Office of Labor Relations

EMPLOYEE BENEFITS PROGRAM

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ADDENDUM 1

TO: PROSPECTIVE RESPONDENTS

FROM: OFFICE OF LABOR RELATIONS (OLR), OFFICE OF LABOR RELATIONS

DATE: NOVEMBER 18, 2020

RE: THE CITY OF NEW YORK OFFICE OF LABOR RELATIONS EMPLOYEE BENEFITS PROGRAM NEGOTIATED ACQUISITION FOR FOR HEALTH BENEFIT SERVICES IN THE FORM OF A MEDICARE ADVANTAGE PLAN UNDER MEDICARE PART C FOR CITY OF NEW YORK RETIREES, AND THEIR DEPENDENTS

EPIN:0021N002

RFP Reference (if applicable)	**Question**	**Answer**
Notice of Intent, Basic Information, Anticipated Funding It is anticipated that the annual funding for the contract awarded as a result of this procurement will be approximately $600M.	What is the anticipated annual funding of $600 Million? Is that for the MA Premium; MOB funding or for something else?	$600 Million represents the approximate **current** medical and hospital spend for retired Medicare eligible participants and their spouses. We assume a Medicare Advantage plan will reduce the City's spend materially through efficiencies and moving to a single program.
Notice of Intent, Basic Information, Payment Structure	In the payment structure section - can the City please provide a definition of what is meant by trend cap?	The City would prefer quotes to be provided for each year of the initial 3 year term of the contract. If the vendor is not able to quote specific rates for the entire period, the City requests a trend cap or rate guarantee with respect to the increases for periods beyond the rates quoted (e.g. year 1 $X per member per month, year 2 not to exceed year 1 by Y%, year 3 not to exceed year 2 by Z%)

RFP Reference (if applicable)	**Question**	**Answer**
City will pay the vendor a national monthly premium rate, including a separate listing of the Affordable Care Act fees included in the premium. The contract must provide either a trend cap or rate guaranty for the initial term of the contract.		
Notice of Intent, 1. Program Background	With the Optional Rx rider, is the City also looking for an integrated MAPD plan for a subset of the membership?	No, The City would like an additional rider quoted for purchase by a subset of the population
Notice of Intent, 4. Negotiations with Vendors	In the full replacement option, can you please confirm that this includes replacing the various other options currently offered to the Medicare retirees?	In the full replacement option, only the MA product would be offered, all other Medicare offerings would cease.
Notice of Intent, 4. Negotiations with Vendors	In the quote option where the new Medicare Advantage plan is quoted with Senior Care Plan remaining as an option for the member to pay the full cost, would the various other options also remain for the members to select from?	No, only the Senior Care Plan would remain as an alternative option. It is expected that members would be contributing the difference between the MA rate and the cost of Senior Care (ie members can buy up).
Technical Questionnaire – Section A, Introductory Questions – C5 Carrier agrees to provide expanded telephone customer service hours beginning June 1, 2021 as required by CMS.	Can the City please provide its definition of “expanded customer service hours?”	CMS does provide a waiver of customer service hours requirements for Employer Group Waiver Plans. The City wants to make sure that the call center hours provided by the vendor meet the needs of its retirees.
Technical Questionnaire – Section A, Introductory Questions – C32 Carrier agrees that costs associated with implementation of the plans will be borne by the Carrier and not charged back to the City.	Does this refer to Carrier’s implementation costs only or does it include the City’s implementation costs?	Carrier implementation costs only.

