) or a preferred provider organization plan offerings (PPO). Thus, any reference to physician networks, accessibility, level of specialists, etc., is in regards to PPO plans.

There may be more than one MAPD vendor selected from this RFP. Subcontracting will be permitted as long as all subcontractors meet CMS standards. All subcontracts must be in place prior to bidding. The MAPD plan must certify to PEIA that all subcontracts have been signed, are currently in effect and are consistent with CMS standards. Pending contracts are not acceptable.

PEIA reserves the right to allow its members, who are currently enrolled in the existing PEIA managed care plans, to be grandfathered into those managed care plans rather than being covered under the MAPD plan.

1.3 Participation Standards

1.3.1 Capitation

Chapter Three contains more information regarding capitation rates.



1.3.2 Contracts Issued

The PEIA will execute contracts with successful respondents independent of the WV Purchasing Division.

1.3.3 Contract Term

PEIA's plan year runs from July 1 to June 30 of each year. PEIA's intent is to enter into an initial contract for twelve (12) or eighteen (18) months, whichever is deemed by both parties to be more advantageous, effective July 1, 2007.

It is the intent of the PEIA to execute annual contract renewals rather than conduct a new procurement for the subsequent plan years. However, PEIA reserves the right to conduct new procurement in subsequent years.

The successful MAPD vendor must provide updated claim experience information and capitation requirements prior to a capitation rate renewal or contract renewal. Taking into consideration CMS' volatile payment rates, the MAPD plan must be able to supply PEIA with an annual, percentage range of increases for the capitation rates. Capitation rates may be renegotiated annually.

1.4 General Information for Applicants

The procurement officer for PEIA will be:

J. Michael Adkins
Deputy Director of Operations
West Virginia Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0710
Telephone: 304/558-6244, ext. 230
Fax: 304/558-4969



1.5 Procurement Schedule

The schedule below presents key milestone dates for the procurement. Additional information regarding procurement activities can be found in Chapter Four.

Proposed RFP Key Milestone Dates

<u>Milestone</u>	<u>Date/Time</u>
RFP Release	December 21, 2006
Mandatory Bidder's Conference (PEIA Offices)	January 4, 2007 10:00 AM EST
Deadline for Submission of Written Questions	January 5, 2007 COB 4:00 PM EST
Response to written Questions	January 10, 2007
RFP Addendum (if necessary)	January 10, 2007
Proposal Submission Deadline	February 2, 2007 COB 4:00 PM EST
Proposal Evaluations and Recommendation to Director	February 5 -16, 2007
Contract Negotiations	February 19 -28, 2007
Contract Effective Date	March 1, 2007
Educational Sessions	April – May 2007
MAPD Coverage Effective Date	July 1, 2007



CHAPTER 2: MAPD PARTICIPATION STANDARDS

2.1 General

This chapter describes the operational and financial standards with which The MAPD plan must comply in full. These standards reflect extensive efforts undertaken by the PEIA to align the requirements for The MAPD plan that serve the needs of the members of the PEIA.

2.2 Licensure/Certification/Accreditation

Participation in this procurement is limited to organizations that are properly certified by CMS to offer an MAPD on an at-risk, prepaid basis. Documentation of CMS accreditation must be submitted to PEIA.

PEIA requires the successful bidder to be capable of enrolling all PEIA Medicare primary retirees residing in the U.S. or abroad.

The successful bidder must also meet all applicable State and Federal laws, rules, and licensure requirements.

2.3 Health Plan Administration

In addition to CMS standards, the MAPD Plan must maintain sufficient administrative staff and organizational components to comply with all standards described in this RFP. This includes:

- Executive Management
- Medical Director's Office
- Accounting and Budgeting function
- Customer Service function
- Medical Claims processing function
- Availability of appeals processing located in Charleston, WV
- Management information systems
- Provider services function
- Auditing function (claims, administrative, operational)

Preference will be given to plans with a strong presence in West Virginia. The MAPD plan must, at a minimum, have an Account Representative located in Charleston, WV.

2.4 Eligibility

The categories of PEIA policyholders eligible for enrollment in the MAPD are described below. The PEIA is solely responsible for determining an individual's eligibility for participation in its health care programs. The MAPD plan is considered a program controlled by the PEIA.



2.4.1 Covered Lives

The PEIA will make available paid claims data for the last two fiscal years of the program to any applicant who requests it, attends the mandatory bidder's conference, and completes the limited data use agreement (Appendix F). The data can be obtained by completing the agreement and submitting it to J. Michael Adkins at the address listed in section 1.4 no later than the day of the mandatory bidder's conference. The data will not be released until the day of the mandatory bidder's conference as indicated in section 1.5.

2.4.2 Enrollment of Dependents

If there are two, or more, Medicare primary PEIA members in one family, each member will be enrolled as a policyholder. Dual eligible individuals shall be enrolled consistent with CMS requirements.

2.4.3 Member Termination

Generally, PEIA may terminate a member due to non-payment of premiums or upon the member's request, consistent with CMS rules.

2.5 Member Marketing and Enrollment Materials

Plan must comply with all applicable State, CMS and agency-specific laws, rules, policies or requirements regarding marketing. This includes, but is not limited to:

- Benefit Booklets
- Evidence of coverage
- Identification Cards
- Rights and responsibilities of enrollees
- Information regarding appeals

Marketing and promotional materials, with the exception of correspondence specific to an individual enrollee, must be submitted to PEIA for review and written approval prior to distribution. Materials must be pre-approved, in writing, by PEIA. Plans must allow PEIA at least 10 days for review and comment after draft materials are submitted. Any material problems or errors identified at any time in materials must be corrected by the MAPD plan as soon as the problems are identified. The MAPD plan will be responsible for all costs associated with printing and distribution.

2.6 Covered Services

The MAPD plan must promptly provide or arrange to provide all medically necessary services included in the covered benefit package and assume financial



responsibility for the provision of the services. The definition of medical necessity shall be consistent with that of CMS.

2.6.1 Member Liability

The MAPD plan cannot hold an enrollee liable for the following:

- The debts of the health plan if it should become insolvent;
- Payment for services (except for allowable cost sharing amounts) provided by the MAPD plan if the MAPD plan has not received payment from the PEIA or CMS, or if the provider, under contract or other arrangement with the MAPD plan, fails to receive payment from the MAPD plan; or
- Payments to providers that furnish covered services under a contract or other arrangement with the MAPD plan that are in excess of the amount that normally would be paid by the enrollee if the service had been received directly from the MAPD plan.

The MAPD plan is permitted to charge copayments and other cost sharing in amounts approved by the PEIA consistent with proposed benefit grid, included herein.

2.6.2 Preventive Services

The MAPD plan must provide clinical preventive services, consistent with CMS standards, as appropriate for age, sex and other risk factors and as recommended by the U.S. Preventive Services Task Force. Preventive services may include, but are not limited to:

- general physical examinations
- hypertension screening
- cholesterol screening
- screening for high blood sugar
- immunizations
- colorectal cancer screening
- prostate screening
- mammography
- Pap tests
- Sigmoidoscopy
- Other procedures known to either prevent disease or to detect disease in its early stage.

The MAPD plan must periodically remind and encourage enrollees to use those clinical preventive services which are available. Emphasis should be placed on the age-appropriateness of screenings and the recommended intervals for different



clinical preventive services. All preventive services must also be significantly linked to a corresponding disease management program, when applicable.

In addition to the required services, the MAPD plan is encouraged to provide supplemental preventive health and wellness services to their members. The PEIA has identified the following preventive services as priorities:

- General health/fitness dietary classes with targeted outreach for members at risk of cancer and heart disease or any other condition that could improve with lifestyle changes;
- Pneumonia and influenza immunizations for “at risk” populations.
- Screening for depression for members with chronic disease

In addition, the MAPD plan should identify any other Preventive Services offered beyond those listed above or CMS standards. If preventative services are available, the MAPD must clearly describe which tools are used in the performance of health risk assessments, identify any vendors used in providing these services, and provide sample materials used in educating the beneficiaries.

2.6.3 Coordinated Care and Disease Management

In addition to the Preventive Services, Coordinated Care and Disease Management Programs are also a priority of PEIA. The MAPD plan must provide various case management and disease management programs consistent with CMS standards and PEIA priorities. PEIA has identified the following areas as priorities:

- Diabetes;
- Tobacco cessation;
- Nutrition/exercise counseling, with targeted outreach for members with heart disease and diabetes, or any other condition that could improve using this type of counseling
- Weight Management
- Chronic Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Polypharmacy
- Chronic Kidney Disease
- Osteoporosis

The MAPD plan must identify all Disease Management programs offered. In addition, the MAPD Plan must provide details regarding the methodology used in the delivery of each of its programs, professional credentials of all individuals involved in the program (RN, RD, MD, etc.), program intensity, duration, and frequency of MAPD plan intervention with participants. Further, the MAPD plan must provide the programs’ format for written care plans, describe how it will report program results to PEIA, identify any vendors used in providing these



services, and provide sample materials used in educating the beneficiaries. The MAPD plan must also allow beneficiaries to participate, or continue participation, in PEIA managed Coordinated Care or Disease Management programs. In addition, the MAPD plan must also be willing to coordinate with the PEIA programs and refer beneficiaries to PEIA programs, when appropriate.

