Introduction

Missouri Consolidated Health Care Plan (MCHCP) is the employee health benefit program for most State of Missouri employees, retirees, and their dependents covering over 96,000 members (lives). An additional 1,000 non-state local government members are covered through their public entity employer.

This contract will provide for a fully-insured Group Medicare Advantage plan on a national basis to cover Medicare primary eligible members of MCHCP as a full replacement to the plans offered currently. Medicare primary members who are eligible as a public entity member or an active state employee are not included as part of this RFP. Current Medicare primary-eligible member plan enrollment is over 15,000 lives. These members are currently enrolled in one of the self-insured PPO plans offered by MCHCP. Prescription drugs are provided through an Employer Group Waiver Plan (EGWP) Prescription Drug Plan (PDP) through Express Scripts and are not included as part of this RFP.

This document constitutes a request for sealed proposals, to provide a fully-insured Group Medicare Advantage plan. A demographic file that includes zip codes for each MCHCP Medicare enrollee is available upon receipt of a signed Limited Data Use Agreement, available as Exhibit A-2 in the response document section of DirectPath.

MCHCP's Contracting Intentions:

- Any contract awarded from this RFP will be effective January 1, 2019.
- MCHCP intends to award a one-year contract with up to five possible one-year renewals. Bidders are required to submit firm, fixed prices for 2019 and not-to-exceed prices for 2020 and 2021. Rates for 2022, 2023 and 2024 will be negotiated.
- Pricing and benefits are subject to negotiation prior to contract award and renewal each year.
- Bidders should understand that MCHCP views its foremost obligation as providing efficient and effective services to its membership. MCHCP will aggressively pursue and implement measures toward meeting this goal. Bidders are strongly encouraged to demonstrate in their response to this RFP that they share a common vision and commitment.
- MCHCP intends for the contractor to cover the cost of an implementation audit in the amount of $50,000 performed by MCHCP or its designee.

Minimum Bidder Requirements

To be considered for contract award, bidders must meet the following minimum requirements:

- The bidder must be licensed as necessary to do business in the State of Missouri in order to perform the duties described in this RFP, and be in good standing with the office of the Missouri Secretary of State and the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP).

- The bidder must be approved by the Centers for Medicare and Medicaid Services (CMS) to offer a Group Medicare Advantage plan in the State of Missouri and nationwide and have earned a minimum of three stars for plan quality and performance for a minimum of three years.

- The bidder must demonstrate the ability to operate a fully insured group Medicare Advantage plan for at least three organizations with 10,000 or more retirees.

- Bidders must be flexible and demonstrate the ability to administer benefits determined by MCHCP. This includes the ability to offer multiple plan designs at MCHCP's option.

- Bidders shall agree to provide claim-level data and capitation information electronically to MCHCP or designated data vendor on a monthly basis, including twelve (12) run-out months (i.e. months following contract expiration). Bidders may be required to demonstrate the ability to provide such data before a contract award is made.

- Bidders shall not link nor attempt to link (unless permitted by this RFP), the award of this contract to any other bids, products or contracts. The bidder may not impose participation requirement. Any bid proposal containing any participation requirements or contingency based upon MCHCP's actual or potential awards of contracts, whether or not related specifically to this RFP, or containing pricing contingencies, shall result in such bid proposal being rejected for non-responsiveness and non-compliance with this RFP.

- Bidders shall not be permitted to alter their rate or any other aspect of the proposal submission after submission except with negotiation and agreement by MCHCP.

- Timely Submission – All deadlines outlined are necessary to meet the timeline for this contract award. Submissions after respective deadlines have passed may be rejected. All bidder documents and complete proposals must be received by the proposal deadline of April 26, 2018, as outlined in the timeline of events for this RFP. Late proposals will not be accepted. MCHCP reserves the right to modify a deadline or extend a deadline for all bidders at its discretion.

- Performance Bond - The contractor must furnish an original performance security deposit in the form of check, cash, bank draft, or irrevocable letter of credit, issued by a bank or financial institution authorized to do business in Missouri, to MCHCP within ten (10) days after award of the contract and prior to performance of service under the contract. The performance security deposit must be made payable to MCHCP in the amount of $2,000,000. The contract number and contract period must be specified on the performance security deposit. In the event MCHCP exercises an option to renew the contract for an additional period, the contractor shall maintain the validity and enforcement of the security deposit for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal, not to exceed $2,000,000.

Background Information

- Missouri Consolidated Health Care Plan is governed by the provisions of Chapter 103 of the Revised Statutes of Missouri. Under the law, MCHCP is directed to procure health care benefits

for most state employees, retirees and their dependents. The law also authorizes non-state public entities to participate in the plan. Rules and regulations governing the plan can be found by following this link http://www.sos.mo.gov/adrules/csr/current/22csr/22csr.asp.

- Current Medicare-eligible state members is 15,054 covered persons. The current number of non-Medicare members who will turn age 65 in CY2019 is 799.
- MCHCP currently contributes a portion of the premium for Medicare-eligible retirees. On average, MCHCP contributes approximately 54 percent of the total premium. Decisions impacting the contribution level are reviewed annually by the MCHCP Board of Trustees. The current contribution policy can be found in 22 CSR 10-2.030 Contributions.
- MCHCP currently contributes approximately 35 percent of the premium for Medicare-eligible Long-Term Disability recipients. There are approximately 50 of these enrollees.
- MCHCP Medicare-eligible members will be required to pay the Medicare Part B premium.

Assumptions and Considerations

Please submit your proposal using the DirectPath online submission tool no later than **Thursday, April 26, 2018, 4 p.m. CT (5 p.m. ET)**. Due to the limited timeframe for proposal analysis and program implementation, **no individual deadline extensions will be granted**.

The board of trustees has final responsibility for all MCHCP contracts. Responses to the RFP and all proposals will remain confidential until awarded by the MCHCP Board of Trustees or its designee or until all proposals are rejected.

Do not contact MCHCP directly regarding this RFP. Questions about the technical procedures for participating in this on line RFP process should be addressed to DirectPath. Any questions concerning the content of the RFP should be submitted via the messaging tool of the DirectPath website.

Proposal Instructions

NOTE: READ THESE INSTRUCTIONS COMPLETELY PRIOR TO RESPONDING TO THE RFP

In order to be considered you must respond to all sections of this RFP. Bidders are strongly encouraged to read the entire RFP prior to the submission of a proposal. The bidder must comply with all stated requirements. Bidders are expected to provide complete and concise answers to all questions. Your responses to all questions must be based on your current proven capabilities. You should describe your future capabilities only as a supplement to your current capabilities.