RFP Reference (if applicable)	**Question**	**Answer**
Technical Questionnaire – Network Size and Composition Describe your process for collaborating with purchasers and key providers to address provider acceptance issues that may surface over time.	Please provide examples of the types of acceptance issues the City is referring to. In addition, define the purchasers and key providers in scope for the context of the question.	Purchasers in this case are your network contracting team, key providers are major hospital networks / physician groups, and examples of issues that may arise are they may refuse to accept out of network members in a passive PPO arrangement even though the provider accepts Medicare.
Technical Questionnaire – Medicare Risk Adjustment The City currently does not provide prescription drug benefits to its retirees. Describe your strategy to gather prescription drug data from retirees, and to manage the MA benefit effectively for those who may not have coverage elsewhere?	Can the City please clarify the intent of the question?	Typically carriers having access to both medical and prescription drug data have a more robust view of the members, and can be more effective in managing care and risk scores. We would like to know your strategy given that likely you will not have any direct access from the City to the member's prescription drug data.
Technical Questionnaire – Medicare Risk Adjustment The plan design, plus what other factors, contribute to the development of the MRA?	Can the City please clarify the intent of the question?	We are looking for insight into your pricing to determine if the rates you are quoting are reasonable and sustainable.
Technical Questionnaire – Prescription Drug Optional Rider	Can the City please advise the type of funding arrangement for the prescription drug rider along with plan design confirmation, as the technical questionnaire references 2017 parameters?	The City is looking for a fully insured optional rider, paid entirely for by the member on a voluntary basis. Pages 25 and 26 of the Technical Questionnaire inadvertently provide the 2017 parameters of the optional rider. These should mirror the standard annual Part D thresholds.

RFP Reference (if applicable)	**Question**	**Answer**
Technical Questionnaire – Case Management 7. What percentage of Medicare Advantage members experienced a home assessment in 2019? How did you approach the home assessment in 2020?	Can the City please clarify what is meant by "approach"?	What is your methodology around home assessments, including how you adjusted this strategy during the COVID-19 pandemic.
Technical Questionnaire – Condition Management 9. If you have special processes for managing members who have dual eligibility (Medicare/Medicaid), describe them briefly	The RFP mentions coordination of benefits with Medicaid. What is the number of dual-eligible retirees?	The City does not have this information.
Technical Questionnaire – Special Care Management Programs – Behavioral Health Management 2. Describe how behavioral health issues will be considered when working with City members for case management and condition management programs.	Can the City please clarify the meaning of this question?	What is your methodology around addressing members with behavioral health issues who also need case and condition management? How does behavioral health factor into your care management protocols.
Technical Questionnaire – Network Programs – Integration with the City's Vendor Health Partners 1.Describe how your organization collaborates to provide integrated delivery of the programs (e.g., data sharing, coordination of care procedures, warm transfers) with the City's other health care initiatives or existing vendors	Will the City provide a list of these initiatives and vendors?	The specific initiatives and vendors are less important than your organization's approach to working with other organizations and with other City agencies to achieve positive health outcomes for the members.

RFP Reference (if applicable)	**Question**	**Answer**
Technical Questionnaire – Network Programs – Integration with the City's Vendor Health Partners 2.The City offers an Employee Assistance Plan to its retirees. Briefly describe how you would propose working with the program to coordinate care?	Will the City provide this EAP for carriers to review before responding?	At this point, please rely on publicly available data on https://www1.nyc.gov/site/olr/eap/eaphome.page
N/A – PPO Options	How many Medicare Advantage PPO options will you be offering? Will you be offering a passive PPO plan alongside a narrower network or will there only be one option offered?	If the City finds offering a Medicare Advantage plan to be in its best interest, there would only be one option offered to participants.
N/A – Open Enrollment	Can the City share how it plans to structure open enrollment periods moving forward?	The likely structure would be a special initial open enrollment period prior to the start date of the Medicare Advantage option, and then standard open enrollment during the late fall each year going forward, where members can elect to change coverage but otherwise will continue to default members into the plan they are currently enrolled in.

RFP Reference (If Applicable)	**Question**	**Answer**
Basic Information Expression of Interest Due Date	Would the City of New York, Office of Labor Relations consider extending the due date to December 2, 2020?	Not at this time
Basic Information Expression of Interest Due Date	If an extension is not feasible, will the City of New York, Office of Labor Relations have technical support available on November 27, 2020 to assist vendors uploading their NA responses?	Yes, please email Ekrupa@olr.nyc.gov with any questions.
Basic Information Anticipated Number Contracts	Please confirm the City of New York, Office of Labor Relations envisions offering one contract to a single carrier.	Confirmed.
1. Program Background	The Notice of Intent states: "we are also asking for potential narrower network/active PPO pricing." Is this requesting a narrow Medicare Advantage traditional PPO (with in and out of network benefits) in and around NY or in all 50 states? Is it permissible for a carrier to offer a Medicare Advantage HMO to be responsive to the narrower network request? Any additional guidance on this would be helpful.	Preferably in all 50 states. However if you have a product that has a narrow network in and around NY and an open network in the rest of the country such an offering would be reviewed. A Medicare Advantage HMO in response to the narrow network request is permissible though not preferred.
1. Program Background	As it relates to the pre-Medicare plan, what are the administrative concerns that the City of New	The City's current IT systems do not allow for different carriers for a single household. So, to the