2.7 Provider Network (Where Applicable, Preferred Provider Organization Plan Networks)

If the MAPD plan is not a noncontracted PFFS model, The MAPD plan must establish and maintain provider networks with a sufficient number of providers and in geographically accessible locations for the populations they serve consistent with the CMS standards. The MAPD plan networks must contain all of the provider types necessary to furnish the prepaid benefit package, including: hospitals, physicians (primary care and specialist), behavioral health providers, allied health professionals, pharmacies, DME providers, etc. PEIA encourages the MAPD plan to use in-state providers when appropriate.

The MAPD plan must assure that persons and entities providing care and services on their behalf in the capacity of physician, dentist, physician assistant, registered nurse, other medical professional or paraprofessional, or other such persons or entities, satisfy all applicable licensing, certification, or qualification requirements under various state laws and that the functions and responsibilities of such persons and entities in providing benefit package services do not exceed those permissible under various state laws.

The MAPD plan shall encourage and foster cultural competency among their providers. Culturally appropriate care is care given by a provider who can relate to the enrollee and provide care with sensitivity, understanding and respect for enrollee's culture and background.

If the plan is considering or intends to make any changes within the contract year that would have a negative effect on a member with regard to access to providers, such change must be clearly disclosed in advance to the Director of PEIA for consideration.

MAPD Plans will receive additional points if network exceeds CMS requirements. The MAPD plan must clearly identify all network providers geographically.

2.7.1 Physicians

In the event networks are utilized, all network physicians must meet one of the following standards:

- Be Board-Certified or -Eligible in their area of specialty;



- Have completed an accredited residency program; or
- Have admitting privileges at a network hospital.

In addition, the MAPD plan must meet the minimum CMS requirements for the number of board-certified physicians within their network if a PPO plan is offered.

2.7.2 Primary Care Physicians

The insured's Primary Care Physician (PCP) can be a general practice doctor, family practice doctor, internist, pediatrician, geriatrician, or, for women in the plan, an OB/GYN. PCP copayments will be set at \$10. Office visit copayments for specialists will be \$20.

The MAPD plan must actively encourage the beneficiaries to utilize one PCP with the intent to connect insureds with a physician who can oversee and coordinate all of their care.

2.7.3 Member-to-Provider Ratios

Member-to-Provider ratios must comply with applicable CMS certification criteria for the following categories based on geographic access and CMS travel time requirements.

- Specialist Providers
- Behavioral health Providers
- Hospitals
- Ancillary Providers (i.e. Lab, DME)

2.7.4 Regarding Network Changes (Where Applicable)

In the event that the MAPD Plan has a significant change in its network and must report this change to CMS, it must concurrently report the event to PEIA.

2.8 Complaint, Grievance and Appeals Resolution

The MAPD plan must develop internal procedures to address organization determinations, complaints, grievances, and appeals consistent with applicable State and Federal Laws and CMS standards.

Also, the MAPD Plan must describe the employer/plan sponsor's role in its appeals process.



2.9 Medical Management and Quality Improvement

PEIA will have the right to conduct other on-site reviews to assess plan performance. PEIA also may, at its discretion, accept the findings of CMS or a national review organization (in lieu of a separate review) in any areas where a national review organization has found the plan to be in full compliance with its accreditation standards.

2.9.1 Medical Records Standards

The MAPD plan must have policies and procedures in place consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards for privacy and security of protected health information and any other applicable state or Federal law related to the privacy or security of information.

2.9.2 Utilization Review Procedures

The MAPD plan must develop and have in place utilization review policies and procedures, consistent with CMS requirements, which include protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims meeting pre-defined criteria. Plans also must develop procedures for identifying and correcting patterns of over- and under-utilization on the part of their enrollees.

2.9.3 Case Management and Care Coordination

The MAPD plan must have systems in place to ensure care coordination, consistent with CMS standards, including at a minimum:

- Management and integration of health care through Primary Care Physician or other means;
- Systems to assure referrals for medically necessary specialty, secondary and tertiary care;
- A system by which enrollees may obtain a covered service or services that the health plan does not provide or for which the plan does not arrange because it would violate a religious or moral teaching of the religious institution or organization by which the health plan is owned, controlled, sponsored or affiliated; and

The MAPD plan must provide coordination services to assist enrollees in arranging, coordinating and monitoring all medical and support services. The health plan must also designate an individual or entity to monitor and supervise enrollees with ongoing medical conditions, including coordination of hospital admission/discharge planning, post-discharge care and continued services.



2.9.3.1 Special Provisions for Members with Complex or Chronic Conditions

PEIA policyholders with complex and chronic conditions will enroll in the MAPD. Therefore, plans, excluding PFFS, must have chronic care improvement plans in place consistent with the CMS standards.

2.9.4 Quality Indicator Measures and Clinical Studies

In addition to the CMS requirements for quality, PEIA will establish performance standards consistent with those described in Appendix C.

2.9.4.1 Clinical and Non-Clinical Quality Improvement Projects

All clinical and non-clinical quality improvement programs must be conducted consistent with the CMS requirements for QI projects.

2.9.4.2 Medical Director

The MAPD plan must designate a Medical Director with responsibility for the development, implementation, and review of the internal quality assurance plan. The Medical Director's position need not be full time but must include sufficient hours to ensure that all Medical Director responsibilities are carried out in an appropriate manner. The MAPD plan also may use assistant or associate Medical Directors to help perform the functions of this office.

The Medical Director must be licensed to practice medicine in their respective state and must be board-certified in his or her area of specialty. The specific responsibilities of the Medical Director must include, but need not be limited to the following:

- Oversight of, or substantial participation in, the health plan's QA/QI Committee;
- Oversight of the development and revision of clinical standards and protocols;
- Oversight of the plan's prior authorization/referral process for non-primary care services;
- Oversight of the plan's recruiting, credentialing, and recredentialing activities;
- Reviewing potential quality of care problems and overseeing development and implementation of corrective action plans;
- Serving as a liaison between the plan and its providers; and



- Being available to the health plan's medical staff on a daily basis for consultation on referrals, denials, and complaints and appeals.

2.9.5 Confidentiality

All enrollee information, medical records, data and data elements collected, maintained or used in the administration of this contract shall be protected by the health plan from unauthorized disclosure. The MAPD plan must provide safeguards that restrict the use or disclosure of information concerning enrollees to purposes directly connected with the administration of this contract. The MAPD Plan selected will be considered part of an Organized Health Care Arrangement as defined in 45 CFR §160.103. As a result of this arrangement, "Protected Health Information" about the enrolled PEIA members can be disclosed by MAPD Plan to PEIA for "treatment," "payment," or "healthcare operations." These terms are defined in 45 CFR §164.501.

2.9.6 Records Retention

The MAPD plan must maintain books and records relating to their West Virginia PEIA managed care program services and expenditures, including reports to PEIA and source information used in preparation of these reports. These reports include but are not limited to financial statements, records relating to quality of care and medical records. In addition, The MAPD plan must agree to permit inspection of their records.

All financial and programmatic records, supporting documents, statistical records and other records of enrollees, which are required to be maintained by the terms of the contract, shall be retained for the entire period required by State and Federal law. If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the required retention period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the regular five years period, whichever is later. The health plan must agree to retain the source records for its data reports for a minimum of five years and must have written policies and procedures for storing this information.

2.9.7 External Monitoring and Evaluation

The PEIA and authorized representatives of the State, including, but not limited to, the State Auditor and other State and/or any applicable federal agencies providing funds, shall have the right, during the MAPD plan's normal operating hours, and at any other time a MAPD plan function or activity is being conducted, and within the provisions set forth under the requirements of HIPAA, to monitor and evaluate, through inspection or other means, the MAPD plan's performance and that of its network providers. During the contract period, access will be provided at all reasonable times. During the five-year post-contract period,



delivery of and access to records will be at no cost to the PEIA.

This includes, but is not limited to, assessments of the quality, appropriateness, and timeliness of services provided to PEIA enrollees, as well as focused clinical studies of acute and chronic health conditions determined to be of high priority to the PEIA, and audits of financial records. This also includes the performance of periodic medical audits and collection of management data to be conducted at least once per year. A thirty (30) day notice will be given prior to onsite visit.

2.10 Operational and Financial Data Reporting

The MAPD plan must provide the PEIA with uniform utilization, quality assurance, claims, grievance and other data on a regular basis as required by PEIA and/or CMS requirements.

2.11 Ownership of Data

To the extent that it is not in conflict with any provision of HIPAA, any data, member specific or otherwise, or any reports collected or prepared by The MAPD plan, in the course of performing their duties and obligations under this program, will be deemed to be owned by PEIA at all times. This provision is made in consideration of The MAPD plan's use of public funds in collecting and preparing such data, information, and reports. In addition, all proposals submitted in response to this RFP become the property of the PEIA and will not be returned.

2.12 Detailed Claims Data Submission

The MAPD plan must submit member level detailed claims payment data to the PEIA data warehouse consultant on a monthly basis. These data must be submitted in an electronic format stipulated by PEIA. The MAPD plan will be required to provide adequate information to allow for appropriate data mapping into PEIA's data warehouse.