If any information contained in the proposal is found to be falsified, the proposal will immediately be disqualified.

Proposals must be valid until January 1, 2019. If a contract(s) is awarded, prices shall remain firm for the specified contract period.

A proposal may only be modified or withdrawn by signed, written notice which has been received by MCHCP prior to the official filing date and time specified.

Contract Term

The initial agreement is for the period of January 1, 2019 through December 31, 2019, with up to five additional one year contracts renewable at the sole option of the MCHCP Board of Trustees.

Clarification of Requirements

It is assumed that bidders have read the entire RFP prior to the submission of a proposal and, unless otherwise noted by the bidder, a submission of a proposal and any applicable amendment(s) indicates that the bidder will meet all requirements stated herein.

The bidder is advised that the only official position of MCHCP is that position which is stated in writing and issued by MCHCP as a RFP and any amendments and/or clarifications thereto. No other means of communication, whether oral or written, shall be construed as a formal or official response or statement.

Schedule of Events

The timeline for the procurement is provided below. No pre-bid conference has been scheduled.

Activity	Timing
Online RFP Released	**Monday April 9, 2018** **8 a.m. CT (9 a.m. ET)**
Intent to Bid Document Due	**Friday, April 13, 2018** **4 p.m. CT (5 p.m. ET)**
Bidder Question Submission Deadline	**Friday, April 13, 2018** **4 p.m. CT (5 p.m. ET)**
MCHCP Responses to Submitted Questions	**Wednesday, April 18, 2018** **4 p.m. CT (5 p.m. ET)**

Online RFP Closes (all proposals due)	**Thursday, April 26, 2018 4 p.m. CT (5 p.m. ET)**
Finalist Interviews/Site Visits (if necessary)	**Late May, 2018**
Final Vendor Selection	**Late June, 2018**
Program Effective Date	**January 1, 2019**

Questions

During this bidding opportunity, MCHCP will be using the online messaging module of the DirectPath application for all official answers to questions from bidders, amendments to the RFP, exchange of information and notification of awards. It is the bidder's responsibility to notify MCHCP of any change in contact information of the bidder. During the bidding process you will be notified via the messaging module of the posting of any new bid-related information.

Any and all questions regarding specifications, requirements, competitive procurement process, etc., must be in writing and submitted through the online messaging module of the DirectPath application by **Friday, April 13, 2018, 4 p.m. CT (5 p.m. ET)**. Questions received after April 13 will be answered and posted through the messaging module as time permits, but there is no guarantee of a response to these questions. For step-by-step instructions, please refer to the *Downloads* section of the DirectPath Application, and click on *User Guides*.

Questions deemed universally applicable will be answered in writing and shared with all vendors who have indicated they are quoting. The team will respond to your questions as they are submitted via the messaging module, with a summary of all questions and answers provided by **Wednesday, April 18, 2018.**

Bidders or their representatives may not contact other MCHCP employees or any member of the MCHCP Board of Trustees regarding this bidding opportunity or the contents of this RFP. If any such contact is discovered to have occurred, it may result in the immediate disqualification of the bidder from further consideration.

Proposal Deadline

ALL questionnaires and pricing proposals must be submitted no later than 4 p.m. CT (5 p.m. ET), Thursday, April 26, 2018.

Disclaimers

MCHCP will not be liable under any circumstances for any expenses incurred by any respondent in connection with the selection process.

The description of coverage and plan design contained in this RFP is solely intended to allow for the preparation and submission of proposals by respondents and does not constitute a promise or guarantee of benefits to any individual.

Confidentiality and Proprietary Materials

Pursuant to Section 610.021 RSMo, proposals and related documents shall not be available for public review until a contract has been awarded or all proposals are rejected. MCHCP maintains copies of all proposals and related documents.

MCHCP is a governmental body under Missouri Sunshine Law (Chapter 610 RSMo). Section 610.011 requires that all provisions be "liberally construed and their exceptions strictly construed to promote" the public policy that records are open unless otherwise provided by law. Regardless of any claim by a bidder as to material being proprietary and not subject to copying or distribution, or how a bidder characterizes any information provided in its proposal, all material submitted by the bidder in conjunction with the RFP is subject to release after the award of a contract in relation to a request for public records under the Missouri Sunshine Law (see Chapter 610 of the Missouri Revised Statutes). Only information expressly permitted by the provisions of Missouri's Sunshine Law to be closed – strictly construed – will be redacted by MCHCP from any public request submitted to MCHCP after an award is made. Bidders should presume information provided to MCHCP in a proposal will be public following the award of the bid and made available upon request in accordance with the provisions of state law.

Evaluation Process

Any apparent clerical error may be corrected by the bidder before contract award. Upon discovering an apparent clerical error, MCHCP shall contact the bidder and request written clarification of the intended proposal. The correction shall be made in the notice of award. Examples of apparent clerical errors are: 1) misplacement of a decimal point; and 2) obvious mistake in designation of unit.

Any pricing information submitted by a bidder must be disclosed on the pricing pages as designated in this RFP. Any pricing information which appears elsewhere in the bidder's proposal shall not be considered by MCHCP.

Awards shall only be made to the bidder(s) whose proposal(s) complies with all mandatory specifications and requirements of the RFP. MCHCP reserves the right to evaluate all offers and based upon that evaluation to limit the number of contract awards or reject any and all offers.

MCHCP reserves the right to request written clarification of any portion of the bidder's response in order to verify the intent of the bidder. The bidder is cautioned, however, that its response shall be subject to acceptance or rejection without further clarification.

MCHCP reserves the right to consider historic information and fact, whether gained from the bidder's proposal, question and answer conferences, references, or any other source, in the evaluation process. The bidder is cautioned that it is the bidder's sole responsibility to submit information related to the evaluation categories and that MCHCP is under no obligation to solicit such information if it is not included with the bidder's proposal. Failure of the bidder to submit such information may cause an adverse impact on the evaluation of the bidder's proposal.