	York, Office of Labor Relations has "accommodating split contracts with multiple carriers in the initial implementation of a Medicare Advantage plan"?	extent there is a split contract, the pre-Medicare carrier and the Medicare carrier must be the same carrier under the current technology.
2. Program Requirements	Does the City of New York, Office of Labor Relations expect respondents to provide a written response to the Program Requirements section or only provide the documents referenced in Section 3, Expression of Interest Content & Instructions: A. Transmittal letter, B. Questionnaire and C. M/WBA plan. Please clarify.	Only the documents referenced in Section 3. It is expected that the responses to the documents referenced in Section 3 will demonstrate your organization's ability to meet the program requirements.
2. Program Requirements, B. Agency Assumption Regarding Contractor Experience	The second bullet point under the heading "B. Agency Assumptions Regarding Contractor Experience" reads "Show and experience as a firm in providing Medicare Advantage programs, particularly to employee groups." Please clarify the meaning and/or intent of the sentence.	The intent is to have the respondent demonstrate Medicare Advantage experience offering group MA products as opposed to only individual market MA products.
2. Program Requirements, D. Agency Assumptions Regarding Contractor Experience, 5	In addition to pre-enrollment materials and all communications that are specific to the City of New York plan, please confirm if it is the intent of City of New York, Office of Labor Relations to review and edit member communication materials including those specific to CMS required letters, communications for Clinical Program participation, and STARS outreaches.	While the City understands that CMS mandates content and will not change mandated language, CMS language is not always clear and the City wants to be aware of any topics that need to be clarified in customized material.
2. Program Requirements, D. Agency Assumptions Regarding Contractor Experience, 16	Please clarify how City of New York, Office of Labor Relations will identify members of entities who require reporting for their payroll? For example, will the City provide an identifier for these members on the EDI file?	The City will identify members in the EDI file.
2. Program Requirements D. Agency Assumptions Regarding Contractor Experience, 18	Please describe start-up and acquisition costs.	Costs incurred by you to implement the program being proposed to the City.
2. Program Requirements D. Agency Assumptions Regarding Contractor Experience, 20	Is it the City of New York, Office of Labor Relations' intent for respondents to have the ability to terminate MA members upon request for any day of the month or will the City comply with MA guidelines which terminates coverage at the end of the month?	The City intends to comply with MA guidelines and terminate coverage at the end of the month.
2. Program Requirements D. Agency Assumptions Regarding Contractor Experience, 23	Will City of New York, Office of Labor Relations require respondents to store dependent information if the dependent was never enrolled in the MA plan?	No.
2. Program Requirements D. Agency Assumptions Regarding Contractor Experience, 26	Confirm if it is the intent of City of New York, Office of Labor Relations to send non Medicare qualifying individuals for enrollment on the EDI file.	Potentially, but only for split contracts where the Medicare eligible member has non-Medicare dependents. As noted in a prior answer, the City's current systems cannot administer a split contract with multiple carriers.
2. Program Requirements D. Agency Assumptions Regarding Contractor Experience, 28	Please clarify what detailed claim data is being requested. Does this request apply to fully insured plans?	The request applies to all plans and programs that would be offered, including fully insured plans. Full de-identified seriatim claims data for the City's population.
2. Program Requirements	Please clarify the types of changes the City of New York, Office of Labor Relations would be expect to test prior to implementation.	Benefit design changes, for example.