2.13 Disclosure of Ownership and/or Control

The MAPD plan must report ownership and control and any other related information to PEIA.

2.14 Solvency Requirements

The MAPD plan must maintain a fiscally sound operation as demonstrated by the following:

- Licensed and in good standing with respective insurance regulatory authority.



- Maintaining adequate liquidity to meet all obligations as they become due for services performed under the provider agreement;
- Maintaining a positive net worth in every annual reporting period as evidenced by total assets being greater than total liabilities based on the health plan's audited financial statement. If the health plan fails to maintain a positive net worth, the plan must submit a financial corrective action plan outlining how a positive net worth will be achieved by the next annual reporting period; and
- Maintaining a net operating surplus in every annual reporting period based on the annual audited financial statement. If the health plan fails to earn a net operating surplus, it must submit a financial corrective action plan outlining how it will achieve a net operating surplus within available financial resources by the end of the next annual reporting period.
- The MAPD Plan must submit the last three years of audited financial statements.
- The MAPD plan must also submit the names of the three (3) largest contracts as well as the three (3) largest terminated contracts. This information should be provided using the forms in Appendix B.

If insolvency insurance protection is carried as a rider to an existing reinsurance policy, the conditions of the coverage must not exclude the MAPD plan's PEIA line of business.

The MAPD plan must notify PEIA within sixty (60) days if any changes are made to their insolvency protection arrangement.

2.15 MAPD Association with PEIA

2.15.1 Capitation Payments

The MAPD plan will be capitated, and therefore is at risk, for all services listed in the prepaid benefit package. PEIA will maintain records of all its respective enrollees and issue payment to the health plan for enrollees on a monthly basis. Payment will be issued based upon verified PEIA eligibility data. In the event of subsequent corrections to the number of enrollees, adjustments will be made in the month such errors are discovered, without interest. In no case will retroactive adjustments be made exceeding sixty (60) days. Capitation payments made 61 or more days beyond the beginning of any month shall have appropriate interest penalties applied.

The MAPD plan must present its capitation proposal alternatively as if it were the only plan selected and as if multiple plans were selected.



2.15.2 Member Contribution to Premiums

2.15.2.1 Employees

If Medicare primary employees share in the premium cost of the program, regular deductions from salaries or wages will be made by PEIA. The PEIA will issue payment to the MAPD plan.

2.15.2.2 Retired Employees

If retired employees share in the premium cost of the program, regular deductions from pension will be made or direct billing to the retiree will occur. The PEIA will issue payment to the MAPD plan.

2.15.2.3 Prohibition Against Billing Members

The MAPD plan and its sub-contractors or its contracted providers or providers that accept assignment (i.e. PFFS) shall not charge a PEIA enrollee for any covered service (subject to the appropriate authorization requirements) except for any cost identified as the enrollee's responsibility in the cost sharing schedule.

2.15.3 Third Party Liability

Pursuit of third party payment for services covered in the capitated benefit package is the responsibility of the MAPD plan, and MAPD health plan capitation rates will be established accordingly. The MAPD plan should utilize and require their subcontractors to utilize or pursue, whenever available, covered medical and hospital services or payments for PEIA enrollees available from other public or private sources. This responsibility includes accident and trauma cases that occur when a PEIA member is enrolled in the health plan. The MAPD plan will retain all funds collected as part of this activity.

Third party liability information must be submitted to the PEIA on an annual basis. PEIA will provide the data specifications and formats for these reports.

2.15.4 Prohibition of Balance Billing

The Omnibus Health Care Act enacted by the West Virginia Legislature in April 1989 applies to the PEIA and its primary members. This Law requires that any West Virginia health care provider who treats a PEIA insured must accept assignment of benefits and cannot balance bill the insured for any portion of charges over and above the PEIA fee allowance or for any discount amount applied to a provider's charge or payment, this is known as the "prohibition of balance billing."

Any provisions regarding balance billing and assignment acceptance from CMS



shall also be enforced by the MAPD plan.

2.16 MAPD Benefits

The MAPD must submit their proposals based on the benefits outlined in Appendix A with no variance. It is understood that if CMS requires a certain benefit level that is superior to a benefit listed in Appendix A, then the CMS benefit should be applied. All benefits described in this Appendix A are subject to change.

In the event your proposal entails a PPO or specific provider network, the out of network coinsurance and out of pocket maximum amounts will be twice that of the in-network amounts, along with varying penalty amounts.

The formulary of the proposals must be in compliance of CMS MAPD plan formulary standards and at a minimum, equivalent to that of the formulary utilized by PEIA PPB plan (Appendix E). The PEIA reserves the right to offer prescription drug coverage to Medicare primary retirees in the event it is determined to be financially advantageous to do so. The MAPD plan must submit proposals under both scenarios; the MAPD option and MA only option.

Further, the MAPD plan must allow for the grandfathering of existing Medicare Retirees' prescription drug coverage, at PEIA's discretion. For example, if a beneficiary is taking a prescription drug that is covered under the existing PEIA formulary and PEIA chooses an MAPD plan whose formulary does not include this particular drug, the MAPD plan must allow for coverage and/or a transition period for a drug that is included on the MAPD plan formulary. The MAPD Plan must clearly describe its plan to address this issue.

The PEIA also offers premium assistance programs to its retiree members who are at or below 250% of the Federal Poverty Level. These programs may impact some of the benefits offered in Appendix A.

CHAPTER 3: CAPITATION

3.1 PEIA Capitation Rates

3.1.1 General

Applicants must submit rate proposals, as described in Chapter Four, against which the PEIA contribution will be applied.

3.1.2 Determination of Member Contribution

PEIA members enrolled in the MAPD plan are required to pay a monthly premium. The contribution shall be equal to the difference between the



established MAPD plan capitation rate and the PEIA's maximum allowable capitation payment amount.

PEIA retiree member premiums are presently adjusted to the years of service of the policyholder, the date the individual retired and current financial condition, when applicable.

3.1.3 Paid Claims Data

The PEIA will make available paid claims data for the last two fiscal years of the program to any applicant who requests it, attends the mandatory bidder's conference, and completes the limited data use agreement (Appendix F). The data can be obtained by completing the agreement and submitting it to J. Michael Adkins at the address listed in section 1.4 no later than the day of the mandatory bidder's conference. The data will not be released until the day of the mandatory bidder's conference as indicated in section 1.5.

CHAPTER 4: PROPOSAL SUBMISSION REQUIREMENTS

4.1 Procurement Process Overview

4.1.1 Delivery

Proposals may be delivered in person or by certified mail to:

J. Michael Adkins
Deputy Director of Operations
West Virginia Public Employees Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0710

Applicants are responsible for ensuring the timely delivery of their proposals to PEIA office. Proposals delivered only to a mail room or to a ground floor security desk, and not delivered to PEIA offices by 4:00 PM will be subject to disqualification.

4.1.2 RFP Amendments

The PEIA reserves the right to amend this RFP at any time prior to the proposal due date by issuing written amendments.



4.1.3 Mandatory Bidder's Conference

The bidder's conference will be held at the PEIA at the address shown in Section 4.1.1 above. The purpose will be to allow the PEIA to respond to questions concerning the RFP, both technical and capitation.

Attendance at the bidder's conference is mandatory. Proposals will not be accepted from applicants who fail to attend.

Applicants are permitted to submit written questions for the conference prior to it. Questions may be mailed, faxed, or hand delivered to the address shown above in Section 4.1.1 and must be submitted in both hard copy and computer diskette (IBM compatible, Microsoft Word 2002 or earlier or WordPerfect Version 11.0 or earlier). All questions should be cross-referenced to the Section number of the RFP to which they relate.

The PEIA will distribute written answers to both the pre-submitted questions and questions received after the bidder's conference. The PEIA will also take questions at the conference itself, although the answers provided will not be binding until distributed in writing at a later date.

4.1.4 Contact with PEIA Representatives

Applicants are prohibited from communicating with any PEIA representatives regarding this procurement, except for the contact listed in Chapter One. This provision is not intended to restrict existing contractors from communicating with PEIA staff regarding ongoing operational matters.

4.1.5 Cost of Preparing Proposals

Applicants are solely responsible for the costs incurred in preparing and submitting their proposals.

4.1.6 Acceptance of Proposals

Each applicant may submit only one proposal. Each proposal may include both PFFS and PPO options. Applicants may withdraw and resubmit their proposals up to the submission deadline.

The PEIA will accept for evaluation all proposals that are complete and timely submitted. PEIA reserves the right to:

- Reject any proposals found to be incomplete or substantially non-responsive to the requirements described herein;



- Waive minor irregularities in proposals, provided such action is in the best interest of the PEIA. Where such waivers are granted, they will in no way modify the requirements of the RFP or the obligations of The MAPD plan awarded contracts through it;
- Award a contract(s), without or without negotiations, based on the terms, conditions, and premises of this RFP and the proposals of selected applicants;
- Request clarification or correction of proposals; and/or
- Reject any or all proposals received, or cancel part or all of this procurement, according to the best interest of the PEIA and its members.