After determining that a proposal satisfies the mandatory requirements stated in the RFP, the comparative assessment of the relative benefits and deficiencies of the proposal in relationship to the published evaluation criteria shall be made by using subjective judgment. The award of a contract resulting from

this RFP shall be based on the lowest and best proposal received in accordance with the evaluation criteria stated below:

Evaluation Criteria

Non-financial:

Provider Network	130 points
Vendor Profile	60 points
Customer Service and Plan Administration	75 points
Account Management and Implementation	30 points
Claims Administration and Audits	40 points
Performance Guarantees	50 points
Utilization and Case Management	60 points
Technology and Security	70 points
Reporting	15 points
Coordination with PBM	15 points
Disease Management	10 points
Wellness, Prevention and Consumer Support	15 points
Behavioral Health	20 points
Denials/Appeals/Grievance Procedure	10 points
Sub-total – Non-financial points	600 points
Bonus Points – MBE/WBE Participation Commitment	10 points

Financial:

Price	400 points

Finalist Evaluation:

References	40 points
Finalist Interview	60 points

MCHCP will limit the number of finalists to the bidders receiving 80 percent (480 points) of the possible 600 non-financial points available or the top two bidders if less than two bidders receive 80 percent of the possible 600 non-financial points.

The bidder's proposed participation of MBE/WBE firms in meeting the targets of the RFP will be considered in the evaluation process. A maximum MBE/WBE participation points of 10 points will be awarded based on the participation amount proposed by the bidder. Awarded MBE/WBE participation points will be added to the non-financial points earned by the bidder and will be included to determine if a bidder meets the 80 percent threshold to obtain finalist status.

Minority Business Enterprise (MBE)/Women Business Enterprise (WBE) Participation

The bidder should secure participation of certified MBEs and WBEs in provider products/services required in this RFP. The targets of participation recommended by the State of Missouri are 10% MBE and 5% WBE of the total dollar value of the contract.

a) These targets can be met by a qualified MBE/WBE vendor themselves and/or through the use of qualified subcontractors, suppliers, joint ventures, or other arrangements that afford meaningful opportunities for MBE/WBE participation.

b) The services performed or the products provided by MBE/WBEs must provide a commercially useful function related to the delivery of the contractually-required service/product in a manner that will constitute an added value to the contract and shall be performed/provided exclusive to the performance of the contract. Therefore, if the services performed or the products provided by MBE/WBEs is utilized, to any extent, in the bidder's obligations outside of the contract, it shall not be considered a valid added value to the contract and shall not qualify as participation in accordance with this clause.

c) In order to be considered as meeting these targets, the MBE/WBEs must be "qualified" by the proposal opening date (date the proposal is due). (See below for a definition of a qualified MBE/WBE.)

d) If the bidder is proposing MBE/WBE participation, in order to receive evaluation consideration for MBE/WBE participation, the bidder must provide the following information with the proposal.

    a. Participation Commitment - If the bidder is proposing MBE/WBE participation, the vendor must complete Section 16 of the Group Medicare Advantage RFP Questionnaire (MBE-WBE Participation Commitment), by listing each proposed MBE and WBE, the committed percentage of participation for each MBE and WBE, and the commercially useful products/services to be provided by the listed MBE and WBE. If the vendor submitting the proposal is a qualified MBE and/or WBE, the vendor must include the vendor in the appropriate table.

    b. Documentation of Intent to Participate – The bidder must either provide a properly completed Exhibit A-6, Documentation of Intent to Participate Form, signed and dated no earlier than the RFP issuance date by each MBE and WBE proposed or must provide a letter of intent signed and dated no earlier than the RFP issuance date by each MBE and WBE proposed which: (1) must describe the products/services the MBE/WBE will provide and (2) should include evidence that the MBE/WBE is qualified, as defined herein (i.e., the MBE/WBE Certification Number or a copy of MBE/WBE certificate issued by the Missouri OEO). If the bidder submitting the proposal is a qualified MBE and/or WBE, the bidder is not required to complete Exhibit A-6, Documentation of Intent to Participate Form or provide a recently dated letter of intent.

e) Commitment – If the bidder's proposal is awarded, the percentage level of MBE/WBE participation committed to by the bidder on Exhibit A-6, Participation Commitment, shall be interpreted as a contractual requirement.

Definition -- Qualified MBE/WBE:

In order to be considered a qualified MBE or WBE for purposes of this RFP, the MBE/WBE must be certified by the State of Missouri, Office of Administration, Office of Equal Opportunity (OEO) by the proposal opening date.

MBE or WBE means a business that is a sole proprietorship, partnership, joint venture, or corporation in which at least fifty-one percent (51%) of the ownership interest is held by minorities or women and the management and daily business operations of which are controlled by one or more minorities or women who own it.

Minority is defined as belonging to one of the following racial minority groups: African Americans, Native Americans, Hispanic Americans, Asian Americans, American Indians, Eskimos, Aleuts, and other groups that may be recognized by the Office of Advocacy, United States Small Business Administration, Washington D.C.

A listing of several resources that are available to assist bidders in their efforts to identify and secure the participation of qualified MBEs and WBEs is available at the website shown below or by contacting the Office of Equal Opportunity (OEO) at:

Office of Administration, Office of Equal Opportunity (OEO)
Harry S Truman Bldg., Room 630, P.O. Box 809, Jefferson City, MO 65102-0809
Phone: (877) 259-2963 or (573) 751-8130
Fax: (573) 522-8078
Web site: http://oeo.mo.gov

Finalist Interview

After an initial screening process, a technical question and answer conference or interview may be conducted, if deemed necessary by MCHCP, to clarify or verify the bidder's proposal and to develop a comprehensive assessment of the proposal. MCHCP reserves the right to interview the proposed account management team. MCHCP may ask additional questions and/or conduct a site visit of the bidder's service center or other appropriate location.

Negotiation and Contract Award

The bidder is advised that under the provisions of this RFP, MCHCP reserves the right to conduct negotiations of the proposals received or to award a contract without negotiations. If such negotiations are conducted, the following conditions shall apply:

- Negotiations may be conducted in person, in writing, or by telephone.
- Negotiations will only be conducted with bidders who provide potentially acceptable proposals. MCHCP reserves the right to limit negotiations to those bidders which received the highest rankings during the initial evaluation phase. All bidders involved in the negotiation process will be invited to submit a best and final offer.

- Terms, conditions, prices, methodology, or other features of the bidder's proposal may be subject to negotiation and subsequent revision. As part of the negotiations, the bidder may be required to submit supporting financial, pricing, and other data in order to allow a detailed evaluation of the feasibility, reasonableness, and acceptability of the proposal.

- The mandatory requirements of the RFP shall not be negotiable and shall remain unchanged unless MCHCP determines that a change in such requirements is in the best interest of MCHCP and its members.

- Bidder understands that the terms of any negotiation are confidential until an award is made or all proposals are rejected.