D. Agency Assumptions Regarding Contractor Experience, 34		
2. Program Requirements D. Agency Assumptions Regarding Contractor Experience, 86	Please Explain in more detail what is meant by the "programming requirements" for communicating/ exchanging data with the City's enrollment database- transmission, reporting, enrollment files, etc.?	The City's current platform (NYCAPS/NYCAPS-R) is an older platform and is generally not conducive to any changes on their end, so the carrier's systems must be able to work with the City's systems as is.
2. Program Requirements D. Agency Assumptions Regarding Contractor Experience, 87	Please clarify when a paper application would be submitted for enrollment vs. an electronic submission. Would the beneficiary be sending the paper application direct to the plan for processing or would it go to City of New York, Office of Labor Relations first? Would the applicant be added to the EDI file at a later date for reconciliation/audit purposes?	While the intent is not to use paper enrollment, the question relates to your ability to handle it for initial enrollment only.
2. Program Requirements D. Agency Assumptions Regarding Contractor Experience, 88	Please elaborate how the five coverage classifications are expected to be accommodated by the respondent for those that include family, non-Medicare, and split members.	As noted previously, the City's systems currently cannot accommodate split contracts with multiple carriers. As noted in Section 1, "The City is also requesting that respondents include a pre-Medicare plan substantially similar to the current CBP plan offering for non-Medicare participants to be made available for split contracts (approximately 14,000 contracts as of December 13, 2019), in the event that the City is unable to accommodate split contracts with multiple carriers in the initial implementation of a Medicare Advantage plan."
3. Expression of Interest Content & Instructions, A. Letter of Transmittal, 7. C. C. The respondent must also affirmatively state whether or not they meet each of the Section 3 - Program Requirements of this Notice of Intent.	Please confirm this should reference Section 2 – Program Requirements of this Notice of Intent (not Section 3).	Confirmed, this should reference Section 2 not Section 3.
3. Expression of Interest & Instructions C. Minority and Women-Owned Business Enterprise (M/WBE) Utilization Plan	Please clarify how the M/WBE plan submitted by vendors will be considered in the evaluation.	As noted in Section 3-C, "the Agency still seeks to promote government contracting opportunities for certified M/WBEs through the implementation of a voluntary M/WBE Utilization Plan". Your response will be scored along with other responses in the evaluation of the bid.
4. Negotiations with Vendors	Please provide additional information regarding negotiations with Vendors, specifically next steps in the process.	The City will review responses provided and determine which, if any, Vendors will be invited to submit financial proposals, as well as to attend finalist presentations. After the presentations, the City will

		determine, which, if any, Vendor to enter negotiations with.
5. Basis for Contract Award and Procedures	The Notice of Intent references the following factors for evaluation and scoring: • Experience - 20% • Organizational Capability - 20% • Program Approach - 60% Please provide the mapping of each component listed above to the appropriate sections of the Medicare Advantage Technical Questionnaire. Also, in its numerical evaluation of Expressions of Interest, is it the intent of OLR to utilize only the information provided in the Letter of Transmittal, the Medicare Advantage Questionnaire and the Minority and Women-Owned Business Enterprise (M/WBE) Plan?	City declines to reply. Correct.
Question C.33	Please confirm Question C.33 from the questionnaire contains the mandatory requirements that must be met to be eligible to respond. There appears to be a discrepancy between 2. Program Requirements, C. and Question C.33 in the Technical Questionnaire. Please confirm the required membership is 250,000 MA members referenced in the questionnaire.	C.33 is the correct requirement: The bidding organization must currently serve a) at least 250,000 Medicare Advantage PPO or HMO members, and can include individual market membership; b) at least one EGWP Medicare Advantage customer with 50,000 members; c) at least five group Medicare Advantage customers with 10,000 or more members each; and d) at least five public sector employers/unions There is also no requirement that the 250,000 members must be in the New York City area.
General	Does the City of New York, Office of Labor Relations have a preference for response format? Should respondents respond in the Technical Questionnaire as provided or is it acceptable to place all questions contained in the questionnaire into the bidder's response template as long as the bidder retains all of the City's original numbering and formatting?	No preference if the bidder retains all of the original numbering and formatting, and the document can be edited.
Section A, C.5`	Please elaborate on the extended telephone service hours being requested.	CMS does provide a waiver of customer service hours requirements for Employer Group Waiver Plans. The City wants to make sure that the call center hours provided by the vendor meet the needs of its retirees.
Section C (in regards deductible)	For the $25 deductible on ambulance, DME, and private duty nursing, is the additional $25 each time for each service? Or does the member only have to pay the $25 deductible one time?	The $25 deductible is a one time charge.
Section C (in regards to Inpatient Hospital Care, Inpatient Mental Health and Inpatient Substance Abuse)	Please clarify the $300 copay per admission • Is the $300 a copay or a deductible? Per the Technical Questionnaire it is a copay, but on the Summary Plan Document it states "$300 deductible" • Is the benefit intent to have a $300 copay per admission for inpatient hospital care?	The $300 is per individual, per confinement up to a maximum of $750 per year, only applicable to days 1-60. There is no overall plan deductible.