4.1.7 Disposition of Proposals

Successful proposals will be incorporated into resulting contracts and will be a matter of public record. All materials submitted by bidders become the property of the PEIA, which may dispose of them as it sees fit. The PEIA shall have the right to use all concepts described in proposals, whether or not such proposals are accepted.

4.1.8 Proposal Composition and Copies

Health plan proposals will consist of two (2) parts:

- General Technical including a description of MAPD Plan and Benefits
- Capitation Proposal

Applicants must submit one original, eight (8) bound copies (three-ring binders are acceptable), one (1) unbound copy of their proposals and (1) electronic copy in a disk format. The original proposal should be identified as such on the cover. *All signatures in the original must be made in blue ink.*

Proposals must be segmented into General Technical and MAPD Plan and Capitation sections. Each section should be separately tabbed and clearly labeled. Every page of applicant proposals, except for section dividers, must be numbered, starting at “1” and continuing sequentially through each section. This requirement applies to exhibits and tables, as well as narrative. Applicants may number their proposals by hand.

4.2 General Technical Proposal

4.2.1 Format

Applicants must organize the General Technical section of their proposals as follows:



- Transmittal Form (B-1)
- Compliance with Participation Standards
- Other Technical Submission Forms (Forms B-2 to B-5)

4.2.2 Transmittal Form

The Transmittal Form should be placed at the very beginning of the General Technical section. It must be signed by an individual duly authorized to make commitments on the applicant's behalf. **Reminder:** *All original signatures must be signed in blue ink.*

4.2.3 Confidentiality of Proprietary Data

The MAPD plan must clearly identify which data are considered proprietary. If the PEIA receives a FOIA request for data, labeled by the MAPD plan as proprietary, the PEIA will notify the MAPD plan, in writing, of the request to allow the MAPD plan time to obtain the appropriate court order to prevent the release of the information. Otherwise, the PEIA will be compelled by state law to release such information.

4.3 Capitation Proposal

In this section, applicants must provide information regarding their financial status, as well as capitation rates for PEIA. Capitation rates must be reported in the format provided in Capitation Proposal Form.

4.3.1 Health Plan Financial Information

Applicants must provide the information listed below for the organization holding a license to operate as a health plan in West Virginia. If the licensed plan is owned by a parent corporation, all financial information must be provided for the parent as well. Also, the applicant must include a letter from the parent corporation indicating its willingness to furnish whatever financial support is necessary to assure the solvency of the plan's operations in West Virginia.

The applicant should provide as much detail and supporting documentation as it feels is warranted for the items listed below to support that it is a fiscally viable entity for purposes of this procurement:

1. Audited financial statements for the three most recent corporate fiscal years, and interim statements for the two most recent quarters for which statements are available. The statements must include a balance sheet, income statement, and a statement of cash flows. Audited statements must be complete with



opinions, notes, and management letters. This should include a SAS 70 Type II report. If no audited statements are available, explain why and submit unaudited financial statements and other supporting financial data.

2. Projected balance sheets, income statements, and monthly cash budget for the three-year period beginning January 1, 2007.

4.3.2 Capitation Rate Proposal and Benefit Package

4.3.2.1 Rate Submission

Applicants must submit capitation rates for the PEIA Medicare Primary Single Policyholder Plan. The MAPD plan must assume a 1% risk factor and submit a plan to validate risk factors in an effort to maximize capitation. The MAPD plan also must disclose the actual CMS risk factors on a quarterly basis, or as requested by PEIA. The Capitation Proposal Form (Appendix G) must be used to submit the capitation rate proposal.

4.3.2.2 Benefit Package

The PEIA is requiring applicants to develop a premium and submit benefits based on the benefit grid as outlined in Appendix A. It is understood that if CMS requires a certain benefit level that is superior to a benefit listed in Appendix A, then the CMS benefit should be applied. All benefits described in this Appendix A are subject to change.

4.3.2.3 PFFS/PPO

Applicants should clearly delineate on capitation forms whether the proposal being submitted is for a MAPD Private Fee-for-Service (FFS) or PPO product and if it is network or non-network. If an applicant is proposing to offer more than one type product, the benefit package information and forms should be submitted in their entirety for each product offered.

4.4 Proposal Evaluation

4.4.1 General

The PEIA will establish an evaluation committee to review proposals received in response to this RFP. Technical proposals will be evaluated on including, but not limited to, the following criteria:

- Geo Access – Adequate services available for all Medicare beneficiaries
- Location of Operations – preference is given to bidders demonstrating a strong presence in West Virginia.



- Implementation Plan – Demonstrated ability to effectively and efficiently take over coverage of Medicare eligible members.
- Percentage of total beneficiaries – If awarded the contract, what percentage of the PEIA covered lives will make up your total covered lives?
- Description of pharmacy benefits structure and formulary.
- Oral presentations and site visits – This may have an impact on the initial scoring in the other technical areas if a conflict arises.

4.4.2 Evaluation Criteria

The purpose of this section is to explain the criteria that will be used in evaluating the proposals. PEIA reserves the right to choose multiple vendors based on these criteria. Each proposing entity will be evaluated using these criteria, regardless of whether multiple vendors are chosen. As stated earlier, each proposing entity will submit the following items to be evaluated:

- Response to Participation Standards (Technical Proposal)
- Signature Page (See Appendix B)
- Cost Proposal (to be submitted sealed under separate cover)
- Signature Page (to be submitted under separate cover with the cost proposal)

The technical section of the proposals will be evaluated by a team of individuals determined by the PEIA Director. Consensus scoring will determine the final score for each proposal. This means that each member of the evaluation team must agree on the score for each and every item before the score is assigned.

The Cost Proposal must be submitted under separate cover and will be evaluated separately using the form in Appendix G. Vendors wishing to request preference for residency status must complete the Vendor Preference Certificate in Appendix D.

A point evaluation system has been designed. A total score of 100 points is possible for the technical and cost proposals combined. The technical proposal will represent 70 points (70%) of the total evaluation score while the cost proposal will represent 30 points (30%). Finalist presentations and site visits may be used to validate the information presented in the proposal. As such, information obtained during oral presentations and/or site visits may be used to adjust the technical scores.

Proposing entities will be selected for the finalist presentation if they obtain a minimum acceptable score for the service(s) they propose. The minimum acceptable score for each technical proposal will be set at 85% (70 points X 85% = **59.5 points**) of the total technical score.



4.4.3 Best Interest of the PEIA

Notwithstanding the evaluation process outlined herein, PEIA reserves the right to make award decisions based upon the best interest of the PEIA and its members.

4.4.4 Miscellaneous Provisions

The following provisions will be incorporated into any agreement entered into between PEIA and the successful bidder. The successful bidder will be asked to sign a form accepting the provisions described below.

4.4.4.1 Arbitration

Any references to arbitration contained in the agreement are hereby deleted. Claims against PEIA or the State of West Virginia arising out of the agreement shall be presented to the West Virginia Court of Claims.

4.4.4.2 Hold Harmless

Any clause requiring the Agency to indemnify or hold harmless any party is hereby deleted in its entirety. The successful bidder must indemnify and hold harmless the State of West Virginia and PEIA for its acts or omissions arising out of the contract.

4.4.4.3 Governing Law

The agreement shall be governed by the laws of the State of West Virginia. This provision replaces any references to any other State's governing law.

4.4.4.4 Taxes

Provisions in the agreement requiring the Agency to pay taxes are deleted. As a State entity, the Agency is exempt from Federal, State, and local taxes and will not pay taxes for any Vendor including individuals, nor will the Agency file any tax returns or reports on behalf of Vendor or any other party.

4.4.4.5 Payment

Any references to prepayment are deleted. Payment will be in arrears.

4.4.4.6 Interest

Should the agreement include a provision for interest on late payments, the Agency agrees to pay the maximum legal rate under West Virginia law. All other references to interest or late charges are deleted.



4.4.4.7 Recoupment

Any language in the agreement waiving the Agency's right to set-off, counterclaim, recoupment, or other defense is hereby deleted.

4.4.4.8 Fiscal Year Funding

Service performed under the agreement may be continued in succeeding fiscal years for the term of the agreement, contingent upon funds being appropriated by the Legislature or otherwise being available for this service. In the event funds are not appropriated or otherwise available for this service, the agreement shall terminate without penalty on June 30. After that date, the agreement becomes of no effect and is null and void. However, the Agency agrees to use its best efforts to have the amounts contemplated under the agreement included in its budget. Non-appropriation or non-funding shall not be considered an event of default.

4.4.4.9 Statute of Limitation

Any clauses limiting the time in which the Agency may bring suit against the Vendor, lessor, individual, or any other party are deleted.

4.4.4.10 Similar Services

Any provisions limiting the Agency's right to obtain similar services or equipment in the event of default or non-funding during the term of the agreement are hereby deleted.

4.4.4.11 Attorney Fees

The Agency recognizes an obligation to pay attorney's fees or costs only when assessed by a court of competent jurisdiction. Any other provision is invalid and considered null and void.

4.4.4.12 Assignment

Notwithstanding any clause to the contrary, the Agency reserves the right to assign the agreement to another State of West Virginia agency, board or commission upon thirty (30) days written notice to the Vendor and Vendor shall obtain the written consent of Agency prior to assigning the agreement.