Any award of a contract resulting from this RFP will be made only by written authorization from MCHCP.

Renewal of Contract

The initial agreement is for the period of January 1, 2019 through December 31, 2019, with up to five additional one-year contracts renewable at the sole option of the MCHCP Board of Trustees.

Proposed pricing for Years 2-3 (CY2020 and CY2021) of this contract, not to exceed the allowed maximum, shall be submitted prior to May 15 of the next plan year. Pricing for Years 4-6 (CY2022, CY2023 and CY2024) will be negotiated and is due prior to May 15 of the next plan year. The contractor must also provide supporting documentation that provides the rationale for any requested rate increase each year.

Using DirectPath

The 2019 MCHCP Group Medicare Advantage RFP contains 2 broad categories of items that you will need to work on via the DirectPath application:

1) Items Requiring a Response:

   a) Questionnaires (e.g., Group Medicare Advantage Questionnaire, etc.) are also online forms to collect your responses to our questions about your capabilities.

   c) Response Documents (e.g., Exhibit A-1 Intent to Bid, etc.) are attachment files (e.g., MS Word or Excel) that are posted to the DirectPath website. They should be downloaded, completed and/or signed by your organization, and then posted/uploaded back to the DirectPath application. When you upload your response, from the drop-down menu, identify each uploaded document as a *Response* document and associate it to the appropriate document by name. For step-by-step instructions, please refer to the *How to Download and Attach Files* User Guide located in the *Downloads* section on the application homepage.

2) Reference Files from Event Administrator:

   a) Documents (e.g. Exhibit B-Scope of Work) that you should download and read completely before submitting your RFP response.

All of these components can be found in the DirectPath application under the 2019 MCHCP Group Medicare Advantage RFP on the Event Details page of the application.

Note that as you use the DirectPath application to respond to this RFP, User Guides are accessible throughout the application by clicking on the help icon or from the *Downloads* area of the DirectPath application homepage. For help with data entry and navigation throughout the application, you can contact the DirectPath staff:

- Phone: 800-979-9351
- E-mail: support@directpathhealth.com

Completing Exhibit A-8 Pricing

The bidder must provide firm, fixed costs for providing services as described in this RFP.

Proposals shall include a fixed premium for program year January 1, 2019 – December 31, 2019, with guaranteed not-to-exceed maximum premiums for program years beginning January 1, 2020 and January 1, 2021. Premiums for program years beginning January 1, 2022, 2023, and 2024 will be negotiated. Any premium data submitted or related to the bidder's proposal including any premium data related to contractual extension options shall be subject to evaluation if deemed by MCHCP to be in the best interest of members of MCHCP.

In determining pricing points, MCHCP will consider the potential three-year cost of the contract including the full not-to-exceed premiums for Years 2 and 3 of the contract. The contractor shall understand that annual renewal premiums for subsequent years of the contract will be negotiated, but must be within the not-to-exceed premiums submitted within this bid. All renewal options are at the sole option of the MCHCP Board of Trustees. Renewal prices are due by May 15 of each year and are subject to negotiation.

Responding to Questionnaires

We have posted two forms for your response:

- Group Medicare Advantage Questionnaire
- Mandatory Contract Provisions Questionnaire

The questionnaires need to be completed and submitted to DirectPath by**, Thursday, April 26, 2018, 4 p.m. CT (5 p.m. ET).**

The questionnaires are located within the *Items Requiring a Response* tab. This tab contains all of the items you and your team are required to access and respond to. For step-by-step instructions, please refer to the *How to Submit a Questionnaire* User Guide located in the *Downloads* section of the DirectPath application homepage. You have the option to "respond online" or through the use of two different off-line (or desktop) tools.

Completing Other Response Documents

The following exhibits must be completed, signed and uploaded to DirectPath:

- Exhibit A-1 - Intent to Bid (due 4 p.m. CT, April 13, 2018)
- Exhibit A-2 – Limited Data Use Agreement (due 4 p.m. CT, April 13, 2018)
- Exhibit A-3 – Proposed Bidder Modifications (due 4 p.m. CT, April 26, 2018)
- Exhibit A-4 – Confirmation Document (due 4 p.m. CT, April 26, 2018)
- Exhibit A-5 – Contractor Certification (due 4 p.m. CT, April 26, 2018)
- Exhibit A-6 – MBE-WBE Intent to Participate Document (due 4 p.m. CT, April 26, 2018)

The follow exhibit must be reviewed and the bidder provide any suggested red-lined changes to the document using Microsoft Word Track Changes functionality. Changes proposed may or may not be accepted by MCHCP.

- Exhibit A-7 – MCHCP Business Associate Agreement (due 4 p.m. CT, April 26, 2018)

RFP Checklist

Prior to the April 26, 2018 close date, please be sure you have completed and/or reviewed each of the documents listed below:

Type	Document Name
Questionnaire	Group Medicare Advantage Questionnaire
Questionnaire	Mandatory Contract Provisions Questionnaire
Response	Exhibit A-1 Intent to Bid.docx DUE: Friday, April 13, 2018
Response	Exhibit A-2 Limited Data Use Agreement.docx DUE: Friday, April 13, 2018
Response	Exhibit A-3 Proposed Bidder Modifications.docx
Response	Exhibit A-4 Confirmation Document.docx
Response	Exhibit A-5 Contractor Certification.docx
Response	Exhibit A-6 MBE-WBE Intent to Participate Document.docx
Response	Exhibit A-7 MCHCP Business Associate Agreement.docx
Response	Exhibit A-8 Medicare Advantage Plan Design and Pricing.xlsx
Reference	Introduction and Instructions – 2019 MCHCP Group Medicare Advantage RFP.pdf
Reference	Attachment 1 – Enrollee file layouts.docx
Reference	Attachment 2 – MCHCP Enrollee file.xlsx (access to this file is granted after receipt of the signed Limited Data Use Agreement)
Reference	Attachment 3 – Provider file layout.docx
Reference	Attachment 4 – Claims experience.xlsx
Reference	Exhibit B – Scope of Work.docx
Reference	Exhibit C – General Provisions.docx

Contact Information

We understand that content and technical questions may arise. All questions regarding this document and the selection process must be submitted through the online messaging module of the DirectPath application by **Friday, April 13, 2018, 4 p.m. CT (5 p.m. ET)**.

For technical questions related to the use of DirectPath, please contact the DirectPath customer support team at support@directpathhealth.com, or by calling the Customer Support Line at 1-800-979-9351.