	• Is this specific to days 1-60? Or would it apply per admission regardless of the day range it falls into? • Is the intent to have two accumulations towards the deductible for Inpatient or will the group move toward an overall plan deductible?	
Section C (in regards to Inpatient Hospital Care, Inpatient Mental Health and Inpatient Substance Abuse	Please clarify the $750 maximum per calendar year: • Is the '$750 maximum per calendar year' the most the member has to pay or the most the plan has to pay? • Does the $750 apply to just days 1-60 or does it apply to the entire year?	The $750 maximum is only applicable to inpatient confinements in days 1-60 (e.g., if the participant has 3 separate inpatient admissions and the first two admissions are for less than 60 days combined, the participant would only be required to pay $150 for the third admission. Any other copays/deductibles for other non-inpatient services would still apply.
Section C (in regards to Inpatient Hospital Care, Inpatient Mental Health and Inpatient Substance Abuse	For Inpatient Hospital Care, Inpatient Mental Health and Inpatient Substance Abuse, are these standalone benefits and they do not reduce on another?	These are not standalone benefits. The $300 copay accumulates towards the $750 maximum regardless of the type of admission.
Section C (in regards to Skilled Nursing Facility)	What is expected to occur after day 100? Please provide clarification on the note '120 day max per confinement'.	The 120 is a typo, both should read 100 days.
Section C (in regards to Outpatient Surgery)	When the deductible hasn't been met, what is the coverage?	The participant pays amounts up to the deductible (standard Part B deductible) and the plan covers the remainder
Section C (in regards Hospital Care when outside the U.S.A)	• Does the plan deductible apply? • Please provide clarification on the Medicare coinsurance amount language. • Is this benefit per occurrence or the total number of days? • Following day 90, what is the benefit?	The Medicare Part A deductible applies, not the plan deductible. The Medicare coinsurance amount is the standard medicare coinsurance for inpatient days 61-90 ($352 per day for 2020). No benefits after 90 days.
Section C (Prescription Drug 2020 Medicare Design)	Please provide clarifying information on the expected tier coverage for each stage.	The current design only provides for two tiers, generic or brand. Preferred/non-preferred brand are treated the same, and specialty drugs are treated depending on their classification as either generic or brand.
Section F; Geo Access	Does the City of New York, Office of Labor Relations have preferred geo access standards? If so, please provide the required geo access standards.	Not at this time.
Additional Downloads on the OLR Website (Appendix A, Iran Divestment Rider, etc.)	Please confirm if bidders need to complete and submit all "Additional Downloads" on the OLR website or if only the "Doing Business Data Form" referenced in the Notice of Intent is required with submission of a bidder's response.	In accordance with the Notice of Intent, please submit only the Doing Business Data Form.
The census provided appears to be a subscriber level census where, if a retiree and their spouse/family members are all covered under the plan, only the retiree is listed with an indicator if more eligibles are covered under their policy. Is it possible to revise the census to a member level census where each unique member currently covered under the plan is listed on a separate line? Our underwriting team will need DOB for each enrollee to properly quantify the group demographics.		Unfortunately this level of detail is not yet available. If we are able to obtain this information we will provide it to all respondents.

General Questions

1. Can the City provide its proposed performance guarantees and contract terms and conditions for review at this time so we can review prior to Technical Response submission?