4.4.4.13 Limitation of Liability

The Agency, as a State entity, cannot agree to assume the potential liability of a Vendor. Accordingly, any provision limiting the Vendor's liability for direct damages or limiting the Vendor's liability under a warranty to a certain dollar amount or to the amount of the agreement is hereby deleted. In addition, any



limitation is null and void to the extent that it precludes any action for injury to persons or for damages to personal property.

4.4.4.14 Right to Terminate

Agency shall have the right to terminate the agreement upon Ninety (90) written notice to Vendor.

4.4.4.15 Termination Charges

Any provision requiring the Agency to pay a fixed amount or liquidated damages upon termination of the agreement is hereby deleted. The Agency may only agree to reimburse a Vendor for actual costs incurred or losses sustained during the current fiscal year due to wrongful termination by the Agency prior to the end of any current agreement term. Upon termination of this agreement, or any extension thereto, the MAPD Plan has the duty to continue to provide any reports required by the agreement or any law or regulation. In addition, the MAPD plan is required to pay all claims incurred from the effective date of the agreement through the termination date, regardless of when the claims are received.

4.4.4.16 Renewal

Any reference to automatic renewal is hereby deleted. The agreement may be renewed only upon mutual written agreement of the parties.

4.4.4.17 Insurance

Any provision requiring the Agency to insure equipment or property of any kind and name the Vendor as beneficiary or as an additional insured is hereby deleted.

4.4.4.18 Right to Notice

Any provision for repossession of equipment without notice is hereby deleted. However, the Agency does recognize a right of repossession with notice.

4.4.4.19 Acceleration

Any reference to acceleration of payments in the event of default or non-funding is hereby deleted.

4.4.4.20 Amendments

All amendments, modifications, alterations or changes to the agreement shall be in writing and signed by both parties.



APPENDICES

APPENDIX A – Benefit Grid

All benefits described below are subject to change.

Benefit	PROPOSED PEIA MAPD Plan	
	In-Network	Out-of-Network
1 - Premium and Other Important Information	Premium varies \$0 Annual Deductible Maximum Out-of-pocket: \$500 for each member. All co-pays and coinsurance count towards the MOOP.	\$0 Annual Deductible Out-of-pocket maximum: \$1000 for each member. All co-pays and coinsurance count towards the MOOP except out of network per admission deductible.
2 - Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist, or hospital that accepts Medicare.	You may go to any doctor, specialist, or hospital that accepts Medicare, but will be responsible for the per admission deductible, higher copayments and out-of-pocket maximum.
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	20% coinsurance ; Substance Abuse is limited to 30 days per plan year; 2 outpatient days of partial hospitalization day programs services will be counted as 1 inpatient day when apply the 30 day max; Rehabilitation is limited to 150 days per plan year.	\$500 deductible per admission 40% coinsurance; Substance Abuse is limited to 30 days per plan year; 2 outpatient days of partial hospitalization day programs services will be counted as 1 inpatient day when applying the 30 day max; Rehabilitation is limited to 150 days per plan year. Additional \$10,000 deductible for transplants performed out-of-network.
4 - Inpatient Mental Health Care	20% coinsurance ; Substance Abuse is limited to 30 days per plan year; 2 days of partial hospital day program services will count as one (1) inpatient day.	\$500 deductible per admission 40% coinsurance; 2 days of partial hospital day program services will count as one (1) inpatient day.
5 - Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	20% coinsurance ; limited to 100 days per plan year	\$500 deductible per admission 40% coinsurance; limited to 100 days per plan year
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	20% coinsurance	40% coinsurance
7 - Hospice	20% coinsurance	40% coinsurance
8 - Doctor Office Visits	\$10 copay for Primary Care Physician office visit	40% coinsurance



	\$20 copay for specialist office visit	40% coinsurance after out-of-network deductible
9 - Chiropractic Services	20% coinsurance for acute treatment by manipulation; \$20 copay applies to the office visit. Subject to 20 visit max. 20 visit max includes any combination of Chiropractic Services, acupuncture, Physical Therapy, Occupational Therapy, Speech, vision therapy.	40% coinsurance for acute treatment by manipulation; subject to 20 visit max. 20 visit max includes any combination of Chiropractic Services, acupuncture, Physical Therapy, Occupational Therapy, Speech, vision therapy.
10 - Podiatry Services	\$20 copay office visit only Other 20% coinsurance . Routine care covered for diabetic patients.	40% coinsurance
11 - Outpatient Mental Health Care	20% coinsurance ; 20 visits per plan year. 20 visit limit includes substance abuse care.	40% coinsurance; 20 visits per plan year . 20 visit limit includes substance abuse Care.
12 - Outpatient Substance Abuse Care	20% coinsurance ; 20 visits per plan year ; 20 visit limit includes mental health care.	40% coinsurance; 20 visits per plan year . 20 visit limit includes mental health care.
13 - Outpatient Services/Surgery	\$50 copay + 20% coinsurance	\$100 copay, then 40% coinsurance
13 a) Office surgery	20% coinsurance	40% coinsurance
14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	40% coinsurance
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	\$25 copay + 20% coinsurance \$50 copay + 20% coinsurance (non-emergency)	\$50 copay + 40% coinsurance \$100 copay + 40% coinsurance
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance	40% coinsurance
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance ; limited to 20 visits per plan year for a combination of all outpatient therapy services Includes vision therapy, chiropractor, speech therapy, Physical Therapy, Occupational Therapy, acupuncture.	40% coinsurance; limited to 20 visits per plan year for a combination of all outpatient therapy services Includes vision therapy, chiropractor, speech therapy, Physical Therapy, Occupational Therapy, acupuncture.
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	40% coinsurance



19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	40% coinsurance
20 - Diabetes Self-Monitoring Supplies (includes coverage for test strips, lancets, and self-management training)	Covered Under Prescription Drug Plan; glucose monitors are not covered under the medical or prescription drug plan. They are provided to the member at no charge.	Covered Under Prescription Drug Plan; glucose monitors are not covered under the medical or prescription drug plan. They are provided to the member at no charge, but only if received from a network pharmacy.
21 - Diagnostic Tests, X-Rays, and Lab Services	20% coinsurance	40% coinsurance
22 - Bone Mass Measurement (for people who are at risk)	20% coinsurance for BMI covered once every 24 months if member meets criteria	40% coinsurance
23 - Colorectal Screening Exams (age 50 and older)	Covered at 100% if members meets criteria	40% coinsurance
24 - Immunizations (Flu vaccine, Hepatitis B vaccine - for people who are at risk, Pneumonia vaccine)	There is no co-payment for the Pneumonia and Flu vaccines. You pay 20% of Medicare-approved amounts for the Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Please contact your doctor for further details.	40% coinsurance
25 - Mammograms (Annual Screening) (for women age 40 and older)	Covered in Full	40% coinsurance
26 - Pap Smears and Pelvic Exams	Pap smear is covered at 100%; pelvic and office visit are subject to the \$10 copay ; this benefit is covered annually	40% coinsurance
27 - Prostate Cancer Screening Exams (for men age 50 and older)	There is no co-payment for approved lab services; the \$10 copay applies to the office visit	40% coinsurance
28 - Prescription Drugs	\$75 individual deductible. \$5/\$15/\$50. If a generic is available the Brand name drug cost is \$5 plus the difference between the generic and brand drug. Maintenance Medication is in 90-day supplies for 2 copays. Out of Pocket maximum is \$1,750 individual.	\$75 individual deductible. \$5/\$15/\$50 plus \$3 out-of-network fee if drugs are purchased out of network. If a generic is available the Brand name drug cost is \$5 plus the difference between the generic and brand drug, plus the \$3 out-of network fee if applicable. Maintenance Medication is in 90-day supplies for 2 copays. Out of Pocket maximum is \$1,750 individual.



29 - Dental Services	20% coinsurance ; Impacted teeth and accident-related only; accident related must be within 6 month of accident for least expensive professionally acceptable alternative treatment	40% coinsurance; impacted teeth and accident-related only; accident related must be within 6 month of accident for least expensive professionally acceptable alternative treatment
30 - Hearing Services	You pay 100% for routine hearing exams and hearing aids. You pay 20% of Medicare-approved amounts for diagnostic hearing exams.	You pay 100% for routine hearing exams and hearing aids. You pay 40% of Medicare-approved amounts for diagnostic hearing exams.
31 - Vision Services	Routine vision services are not covered. You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. If at risk, you are covered for annual glaucoma screenings. You pay 20% of Medicare-approved amounts for diagnostic.	Routine vision services are not covered. You are covered for one pair of eyeglasses or contact lenses after each cataract surgery. If at risk, you are covered for annual glaucoma screenings. You pay 40% of Medicare-approved amounts for diagnostic services.
32 - Physical Exams	\$10 Copay for PCP office visits, including one physical exam every 2 years; more often if recommended by your physician	40% coinsurance
33 - Health/Wellness Education	Eligible to participate in wellness screenings	
34 - Transportation (Routine)	Not Covered	Not Covered
35 - Acupuncture	20% coinsurance subject to 20 visit max. 20 visit max includes any combination of Chiropractic Services, acupuncture, Physical Therapy, Occupational Therapy, Speech, vision therapy.	40% coinsurance; subject to 20 visit max. 20 visit max includes any combination of Chiropractic Services, acupuncture, Physical Therapy, Occupational Therapy, Speech, vision therapy.
36 - Optional Supplemental Benefits	Vision and dental offered through Flexible Benefits. PEIA offers this coverage on a voluntary basis. Member pays 100% of costs.	Vision and dental offered through Flexible Benefits. PEIA offers this coverage on a voluntary basis. Member pays 100% of costs.
37 - Transportation / Lodging / Meals (For Transplant Services Only)	Up to \$5,000 per year for travel, meals and lodging for patient and family member <i>or</i> friend.	Not Covered.