EXHIBIT B
SCOPE OF WORK

B1. GENERAL REQUIREMENTS

B1.1 The contractor shall provide a fully-insured Group Medicare Advantage Plan for State members in accordance with the provisions and requirements of this document on behalf of Missouri Consolidated Health Care Plan (hereinafter referred to as MCHCP). The contractor understands that in carrying out its mandate under the law, MCHCP is bound by various statutory, regulatory and fiduciary duties and responsibilities and contractor expressly agrees that it shall accept and abide by such duties and responsibilities when acting on behalf of MCHCP pursuant to this engagement. The contractor agrees that any and all subcontracts entered into by the contractor for the purpose of meeting the requirements of this contract are the responsibility of the contractor. MCHCP will hold the contractor responsible for assuring that subcontractors meet all of the requirements of this contract and all amendments thereto. The contractor must provide complete information regarding each subcontractor used by the contractor to meet the requirements of this contract.

B1.2 The contractor must maintain sufficient liability insurance, including but not limited to general liability, professional liability, and errors and omissions coverage, to protect MCHCP against any reasonably foreseeable recoverable loss, damage or expense under this engagement.

B1.3 The contractor is obligated to follow the performance standards as agreed to in Section 20 of the Group Medicare Advantage Plan Questionnaire.

B1.4 The contractor must furnish an original performance security deposit in the form of check, cash, bank draft, or irrevocable letter of credit, issued by a bank or financial institution authorized to do business in Missouri, to MCHCP within ten (10) days after award of the contract and prior to performance of service under the contract. The performance security deposit must be made payable to MCHCP in the amount of $2,000,000. The contract number and contract period must be specified on the performance security deposit. In the event MCHCP exercises an option to renew the contract for an additional period, the contractor shall maintain the validity and enforcement of the security deposit for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal, not to exceed $2,000,000.

B2. ELIGIBILITY REQUIREMENTS - The contractor shall comply and agree with the following regarding eligibility requirements:

B2.1 The contractor shall agree that eligible Medicare-primary members are those who are eligible as defined by applicable state and federal laws, rules and regulations, including revision(s) to such. MCHCP is the sole source in determining eligibility.

B2.2 Termination: The contractor must agree that:

B2.2.1 A member's coverage under this agreement terminates under those conditions specified in MCHCP’s statutes, and Rules and Regulations.

B2.2.2 The contractor shall not regard a member as terminated until the contractor receives an official termination notice directly from MCHCP.

B3. LEVEL OF BENEFITS

B3.1 The contractor must administer the minimum benefits, in terms of covered services and member responsibility, as described in the stated plan design. If the bidder has limitations in administering the stated plan designs based on state filings, then the bidder must identify those limitations and offer an alternative that closely matches the stated plan designs. Bidders may separately propose additional services or options to be included in the plan design at MCHCP's discretion.

B3.2 The contractor must agree to include all benefits covered by Medicare Parts A and B, wraparound services MCHCP chooses to include, and benefits proposed by the contractor and agreed to by MCHCP.

B3.3 Under no circumstances shall the contractor require a member to pay for any covered services except for stated premiums, deductibles, co-payments, coinsurance and non-covered services. Members shall not be required to pay any additional enrollment fees, application fees or other charges in addition to the monthly premium.

B3.4 The contractor must coordinate, cooperate, and electronically exchange information with MCHCP's contracted pharmacy benefit manager (currently Express Scripts, Inc.) and any other MCHCP contracted vendor necessary to operate MCHCP's benefits. Frequency of electronically exchanged information can be daily.

B3.5 Plan designs and benefits requested are subject to change each plan year. MCHCP will review any request for additional fees resulting from such changes and retains final authority to make any changes. A consultant may be utilized to determine the cost impact.

B4. NETWORK

B4.1 The contractor must have in place a broad national network. If the provider will be leasing networks in areas where their own network is insufficient, this will be disclosed to MCHCP.

B4.2 The contractor shall maintain a network that is sufficient in number and types of providers, in accordance with CMS guidelines, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.

B4.3 MCHCP requires that network providers be responsible for obtaining all necessary pre-certifications and prior authorizations and for paying any assessed penalties for not obtaining necessary authorizations.

B4.4 The contractor shall have a process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of the enrolled members. In addition to looking at the needs from an overall member population standpoint, the contractor shall ensure the network is able to address the needs of those with special needs including but not limited to, visually or hearing impaired, limited English proficiency, and low health literacy. The contractor shall notify MCHCP within five business days if the network geographic access changes from what was proposed by the contractor.

B5. REPORTING REQUIREMENTS

B5.1 The contractor agrees that all data required by MCHCP shall be confidential and will not be public information. The contractor further agrees not to disclose this or similar information to any competing company, either directly or indirectly.

B5.2 MCHCP reserves the right to retain a third party contractor (currently Truven Health Analytics®, part of IBM Watson Health) to receive claims-level data from the contractor and store the data on MCHCP's behalf. This includes a full claim file including, but not limited to all financial, demographic and utilization fields. The contractor agrees to cooperate with MCHCP's designated third party contractor, if applicable, in the fulfillment of the contractor's duties under this contract, including the provision of data as specified without constraint on its use. The contractor shall agree to:

B5.2.1 Provide claims, person-level capitation and utilization data to MCHCP and/or MCHCP's data vendor in a format specified by MCHCP with the understanding that the data shall be owned by MCHCP;

B5.2.2 Provide data in an electronic form and within a timeframe specified by MCHCP;

B5.2.3 Place no restraints on use of the data provided MCHCP has in place procedures to protect the confidentiality of the data consistent with HIPAA requirements; and

B5.2.4 This obligation continues for a period of one year following contract termination at no additional cost to MCHCP.

B5.3 The contractor shall provide standard reports to MCHCP on a quarterly and annual basis. MCHCP and the contractor will negotiate the format and content upon award of this contract. A sample of the bidder's standard reports must be submitted with the proposal. The reports shall be submitted to MCHCP quarterly and are due within 30 days of the end of the quarter reported. Annual reports are due within 45 days of the end of the year. Periodic in-person meetings will be required for sharing of data and results.

B5.4 The contractor shall provide MCHCP with copies of HEDIS results, CAHPS survey results, and any other CMS required reporting for Medicare Advantage enrollees.

B5.5 At the request of MCHCP, the contractor shall submit additional ad hoc reports on information and data readily available to the contractor.