Answer: Not at this time. Proposed performance guarantees and contract terms will be provided to the respondents selected by the Evaluation Committee to enter into negotiations.

2. Please provide an updated census which includes separate information for all members and dependents indicating their individual information of: Medicare status, Plan Enrollment, Date of Birth, Gender, and Home Zip Code.

Answer: Dependent information is not currently available. If it becomes available it will be provided to all respondents.

3. The members in the Non-Medicare Coverage Class, both Individual & Family, are over age 65. Would you please provide additional information as to why they are not enrolled in Medicare?

Answer: This is due to timing issues with the data. When the data was cut these particular individuals had not yet been migrated to the Medicare plan (e.g. the participant had just retired and is still on the active plan until they can be moved to a Medicare plan). For all intents and purposes these participants should be treated as Medicare.

4. What is the election period for new retirees? Can they elect/age-in to the MA plan monthly as they retire or are they only allowed to enter at the time of the new plan year?

Answer: To the extent that members are only offered one plan, they will be included in the MA plan as they require, as long as they are covered under Medicare Parts A and B. If there is a choice in plans, they will be offered at retirements.

5. Per the RFP: “It is anticipated that the base term of the Contract awarded from this negotiated acquisition procurement will be from on or about July 1, 2021 to June 30, 2026.” However, will the plan year for benefits run on a calendar year basis? Do deductibles and out-of-pocket maximus re-set on a calendar year basis (1/1 each year) or on 7/1 to 6/30 yearly basis?

Answer: Deductibles and out-of-pocket maximums re-set on a calendar year basis. The July 1 – June 30 timeframes are due to City Fiscal Year requirements only.

6. Will the other Medicare Advantage plans that are currently in-force remain or will they be replaced with the new Medicare Advantage plan that is the basis of this procurement?

Answer: The City has not yet determined whether it will offer the Medicare Advantage as the only plan option, or offer both a Medicare Advantage and the current Senior Care program as a buy up option.

7. If a retiree can age in monthly – are they expecting any member deductible and out-of-pocket spend on their commercial plan – to be carried over to the new Medicare Advantage plan?

Answer: No carryover of the commercial plan cost sharing to the MA plan.

8. Per the RFP: “Assuming a July 1, 2021 implementation date, what are the options for managing a mid-year transition with respect to deductibles, out of pocket expenditures and other cost sharing operated on a calendar year basis?”. Please clarify that the cost sharing (deductibles, out-of-pocket maximums) and plan design will operate on a calendar year basis (1/1-12/31) starting in 2022?

Answer: Confirmed, plan design will operate on a calendar year basis after the first 6 months.

Medicare eligible retirees and Medicare eligible dependents

1. For the GHI/Empire Blue Cross Blue Shield Senior Care Plan (Senior Care) population for Medicare eligible retirees and Medicare eligible dependents, please provide the most recent 24 months of medical claims experience broken out separately on a month by month basis for containing the following information:

- Medicare allowed amount
- Medicare paid amount
- Plan paid claims
- Retiree cost share (copays, deductibles)

Answer: This information will not be provided at this point.

2. For Medicare eligible retirees and Medicare eligible dependents that have chosen the Prescription Drug Rider through Senior Care, please provide the most recent 24 months of prescription drug claims experience broken out separately on a month by month basis for containing the following information:

- Medicare allowed amount
- Medicare paid amount
- Plan paid claims
- Retiree cost share (copays, deductibles)

Answer: This information will not be provided at this point.

3. Please provide 2021 renewal for the Senior Care plan

Answer: Declined.

Pre-Medicare/Non-Medicare Participants

1. Please provide 24 months of Medical and Pharmacy claims with corresponding monthly membership.

Answer: Declined

2. Please provide 24 months of Large Claims by individual with Diagnoses and if available Prognosis.

Answer: Declined

3. Please provide current carrier rates.

Answer: Declined.

4. Please provide carrier 2021 renewal (if available).

Answer: Declined

5. Would the City consider a Self-Funded quote option for the pre-65 population?

Answer: Self-Funded arrangement are not currently allowed under City administrative code. However, a minimum premium arrangement, which operates substantially like a self-funded arrangement is allowed.