APPENDIX B – Transmittal Forms

B-1 Transmittal Form

I hereby attest to the following on behalf of _____:

- We have read, understand, and are able and willing to comply with all standards and participation requirements described in the RFP for the programs in which we are applying to participate, as well as in the corresponding contracts;
- All of the information contained in this proposal is accurate and truthful to the best of our knowledge;
- If proposing to participate in the PEIA program, our capitation rates have been approved by the CMS (or respective state's insurance regulatory authority, if applicable) and were developed independently, without collusion, conflict of interest, consultation, communication, or agreement for the purpose of restricting competition, as to any matter relating to such rates with any other applicant, prospective applicant or competitor. Our capitation rates further have not been knowingly disclosed prior to award, either directly or indirectly, to any other applicant or competitor;
- This proposal will be held firm until at least June 30, 2007; and
- Neither we, nor any of our representatives have paid, agreed to pay, or will pay directly or indirectly to any person, firm, or corporation any money or valuable consideration for assistance in procuring or attempting to procure the agreement(s) referred to herein.

Signature

Name (Print)

Title

Date

Applicant point of contact regarding proposal:

Name: _____

Title: _____

Tel: _____

Fax: _____



B-2 – Top Three Clients Form

Instructions to Applicants: Complete the chart, listing your top 3 clients/groups starting with the largest number of covered lives (other than PEIA). Include current phone number and address for contact persons. Points will be deducted for failure to provide contact information.

	Client/Group	Number of Enrollees	Initial Offer Date	Contact Name	Address	Telephone Number
1						
2						
3						

B-3 – Terminated Contracts Form

Instructions to Applicants: Complete the chart below, listing the 3 largest all groups with 25 or more enrollees that have terminated their contracts with your plan since December 31, 2003. Include current phone number and address for of cooperative contact persons. Points will be deducted for failure to provide contact information.

	Client/Group	Number of Enrollees	Initial Offer Date	Contact Name	Address	Telephone Number
1						
2						



3						
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B-4 – Plan Management Form

Instructions to Applicants: Identify the Account Team that will be devoted to PEIA. Also indicate whether the position is salaried or contracted. Include up-to-date resume for each individual (or a job description for vacant positions) behind this form.

Position	Name	Date of Hire	% FTE PEIA	Check the Appropriate Box	
				Salaried	Contracted
CEO/Executive Director					
CFO					
Medical Director					
QA/QI Director					
UM Director					
Member Services Director					
Provider Services Director					
Complaints/Grievances Director					
Claims Director					



MIS Director					
Other:					

B-5 – Staffing Form

Instructions to Applicants: Indicate the number of non-clerical, non-secretarial FTEs employed or contracted in each of these areas. Also indicate the number of additional FTEs anticipated for hire/contracting if awarded a contract in all regions bid.

Function	Current FTE Count	Additional to Hire	Total	% of Total to be Devoted to PEIA
Accounting and Budgeting				
Medical Director's Office				
QA/QI				
Medical Management				
Member Services				
Provider Services				
Complaints/Grievances				



Claims				
MIS				



APPENDIX C – Performance Standards and Penalties

Medical Claims Quality

Financial Error Claim is one either incorrectly settled with respect to dollar amount or incorrectly settled, in whole or in part, with respect to a wrong payee. No claim shall be declared a financial error claim if incorrect (actual) settlement amount differs from corrected (audited) settlement amount by less than one dollar.

Financially Correct Claim is a claim which is not a financial error claim.

Financial Accuracy Amount is 100% for any settled claim, which is not a financial error claim. If a financial error claim is one involving a wrong payee, then the financial accuracy amount is the amount of claim settlement directed to the wrong payee.

Quality performance measurements with respect to financial error claims and related financial accuracy amounts shall be based on MAPD Plan's quarterly internal audit and shall be reported quarterly to PEIA. MAPD Plan will audit a statistically valid random sample of all settled claims for each quarterly audit period. Performance measurements reported to the PEIA shall be based on the entirety of that sample. Sample size and performance measurements shall be reported to the PEIA quarterly.

Two quarterly performance measurements shall be calculated each quarter as follows (N denotes the audit sample size):

$$Q1 - \text{Financially Correct Claim Percent} = 100 * (1 - (\text{Number of Financial Error Claims}/N))$$

Financially Correct Claim Percent (Q1) is rounded to two decimals in order to determine the performance standard and penalty amount, if applicable.

$$Q2 - \text{Financial Accuracy Amount Percent} =$$

$$100 * (1 - (\text{Sum of Financial Accuracy Amounts}/\text{Sum of Audit Claim Settlement Amounts}))$$

Financial Accuracy Amount (Q2) is rounded to two decimals in order to determine the performance standard and penalty amount, if applicable.

Timeliness

Claim turnaround time is defined as the number of working days after the date the claim is received until the date the claim is finalized. Finalized claims include those which are read for release of payments, denied, applied to deductible, closed, or referred to PEIA for handling.



For example, a claim received on Tuesday and finalized on the next day, Wednesday, has a turnaround time of one day. Similarly, that same claim finalized, instead, on the Tuesday one week hence, would have a turnaround time of five days.

Claim turnaround time should be calculated by reference to the “Turnaround Days” and “Number of Claims – Cumulative %” columns in a report which will be produced each quarter. For purposes of this performance standard and corresponding measurement, this report will exclude all claims, which are either adjustments or claims which were delayed in processing at the request of the PEIA as a result of PEIA actions or in accordance with the Plan.

The following timeliness performance measurement shall be calculated each quarter:

Percent of Claims Finalized in Twelve (12) Working Days (T1) = Turnaround time (T1) will be rounded to two decimals in order to determine performance standard and penalty amount, if applicable.

Telephone Responsiveness

Telephone responsiveness shall be calculated each quarter under the following three (3) performance measurements:

Abandonment Percentage

Telephone responsiveness for both provider and member customer service inquires shall be measured by the Summary Abandonment Rate Percentage Report, which will be produced each quarter. The abandonment rate percentage is denoted as A1. The abandonment rate percentage (A1) is rounded to two decimals in order to determine the performance standard and penalty amount, if applicable.

Average Speed of Answer

Telephone responsiveness for both provider and member customer service inquires shall also be measured by a report using the MAPD Plan’s call center software. S1 will denote the average speed of answer and will be rounded to two decimals in order to determine the performance standard and penalty amount, if applicable.

Blockage Percentage

Telephone responsiveness for the entire toll free line shall also be measured by a report using the MAPD Plan’s call center software, which will be produced each quarter. The blockage percentage is denoted as B1. The blockage percentage will be rounded to two decimals in order to determine the performance standard and penalty amount, if applicable.



Penalty Calculations

- The MAPD Plan shall be subject to penalties for the following performance measurements:
- Financially Correct Claims Percentage (Q1)
- Financial Accuracy Percent (Q2)
- Percent of Claims Finalized in 12 Working Days (T1)
- Telephone Calls Abandonment Percentage (A1)
- Average Speed of Answer in Seconds (S1)
- Blockage Percentage (B1)

The penalty amount is determined by multiplying the average number of members during the quarter by the respective rates described below. Said performance penalties apply only for claims received during the contract. Required performance standards and penalties applied when performance standards are not met are:

<u>Performance Standard</u>	<u>Rating</u>	<u>Penalty</u>	<u>Rating</u>	<u>Penalty</u>
Q1 98%	96%-98%	\$0.35	less than 96%	\$0.50
Q2 At least 99.5%	96%-98%	\$0.35	less than 96%	\$0.50
T1 At least 92%				\$0.50
A1 5% or less				\$0.25
S1 30 seconds or less				\$0.25
B1 1% or less				\$0.25

Consideration will be given the MAPD PLAN for the 1st quarter’s performance standards with regard to the application of the financial penalties.