B5.6 MCHCP will determine the acceptability of all claim files and reports submitted based upon timeliness, format and content. If reports are not deemed to be acceptable or have not been submitted as requested, the contractor will receive written notice to this effect and the applicable liquidated damages, as defined in Section 20 of the Group Medicare Advantage Plan Questionnaire, will be assessed.

B6. GENERAL SERVICE REQUIREMENTS

B6.1 The contractor shall agree that any state and/or federal laws and applicable rules and regulations enacted during the terms of the contract which are deemed by MCHCP to necessitate a change in the contract shall be incorporated into the contract. MCHCP will

review any request for additional fees resulting from such changes and retains final authority to make any changes. A consultant may be utilized to determine the cost impact.

B6.2 The contractor must agree that during the life of the contract or any extension thereof, MCHCP and auditors designated by MCHCP shall have access to and the right to examine any pertinent books, documents, papers, or records of the contractor involving any and all transactions related to the performance of the contract. Also, the contractor must furnish all information necessary for MCHCP to comply with all state and/or federal regulations. MCHCP would be responsible for the cost of any such audit or review.

B6.3 The contractor must promptly inform MCHCP of any compliance actions imposed by CMS, including sanctions.

B6.4 The contractor must have an active, current website that is updated regularly. MCHCP members must be able to access this site to obtain current listings of active network providers and other information. If MCHCP discovers that provider information contained at the contractor's website is inaccurate, MCHCP will contact the contractor immediately. The contractor must correct inaccuracies within 10 days of being notified by MCHCP.

B6.5 The contractor shall agree that any products contracted for will be branded or co-branded as MCHCP products, to the extent allowed by Medicare/CMS guidelines.

B6.6 The contractor shall have appeal and grievance procedures that comply in all respects to relevant state and federal law.

B7. ACCOUNT MANAGEMENT

B7.1 The contractor shall establish and maintain throughout the term of the contract an account management team that will work directly with MCHCP staff. This team must include, but is not limited to, a dedicated account executive, a customer service manager, medical director, a clinical contact, a person responsible for preparing reports, and a management information system representative. Approval of the account management team rests with MCHCP. The account executive and service representative(s) will deal directly with MCHCP's benefit administration staff. The account management team must:

B7.1.1 Be able to devote the time needed to the account, including being available for telephone and on-site consultation with MCHCP. Bidders who are not committed to account service will not receive serious consideration.

B7.1.2 Be extremely responsive.

B7.1.3 Be comprised of individuals with specialized knowledge of the contractor's networks, claims and eligibility systems, system reporting capabilities, claims adjudication policies and procedures, administrative services, and relations with third parties.

B7.1.4 Be thoroughly familiar with virtually all of the contractor's functions that relate directly or indirectly to the MCHCP account.

B7.1.5 Act on behalf of MCHCP in cutting through the bureaucracy of the contractor's organization. The account management team must be able to effectively advance the

interest of MCHCP through the contractor's corporate structure.

B7.1.6 The contractor agrees to provide MCHCP with at least 15 days advance notice of any material change to its account management and servicing methodology or to a personnel change in the contractor's account management and servicing team.

B7.1.7 The contractor agrees to allow MCHCP to complete a formal performance evaluation of the assigned account management team annually.

B7.2 MCHCP requires the contractor to meet with MCHCP staff and/or Board of Trustees as requested to discuss the status of the MCHCP account in terms of utilization patterns and costs, as well as propose new ideas that may benefit MCHCP and its members.

B7.2.1 The contractor is expected to present actual MCHCP claims experience and offer suggestions as to ways the benefit could be modified in order to reduce costs or improve the health of MCHCP members. Suggestions must be modeled against actual MCHCP membership and claims experience to determine the financial impact as well as the number of members impacted.

B7.2.2 The contractor must also present benchmark data by using the health plan's entire book of business, a comparable client to MCHCP, and/or some other industry norm.

B8. CUSTOMER SERVICE

B8.1 The contractor must provide a high quality and experienced customer service unit. The health plan staff members must be fully trained in the MCHCP benefit design(s), and the contractor must have the ability to track and report performance in terms of telephone response time, call abandonment rate, and the number of inquiries made by type.

B8.2 The contractor shall maintain a toll-free telephone line to provide prompt access for members and physicians to qualified customer service personnel. At a minimum, customer service must be available between the hours of 8:00 a.m. and 5:00 p.m. CT, Monday through Friday except for designated holidays.

B8.3 The contractor shall refer any and all questions received from members regarding MCHCP eligibility or premiums to MCHCP.

B8.4 The contractor is responsible for developing, printing and mailing identification cards directly to the member's home. The contractor is responsible for these production and mailing costs.

B8.5 The contractor shall agree to develop, print and mail (via first class mail) all communication materials including the Summary of Benefits and Coverage (SBC) to be distributed to the MCHCP membership. MCHCP reserves the right to customize these materials to the extent allowed by Medicare/CMS, and the contractor shall agree that MCHCP reserves the right to review and approve all written communications and marketing materials developed and used by the contractor to communicate specifically with MCHCP members at any time during the contract period. This does not refer to such items as provider directories and plan-wide newsletters as long as they do not contain information on eligibility, enrollment, benefits, rates, etc., which MCHCP must review. Notwithstanding the foregoing, nothing herein prohibits contractor from communicating directly with members in the regular course of providing services under the contract (e.g., responding to member inquiries, etc.). Draft

material for open enrollment held in October of each year shall be made available to MCHCP for review and comment by July 1 of each year unless another date is agreed upon by both the contractor and MCHCP. Open Enrollment material shall be mailed by September 1 of each year unless another date is agreed upon by both the contractor and MCHCP. MCHCP may request enrollment meeting assistance from the contractor and will coordinate the utilization of contractor employees when needed.

B8.6 No provider may be listed on the contractor's website or distributed to the membership through the contractor's customer service unit unless a signed contract is in place. The contractor shall routinely monitor the provider listing for completeness and accuracy.

B8.7 The contractor must provide MCHCP members with a toll-free number to request printed provider directories. The contractor must distribute printed provider directories including lists of participating hospitals, PCPs, specialists, and mental health providers to all members that request such information. These printed directories must be mailed to the member within three business days of receipt of such request. The contractor bears all costs for printing and mailing these materials. Contractors are also required to provide this information via their website.