Notice of Intent Questions

1. Agency Assumptions Regarding Contractor Approach – Minimum Requirements 65 and 66 – Subrogation and overpayment recoveries are typically not applicable to fully insured plans. Can the City confirm that these provisions would not apply under a fully insured arrangement, as there would be no City claim account and the carrier would assume all financial risk?

Answer: Confirmed.

2. Agency Assumptions Regarding Contractor Approach – Minimum Requirement 73 – Can the City provide additional detail on its existing EAP program and what specific coordination is required?

Answer: At this point, please rely on publicly available data on https://www1.nyc.gov/site/olr/eap/eaphome.page

3. Agency Assumptions Regarding Contractor Approach – Minimum Requirement 87 – Can the City clarify what proportion of post-65 Medicare Advantage enrollments are currently received in paper format and how many non-NYCAPS agencies this represents? Typically, Medicare Advantage enrollments are provided on a single electronic file.

Answer: 10% of post-65 Medicare Enrollments are currently received in paper format by the current carrier. These Non-NYCAPS agencies represents the City Cultural/Library Institutions and the CUNY Senior Colleges.

Technical Questionnaire Questions

1. Minimum Requirement C.12 – Please confirm that the City requires final reconciliation of annual premium payments by February 28th of the succeeding plan year. This date appears to apply to a 1/1 plan effective date, rather than the requested 7/1 effective date.

Answer: Other than the initial 6-month period (7/1/2021 – 12/31/2021), the plan will operate on a calendar year basis.

2. Minimum Requirement C.13 – Please clarify which services would be in scope for the requested post-implementation audit?

Answer: All services provided under the negotiated contract with the City.

3. Integration with the City's Health Vendor Partners – Please provide additional detail on any ongoing initiatives or existing vendors carriers would need to collaborate with to provide integrated delivery of programs.

Answer: As noted above, the specific initiatives and vendors are less important than your organization's approach to working with other organizations and with other City agencies to achieve positive health outcomes for the members.

4. Section C – Plan Design (p. 24) – Section C refers to "$25 deductible for ambulance, DME, and private duty nursing after Part B deductible has been reached." However, page 22 of the Senior Care Benefit Booklet says "5. Services for Private Duty Nursing. We will not cover private duty nursing services." Can the City clarify if the intent is to cover private duty nursing, and if so, should it be covered at $0, unlimited allowance, after deductible?

Answer: The $25 deductible for those services is pulled directly from the GHI Senior Care website.

5. Section C – Plan Design (Prescription Drug Optional Rider) - The $3700 and $4950 thresholds listed in the Prescription Drug Optional Rider chart, along with the Gap copays of 51% and 40%, are the 2017 CMS threshold values. Are these thresholds and Gap copays what should be used to quote a 2021 Part D benefit, or should carriers use the updated 2021 threshold values?

Answer: Pages 25 and 26 of the Technical Questionnaire inadvertently provide the 2017 parameters of the optional rider. These should mirror the standard annual Part D thresholds.

1. Technical Questionnaire, Network Size Page 12: In this question the City requests an "Extended Service Area network, but would be interested in understating your passive PPO network options." We view both of these items as the same thing, with carriers using different words to describe a network where the member benefit is the same, regardless of using in our out of network providers. Are you asking for a PPO where there is a benefit differential? Can you clarify this question and The City's understanding of these two terms, passive PPO and ESA?

Answer: This is an oversight, we are interested in your active PPO network options as well.

2. Based on data from year's past in 2018 and 2019, how many retirees had met the deductibles by 7/1.

Answer: This information is not readily available.

3. Technical Questionnaire, Plan Design, Page 20: Refers to Section F and plan design. We see plan designs in Section C, beginning at page 24. Can you confirm this is the correct reference is the plan design on page 24?

Answer: The correct reference is Section C starting on page 24.

4. Please confirm the number of members who currently have the drug rider. The RFP lists 6300.

Answer: Correct – this is optional, retiree-pay-all.