Pharmacy Claims Quality

Service Performance Guarantees	Standard	Penalty
1. Network Size	At least 93% of members will have 1 network pharmacy within 10 miles if any retail pharmacy is available in that distance. MAPD Plan shall perform a GeoAccess analysis of members upon request of PEIA, and shall notify PEIA any time the number of	\$60,000 for the year in which access is not met. Performance will be reported quarterly, if applicable. Penalties, if any, will



	network pharmacies in West Virginia decreases by 3% or more	be paid annually.
2. Retail Point-of-Sale Claims Adjudication Accuracy	MAPD Plan guarantees a financial accuracy rate of at least 98% for all Rx claims processed at point-of-sale.	\$60,000 for the year in which this standard is not met. Performance will be measured by an annual audit conducted by PEIA
3. Point-of-Sale Network System Downtime	MAPD Plan guarantees that the Anchor claims processing system will be operating at least 99.5% of scheduled uptime of 162 hours per week, as measured annually on the MAPD Plan book-of-business.	\$60,000 for the year in which this standard is not met. Performance will be reported quarterly. The guarantee will be measured and penalties, if any, will be paid annually.
4. Reporting Requirements	MAPD Plan guarantees that all claims information will be available for electronic reporting within 10 business days after billing, and that Executive Reports and Performance Guarantee Reports will be available 45 days after the end of the calendar quarter	\$5,000 for any month in which this standard is not met. This guarantee will be measured monthly and reported quarterly. Penalties, if any, will be paid quarterly.
5. Desk Audits	MAPD Plan will perform desk audits on at least 10% of network pharmacies each year.	\$60,000 for the year in which this standard is not met. Performance will be reported quarterly and measured annually. Penalties, if any will be paid annually.
6. On-Site Audits	MAPD Plan will perform on-site audits of at least 10% of West Virginia pharmacies that are identified in desk audits as outliers, according to a mutually agreed-upon definition of outlier	\$60,000 for the year in which this standard is not met. Performance will be reported quarterly and measured annually. Penalties, if any will be paid annually.
7. Call Answering Time	MAPD Plan guarantees that the average speed of answer (ASA) of member calls will not exceed 30 seconds, excluding calls abandoned before answering.	\$5,000 for any month in which this standard is not met. This guarantee will be measured monthly and reported



		quarterly. Penalties, if any, will be paid quarterly.
8. Call Abandonment Rate	Not more than 3% of member calls will be abandoned. Abandoned calls do not include outages caused by phone company.	\$5,000 for any month in which this standard is not met. This guarantee will be measured monthly and reported quarterly. Penalties, if any, will be paid quarterly.
9. Turnaround time on Correspondence	MAPD Plan shall respond to all correspondence from recipients and providers within an average of five (5) business days.	\$5,000 for any month in which this standard is not met. This guarantee will be measured monthly and reported quarterly. Penalties, if any, will be paid quarterly.
10. Mail Order	MAPD Plan will guarantee that all mail service prescriptions will be shipped within an average of 5 business days or less from receipt by MAPD Plan.	\$5,000 for any month in which this standard is not met. This guarantee will be measured monthly and reported quarterly. Penalties, if any, will be paid quarterly.



APPENDIX D- Vendor Preference Certificate

Certification and application* is hereby made for Preference in accordance with West Virginia Code, §5A-3-37.

West Virginia Code, §5A-3-37, provides an opportunity for qualifying vendors to request (at the time of bid) preference for their residency status. Such preference is an evaluation method only and will be applied only to the cost bid in accordance with the *West Virginia Code*. This certificate for application is to be used to request such preference. PEIA will make the determination of the Resident Vendor Preference, if applicable.

A. Application is made for 2.5% preference for the reason checked:

___ Bidder is an individual resident vendor and has resided continuously in West Virginia for four (4) years immediately preceding the date of this certification;

or

___ Bidder is a partnership, association or corporation resident vendor and has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification; or 80% of the ownership interest of Bidder is held by another individual, partnership, association or corporation resident vendor who has maintained its headquarters or principal place of business continuously in West Virginia for four (4) years immediately preceding the date of this certification;

or

___ Bidder is a nonresident vendor which has an affiliate or subsidiary which employs a minimum of one hundred state residents and which has maintained its headquarters or principal place of business within West Virginia continuously for the four (4) years immediately preceding the date of this certification.

B. Application is made for 2.5% preference for the reason checked:

___ Bidder is a resident vendor who certifies that, during the life of the contract, on average at least 75% of the employees working on the project being bid are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid;

or

___ Bidder is a nonresident vendor employing a minimum of one hundred state residents or is a nonresident vendor with an affiliate or subsidiary which maintains its headquarters or principal place of business within West Virginia employing a minimum



of one hundred state residents who certifies that, during the life of the contract, on average at least 75% of the employees or Bidder's affiliate's or subsidiary's employees are residents of West Virginia who have resided in the state continuously for the two years immediately preceding submission of this bid.

Bidder understands if the Secretary of Tax & Revenue determines that a Bidder receiving preference has failed to continue to meet the requirements for such preference, the Secretary may order the Director of Purchasing to: (a) rescind the contract or purchase order issued; or (b) assess a penalty against such Bidder in an amount not to exceed 5% of the bid amount and that such penalty will be paid to the contracting agency or deducted from any unpaid balance on the contract or purchase order.

By submission of this certificate, Bidder agrees to disclose any reasonably requested information to PEIA and authorizes the Department of Tax & Revenue to disclose to the PEIA Director appropriate information verifying that Bidder has paid the required business taxes, provided that such information does not contain the amounts of taxes paid nor any other information deemed by the Tax Commissioner to be confidential.

Under penalty of law for false swearing (West Virginia Code, §61-5-3), Bidder hereby certifies that this certificate is true and accurate in all respects; and that if a contract is issued to Bidder and if anything contained within this certificate changes during the term of the contract, Bidder will notify the Purchasing Division in writing immediately.

*Check any combination of preference consideration(s) in either "A" or "B", request up to the maximum of 5% preference for both "A" and "B".



APPENDIX E – Preferred Drug List

NEW Plan Year 2007 Preferred Drug List Goes Into Effect January 1, 2007

Following is a list of the most commonly prescribed drugs on the West Virginia Public Employees Insurance Agency (PEIA) preferred drug list. It is an abbreviated version of the drug list that is at the core of the PEIA pharmacy benefit plan. The list is not all-inclusive and does not guarantee coverage. In addition to using this list, you're encouraged to ask your doctor to prescribe generic drugs whenever possible. **THIS LIST WILL BE EFFECTIVE January 1, 2007 and IS SUBJECT TO CHANGE.**

KEY

Following is a list symbols used on this list, as well as the explanation for each:

[G] indicates that a generic is available for at least one or more strengths of the brand medication.

[PA] indicates Prior Authorization is required.

[PA*] indicates Step Therapy.

[PA**] indicates Prior Authorization is required for dependents for medical necessity.

[QLL] indicates Quantity Level Limits.

[SP] indicates specialty product with \$50 copay per 30 days supply

[PA\$] indicates that Step Therapy and \$30 copay apply

For the member: Generic medications contain the same active ingredients as their corresponding brand name medications, although they may look different in color or shape. They have been FDA-approved under strict standards.

For the physician: Please prescribe preferred products and allow generic substitutions when medically appropriate.

PLEASE NOTE: the * next to a drug signifies the drug is subject to non-preferred status when generic becomes available throughout the year.

Brand name drugs are listed in CAPITAL letters.

A

ABILIFY
ACTIVELLA
ACTONEL
ACTONEL
W/CA
ACTOS
ACTOPLUS MET
acyclovir
ADDERALL XR* [G]
ADVANCED
NATALCARE
ADV AIR DISKUS
ADVICOR [PA*]
ALDARA
ALINIA
ALKERAN
allopurinol
ALPHAGAN P
ALORA
alprazolam
AMBIEN*
AMBIEN PAK
aminophylline
amitriptyline
amox t/potassium
clavulanate
amoxicillin
amphetamine salt
ANDRODERM
ANDROGEL
ANTABUSE
ARANESP [PA], [SP]
ARICEPT
ASACOL
ASTELIN
atenolol
atenolol/
chlorthalidone
ATROVENT/ HFA
AV ANDAMET
AV ANDIA

AVELOX, ABC PACK
AVODART
azithromycin

B

BAYER
ASCENSIA
ELITE
TEST STRIPS
BAYER
ASCENSIA
AUTODISC
TEST STRIPS
BAYER
MICROFILL
TEST STRIPS
benazepril/ hetz
benzonatate
BENICAR/HCT [PA*]
BETASERON [SP]
bisoprolol fumarate/hetz
bimonidine tartrate
bromfenex,-PD
bumetanide
bupropion
bupropion sr
buspirone hcl
butalbital/appap/caffeine
BYETTA

C

CAPITAL W/CODEINE
captopril
CARAFATE SUSP
carbamazepine
CARBATROL
carisoprodol
cartia xt
CASODEX
cefaclor
cefuroxime

CELLCEPT
CELONTIN
CETROTIDE [SP]
choline mag
trisalicylate
cimetidine
ciprofloxacin
CIPRODEX
CIPRO HC
citalopram
clarithromycin
clidinium/
chlordiazepoxide
CLIMARA PRO
clindamycin
phosphate
clobetasol
propionate
clonidine hcl
clotrimazole
clotrimazole/
betamethasone
COLAZAL*
COMBIVENT
CONCERTA*
COREG*
CREON [G]
CRESTOR [PA*]
cromolyn sodium
cyclobenzaprine
cyclosporine,
modified
CYMBALTA[PA*]

D

dantrolene sodium
DAPSONE
DEPAKOTE
desmopressin
acetate
desogestrel- ethinyl
estradiol [PA**]

desoximetasone
DESOXYN
dextroamphetamine
sulfate
DIAMOX SEQUELS
dicyclomine hcl
diclofenac sodium
diflunisal
diltiazem, er
DIOVAN/HCT [PA*]
DITROPAN XL* [G]
DOVONEX