B8.8 The contractor(s) shall have a variety of tools and information sources for MCHCP members. This may include, but is not limited to, the following:

- New member information
- Cost transparency tools that shall utilize network provider rate information and are at a provider level detail as well as in summary
- Member ability to view claim status
- Member information to track deductible, coinsurance and out-of-pocket maximum status
- Electronic explanation of benefits
- Ability to query and download up to twenty-four (24) months of claims data

B9. INFORMATION TECHNOLOGY AND ELIGIBILITY FILE

B9.1 The contractor shall be able to accept all MCHCP eligibility information on a weekly basis utilizing the ASC X12N 834 (005010X095A1) transaction set. MCHCP will supply this information in an electronic format and the contractor must process such information within 24 hours of receipt. The contractor must provide a technical contact that will provide support to MCHCP Information Technology Department for EDI issues. MCHCP is willing to work with the contractor on these requirements after the contract is awarded.

B9.1.1 It is MCHCP's intent to send a transactional based eligibility file weekly and a periodic full eligibility reconciliation file.

B9.1.2 MCHCP will provide a recommended data mapping for the 834 transaction set to the contractor after the contract is awarded.

B9.1.3 After processing each file, the contractor will provide a report that lists any errors and exceptions that occurred during processing. The report will also provide record counts, error counts and list the records that had an error, along with an error message to indicate why it failed. A list of the conditions the contractor audits will be provided to ensure the data MCHCP is sending will pass the contractor's audit tests.

B9.1.4 The contractor shall provide access to view data on their system to ensure the file MCHCP sends is correctly updating the contractor's system.

B9.1.5 The contractor will supply a data dictionary of the fields MCHCP is updating on their system and the allowed values for each field.

B9.1.6 The contractor shall provide MCHCP with a monthly file ("eligibility audit file") in a mutually agreed upon format of contractor's eligibility records for all MCHCP members. Such file shall be utilized by MCHCP to audit contractor's records. Such eligibility audit file shall be provided to MCHCP no later than the second Thursday of each month.

B9.1.7 The preferred method of file transfer is HIPAA compliant SFTP service. No PGP required.

B9.2 The contractor must be able to support single sign-on from MCHCP's Member Portal to the contractor's Member Portal utilizing Security Assertion Markup Language (SAML).

B9.3 The contractor must work with MCHCP to develop a schedule for testing of the eligibility test record set on electronic media. MCHCP requires that the contractor accept and run an initial test record set no later than September 28, 2018. Results of the test must be provided to MCHCP by October 12, 2018.

B10. IMPLEMENTATION

B10.1 The contractor must provide a proposed written implementation plan in the response to this RFP. The final implementation schedule must be agreed to by MCHCP and the contractor within 30 days of the contract award. At a minimum, the timeline must include the required dates for the following activities:

- Testing of eligibility file;
- Acceptable date for final eligibility file;
- ID card and member material production and distribution;
- Finalization of benefit design; and
- Testing of claim file to data warehouse vendor

B10.2 The contractor must work with MCHCP to develop a schedule for testing of the eligibility test record set on electronic media. MCHCP requires that the contractor accept and run a test record set no later than September 7, 2018. Results of the test must be provided to MCHCP by September 21, 2018.

B10.3 At least forty-five (45) days prior to January 1, 2019 effective date, MCHCP or its designee will have a readiness review/pre-implementation audit of the contractor(s), including an on-site review of the contractor's facilities. The contractor shall participate in all readiness review activities conducted by MCHCP staff or its designee to ensure the contractor's operational readiness for all services (e.g. claims, eligibility, member services, network access, network management, medical management, contractor's staff education, etc.). MCHCP or its designee will provide the contractor with a summary of findings as well as

areas requiring corrective action. The contractor is responsible for all costs associated with this review/audit, including travel expenses of the MCHCP review team or its designee.

B10.4 The contractor must agree to place three (3) percent of annual premium at risk as an implementation fee guarantee for the successful implementation of MCHCP's plan on January 1, 2019.

B10.5 The contractor must agree to guarantee a control of trend increases within the plan which will not negatively impact members.

B10.6 The contractor will agree to a multi-year rate guarantee.

B11. CLINICAL MANAGEMENT

B11.1 The contractor shall integrate and coordinate the following types of services in order to utilize health care resources and achieve optimum patient outcome in the most cost effective manner: utilization management, case management, discharge planning, disease and demand management, quality management, and medical policy and technology assessment.

B11.2 The contractor shall prospectively and concurrently review the medical necessity, appropriate level-of-care and length-of-stay for scheduled hospital admissions, emergency hospital admissions, medical, surgical, mental health, and other health care services.

B11.3 The contractor shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. The contractor may develop its own clinical review criteria, or may purchase or license clinical review criteria from qualified vendors. The contractor shall make available its clinical review criteria upon request.

B11.4 The contractor shall provide physician-to-physician communication. A licensed clinical peer of the same medical specialty shall evaluate the clinical appropriateness of adverse determinations.

B11.5 The contractor shall obtain all information required to make a utilization review decision, including pertinent clinical information. The contractor shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

B11.6 Utilization management services will be conducted by licensed registered nurses and the contractor shall have available for review on a daily basis board certified specialists representing all appropriate specialties. The utilization management staff must consult with appropriate specialists and sub-specialists in conducting utilization review of hospital, physician, mental health services, and other outpatient services.

B11.7 The contractor shall provide a toll-free telephone number and adequate lines for plan members and providers to access the utilization management program.

B11.8 The contractor shall identify case management opportunities and provide case management services for members with specific health care needs which will assist patients and providers in the coordination of services across the continuum of health care services, optimizing health care outcomes and quality, while minimizing cost.

B11.9 The contractor shall have a mechanism to proactively identify and target for intensified management those cases having the potential to incur large expenditures.

B11.10 The contractor shall provide case managers who will be experienced, professional registered nurses, licensed clinical social workers, and counselors who work with patients and providers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

B11.11 Contractor is encouraged to offer disease management programs and services that the contractor may have in place.

B11.11.1 Bidder shall provide evidence of the effectiveness of its disease management programs, if applicable. Evidence should include member health improvement and the impact on costs.

B11.11.2 Contractor may be required to provide a progress report of MCHCP specific disease management programs at a minimum, after six months and one year of this contract.

B11.12 The contractor shall provide a toll-free line staffed by licensed RNs to answer medical questions from members. The nurse line must be available 24 hours a day, seven days a week.

B12. PAYMENTS

B12.1 The contractor shall agree that the monthly premiums due the contractor will be self-billed on a monthly basis and payment initiated via ACH by the tenth of the month following the month of coverage. MCHCP will remit all payments and provide all associated reports electronically.