5. Can you provide more information on your EAP plan and features available to retirees? This is referenced on page 39 of the questionnaire.

Answer: At this point, please rely on publicly available data on https://www1.nyc.gov/site/olr/eap/eaphome.page

6. Can you please provide a member level census that includes both medical and pharmacy plan indicators so we know who is enrolled in each of the plan options available today?

Answer: Declined

7. Does the current Senior Care plan include any non-Medicare covered services like SilverSneakers, hearing aid allowances, vision allowances, etc.?

Answer: No

8. The prescription drug rider outlined on page 26 & 27 of the RFP, are CMS limits from prior years. Please confirm the prescription drug rider is a Part D plan and will follow the 2021 CMS limit requirements?

Answer: Pages 25 and 26 of the Technical Questionnaire inadvertently provide the 2017 parameters of the optional rider. These should mirror the standard annual Part D thresholds

9. The current Senior Care plan design includes Private Duty Nursing benefit after a $25 deductible, does the plan have a dollar limit per day after deductible?

Answer: This information will be provided to the respondents selected to enter into negotiations with the City.

10. The current Senior Care plan design for Skilled Nursing Facility outlined on page 26 of the plan design section has a 120 days per confinement, the SPD has 100 days, please confirm if we should follow 120 outlined in the RFP or follow what is in the SPD provided?

Answer: The 120 days is an oversight, both numbers should be 100 days.

11. Are you able to provide a full plan benefit summary of the Senior Care plan?

Answer: Please refer weblink for to the New York City Health Benefits Summary Program Description for information about Senior Care https://www1.nyc.gov/assets/olr/downloads/pdf/health/health-full-spd.pdf

12. Can you please provide the latest 12-24 months of medical claims, including corresponding member counts by month for each product/plan, for Medicare eligible retirees only. (Claims should exclude under 65 spouses/dependents and non-Medicare eligible retirees). This will be helpful if determining if alternative designs PPO would drive additional savings as asked in the RFP.

Answer: This information is not available.

13. Can you please provide the corresponding 12-24 months of CMS revenue totals for each of the Medicare Advantage plans.

Answer: This information is neither available nor relevant, as most members are not covered under MA today.

14. Can you please provide the 2019 full year MA only risk score for each of the Medicare Advantage populations.

Answer: This information is not available, nor relevant as most members are not covered under MA today.

a. Please describe whether those 2019 MA risk scores include any mid-year reconciliation estimates or final reconciliation estimates.

Answer: N/A

15. Please provide the following member level pharmacy data (the member level data as requested below will not reveal any information about the incumbent cost structure):

A member level RX claim file for all Medicare retirees for each RX plan. We will need one file that contains claim level information. The information should be provided in summary as well as in detail format. The detail format file should be in delimited text format, inclusive of a header row. The data should be provided for the Medicare eligible population we are quoting. Such as both Medicare eligible pre- and post-65s, including disableds.

The File should include:

a. Unique Member ID
b. Pharmacy ID
c. NDC-11
d. AWP
e. Dispense Date
f. Retail vs. Mail Indicator
g. Days supply
h. Quantity or Units Dispensed
i. Duplicate records and originals/reversals should be removed

Not required, but useful information:

j. Current Formulary Tier
k. Low Income Status (Yes/No indicator)

Answer: Declined - information is not available.

16. If member level utilization data is not available, please provide the generic dispense rate (GDR) for the current Rx plan/plans.

Answer: Not available

17. Will carriers have the chance to ask follow-up questions around the additional data requested if received?

    Answer:

18. Please confirm we can create a “Supplemental Information” section on our Table of Contents where we can provide the supporting information to our proposal that does not have a place holder in your submission instructions.

Answer: Yes

19. Could you provide the number of retirees enrolled with Family – Medicare coverage who cover additional dependents other than a spouse?

Answer: Declined – not available

20. Could you provide the following claim data for the Non-Medicare population preferably 24-36 month of claim data with monthly detail to include:

a. Subscriber count
b. Member count
c. Premium
d. Incurred or Paid claims
e. Large Claim History (diagnosis, prognosis, current status) that corresponds to the same time period as the monthly claim data.

Answer: Declined – not available