E

EFFEXOR XR [PA*]
EMEND [QLL]
enalapril maleate, hetz
erythromycin
erythromycin
/benzoyl perox

ESTINYL

estradiol
ESTRING
estropiate
ethinyl estradiol [PA**]
ethinyl estradiol-
levonorgestrel [PA**]
EVISTA
EXELON

F

FEMARA
fentanyl citrate [PA]
FINACEA
finasteride
FLOMAX
FLOVENT*
ROTADISK
FLOVENT HFA
fluocinonide
fluconazole [PA]

fluorouracil
fluoxetine hcl
flurazepam
flutamide
fluticasone
fluvoxamine
FOLTX
FORADIL
FORTEO [PA],[SP]
FOSAMAX/Plus D

G

gabapentin
GABTRIL
GANTRISIN SUSP.
gemfibrozil
gentamicin sulfate
glipizide
glyburide
GRIFULVIN V TAB
guaifenesin la

H

haloperidol
homatropine
hydrobromide
HUMALOG (vials
only)
HUMATROPE
[PA],[SP]
HUMULIN (vials
only)
hydrochlorothiazide
hydrocodone
w/guaifenesin
hydrocodone/
acetaminophen
hydrocortisone
acetate
hyoscyamine sulfate

WVPDL 01/01/06 Revised 03/24/06



I

ibuprofen
 IMITREX* [QLL]
 INDERAL LA
 indomethacin
 INNOPRAN XL
 INTAL
 ipratropium bromide

K

ketoconazole
 KEPPRA

L

lactulose
 LAMICTAL
 LAMISIL* [PA]
 LANTUS (vials only)
 leucovorin
 levothyroxine sodium
 LEVAQUIN
 LEXAPRO[PA*]
 LEVOXYL]
 lidocaine hcl viscous
 LIDODERM
 lisinopril/ hctz
 lithium carbonate, er
 LIVOSTIN*
 LOTREL [PA*]
 lovastatin
 LUMIGAN

M

MALARONE
 MATULANE
 medroxyprogesterone
 megestrol
 MENEST
 MEPHYTON
 mephobarbital
 MEPRON
 mercaptopurine
 MESTINON SA
 METANX
 metformin,
 extended release
 methocarbamol
 methotrexate
 methylphenidate hcl
 methylprednisolone
 metolazone
 metoprolol
 metronidazole
 microgestin fe [PA**]
 migergot
 MIRAPEX
 mirtazapine soltab
 misoprostol
 MOBAN
 MONUROL
 morphine sulfate sa tab
 MSIR [G]
 mupirocin
 MYCOBUTIN

N

nabumetone
 nadolol

naproxen
 NARDIL
 NASCOBAL
 NASONEX
 NATALCARE
 NEBUPENT
 NEXIUM [PA\$]
 NIASPAN *[G]
 nifedipine, er
 NIMOTOPnitrofurantoin
 macrocrystal
 nizatidine
 norethindrone-
 ethinyl estradiol
 [PA**]
 norethindrone-
 mestranol [PA**]
 norgestrel ethinyl
 estradiol [PA**]
 NOVOFINE 30
 NOVOLIN (vials only)
 NOVOLOG (vials only)
 NUTROPIN , AQ
 excluding Depot [PA],
 [SP]
 nystatin
 nystatin w/triamcinolone

O

omeprazole
 OMNICEF*
 ORTHO EVRA[PA**]
 ORTHO TRI-CYCLEN
 LO [PA**]
 OXSORALEN/ULTRA
 oxybutynin chloride
 o
 OXYCONTIN [PA]
 oxycodone/
 acetaminophen
 OXYTROL

P

PANCREASE MT 4
 paroxetine hcl
 PEGANONE
 PEGASYS [SP]
 penicillin v potassium
 PENTASA
 perphenazine
 PHOSLO
 PLAVIX
 podofilox solution
 potassium chloride
 potassium citrate er
 PRANDIN
 PRECOSE
 PRED G
 PRED MILD
 prednisolone acetate
 prednisone
 PREMARIN
 PREMARIN LOW
 DOSE
 PREMPHASE
 PREMPRO
 PREMPRO LOW DOSE
 PRENATE
 ADVANCE [G]
 PREVACID [PAS]
 PRIMSOL

prochlorperazine
 PROCRI [PA],
 [SP]
 proctozone – HC
 PROGRAF
 promethazine
 promethazine/codein
 e
 promethazine vc
 PROMETRIUM
 propranolol
 PROTOPIC
 PULMICORT

Q

quetiapine fumarate
 QVAR

R

RAZADYNE (not
 ER)
 REBIF [SP]
 REGRANEX [PA]
 RENACIDIN
 RENAGEL
 REQUIP*
 RESTASIS
 ribasphere
 ribavirin
 RIDAURA
 RILUTEK
 RISPERDAL
 (excluding M-tabs)
 ROZEREM

S

SAIZEN [PA],[SP]
 salsalate
 selenium sulfide
 SEREVENT,
 DISKUS
 SEROQUEL
 simvastatin
 SINGULAIR [PA*]
 SKELAXIN*
 SPIRIVA
 STALEVO
 STARLIX
 STIMATE
 STRATTERA
 [PA*]
 STROMECTOL
 SUBUXONE
 SUBUTEX
 SULAR [PA*]
 SYNAREL

T

TAMIFLU [QLL]
 tamoxifen
 TARGRETIN
 TASMAR
 TAZORAC [PA]
 TEGRETOL XR
 temazepam
 theophylline
 anhydrous
 thioguanine
 thioridazine hcl

thyroid
 ticlopidine hcl
 TIKOSYN
 TILADE
 timolol hcl
 tobramycin sulfate
 TOPAMAX [PA]
 TOPROL XL* [G]
 TRACLEER
 tretinoin
 TREXALL
 TRICOR
 trazodone hcl
 triamcinolone
 acetamide
 triamterene/hctz
 triazolam
 trifluoperazine hcl
 TRILEPTAL
 TRUSOPT

U

UNIPHYL [G]
 UNITHROID

URSO/FORTE

V

VAGIFEM
 VALCYTE
 VANCOCIN HCL
 venlafaxine
 VENTAVIS
 VENTOLIN HFA
 verapamil hcl
 VESANOID
 VFEND [PA]
 VIGAMOX
 VINATE II
 VOLTAREN OPHTH.
 VYTORIN [PA*]

W

WELLBUTRIN XL*
 [PA*]

X

XALATAN
 XYREM

Y**Z**

ZADITOR
 ZETIA [PA*]
 ZELNORM
 ZEMPLAR

 ZOFRAN, ODT* [QLL]
 ZOMIG/ ZMT [QLL]
 zonisamide
 ZOVIRAX OINT
 ZYLET
 ZYMAR
 ZYPREXA (excluding
 Zydys)
 ZYVOX



APPENDIX F – Limited Data Use Agreement

A limited data set is a set of records containing protected health information (PHI), from which direct identifiers have been removed, but in which certain potentially identifying information remains. The use or disclosure of a limited data set is limited to research, public health, and health care operations purposes only.

Name of data recipient:

Description of data: De-identified PEIA Paid Claims Data for its retiree population.

Purpose of use: PEIA will be disclosing a limited data set to health plans that will be submitting bids in response to this RFP as part of its health care operations. The data will be used by bidding health plans to prepare the cost estimate portion of its proposal.

By signing this agreement the recipient agrees:

- Not to further use or disclose any of the information, outside the purpose listed above, without prior written permission from PEIA or as otherwise required by law;
- That any further information requested by Recipient, or its Affiliates, regarding these reports must be made in writing to PEIA.
- Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the data use agreement;
- Report to PEIA any use or disclosure of the information not provided for by its data use agreement, of which it becomes aware;
- Ensure that any agent, including any affiliates, to whom it provides the limited data set agrees to the same restrictions and conditions that apply to the limited data set recipient with respect to such information; and
- Not to identify the information or to contact the individuals to whom the information pertains, if applicable.
- Properly and completely dispose of all data provided by PEIA upon completion of the project described above in “Purpose of use.”

PEIA may terminate the agreement if it notifies the recipient of a pattern of activity or practice that constitutes a material breach or violation of the data use agreement, or law, unless the recipient cures the breach or ends the violation within a reasonable time, as determined by PEIA. PEIA will take reasonable steps to cure the breach or end the violation and if such steps are unsuccessful PEIA will discontinue disclosure and report the violation to the appropriate authorities.

Signature of Recipient Representative

Date

Signature of PEIA Representative

Date



APPENDIX G – Capitation Cost Proposal Form

PEIA will consider any further risk sharing arrangements offered by the bidder which will allow it a positive financial benefit in the event of successful underwriting experience. The bidder must provide a detailed explanation of any such arrangement that it wishes to propose.

	Medical Plan	Drug Plan	Combined Medical and Drug Plan
Medical Claims			
Drug Claims			
Administration Cost			
Profit Allowance			
Total Annual Per			
Medicare Contract			
Monthly Capitation Bid Total			
Less CMS Capitation			
PEIA Capitation Per Contract			