B12.2 The contractor shall have the right to audit appropriate MCHCP records to determine the accuracy of the monthly payment.

B12.2.1 Any discrepancies must be identified by the contractor within 90 days after receipt of the payment and such discrepancy must be submitted in writing to MCHCP. Failure to identify a discrepancy within the timeframe stated shall be considered as acceptance of MCHCP's calculations and records.

B12.3 The contractor shall agree and understand that no broker commissions shall be paid by MCHCP.

B13. CLAIMS PAYMENT

B13.1 The contractor shall process all claims with incurred dates of service beginning with the contract effective date through December 31, 2019 and each subsequent year of this agreement.

B13.2 The contractor’s claim system must have processes and edits in place to identify improper provider billing. This includes, but is not limited to, up-coding, unbundling of services, “diagnosis creep”, and duplicate bill submissions.

B13.3 The contractor shall agree that if a claims payment platform change occurs throughout the course of the contract, MCHCP reserves the right to delay implementation of the new system for MCHCP members until a commitment can be made by the contractor that transition will be without significant issues. This may include requiring the contractor to put substantial fees at risk to ensure a smooth transition.

B13.4 All penalties assessed by law for failure to timely pay claims will be borne by the contractor.

B13.5 After the contract terminates, the contractor is required to continue processing claims as incurred during the insurance contract period at no additional cost to MCHCP.

B14. PERFORMANCE STANDARDS

B14.1 Performance standards are outlined in Section 20 of the Group Medicare Advantage Plan Questionnaire. The contractor shall agree that any liquidated damages assessed by MCHCP shall be in addition to any other equitable remedies allowed by the contract or awarded by a court of law including injunctive relief. The contractor shall agree that any liquidated damages assessed by MCHCP shall not be regarded as a waiver of any requirements contained in this contract or any provision therein, nor as a waiver by MCHCP of any other remedy available in law or in equity.

B14.2 Contractors are required to utilize the DirectPath Vendor Manager product that allows contractors to self-report compliance and non-compliance with performance guarantees. Unless otherwise specified, all performance guarantees are to be measured quarterly, reconciled quarterly and any applicable penalties paid quarterly. MCHCP reserves the right to audit performance standards for compliance.

B14.3 All performance guarantees must be finalized before a contract will be awarded and are subject to negotiation annually.

B15. TRANSITION ASSISTANCE

B15.1 In the event of contract termination or expiration, the contractor shall provide all reasonable and necessary assistance to MCHCP to allow for a functional transition to another contractor.

B16. MCHCP REQUIREMENTS AND SERVICE

B16.1 MCHCP will provide the following administrative services to assist the contractor:

- Certification of eligibility
- Enrollments (new, change, and terminations) in an electronic format
- Maintenance of individual eligibility and membership data
- Payment of monies due the contractor
- Coordination of open enrollment period, if necessary

EXHIBIT C
GENERAL PROVISIONS

C1. TERMINOLOGY AND DEFINITIONS

Whenever the following words and expressions appear in this Request for Proposal (RFP) document or any amendment thereto, the definition or meaning described below shall apply.

C1.1 **Amendment** means a written, official modification to an RFP or to a contract.

C1.2 **Bidder** means a person or organization who submitted an offer in response to this RFP.

C1.3 **Breach** shall mean the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI as defined, and subject to the exceptions set forth, in 45 C.F.R. 164.402.

C1.4 **Contract** means a legal and binding agreement between two or more competent parties, in consideration for the procurement of services as described in this RFP.

C1.5 **Contractor** means a person or organization who is a successful bidder as a result of an RFP and/or who enters into a contract or any subcontract of a successful bidder.

C1.6 **Employee** means a benefit-eligible person employed by the state and present and future retirees from state employment who meet the plan eligibility requirements.

C1.7 **May** means that a certain feature, component, or action is permissible, but not required.

C1.8 **Member** means any person covered as either a subscriber or a dependent in accordance with the terms and conditions of the plan.

C1.9 **Must** means that a certain feature, component, or action is a mandatory condition. Failure to provide or comply may result in a proposal being considered non-responsive.

C1.10 **Off-shore** means outside of the United States.

C1.11 **Participant** has the same meaning as the word member.

C1.12 **PHI** shall mean Protected Health Information, as defined in 45 C.F.R. 160.103, as amended.

C1.13 **Pricing Pages** apply to the form(s) on which the bidder must state the price(s) applicable for the services required in the RFP. The pricing pages must be completed and uploaded by the bidder prior to the specified proposal filing date and time.

C1.14 **Privacy Regulations** shall mean the federal privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, codified at 45 C.F.R. Parts 160 and 164 (Subparts A & E).

C1.15 **Proposal Filing Date and Time** and similar expressions mean the exact deadline required by the RFP for the receipt of proposals by DirectPath system.

C1.16 **Provider** means a physician, hospital, medical agency, specialist or other duly licensed health care facility or practitioner certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received. A doctor/physician as defined in 22 CSR 10-2010(22). Other providers include but are not limited to:

C1.16.1 Audiologist (AUD or PhD);
C1.16.2 Certified Addiction Counselor for Substance Abuse (CAC);
C1.16.3 Certified Nurse Midwife (CNM) – when acting within the scope of his/her license in the state in which s/he practices and performing a service which would be payable under this plan when performed by a physician;
C1.16.4 Certified Social Worker or Masters in Social Work (MSW)
C1.16.5 Chiropractor;
C1.16.6 Licensed Clinical Social Worker
C1.16.7 Licensed Professional Counselor (LPC);
C1.16.8 Licensed Psychologist (LP);
C1.16.9 Nurse Practitioner (NP);
C1.16.10 Physician Assistant (PA);
C1.16.11 Occupational Therapist;
C1.16.12 Physical Therapist;
C1.16.13 Speech Therapist;
C1.16.14 Registered Nurse Anesthetist (CRNA);
C1.16.15 Registered Nurse Practitioner (ARNP); or
C1.16.16 Therapist with a PhD or Master's Degree in Psychology or Counseling.

C1.17 **Request for Proposal (RFP)** means the solicitation document issued by MCHCP to potential bidders for the purchase of services as described in the document. The definition includes these Terms and Conditions as well as all Pricing Pages, Exhibits, Attachments, and Amendments thereto.

C1.18 **Respondent** means any party responding in any way to this RFP.

C1.19 **Retiree** means a former employee who, at the time of termination of employment, met the eligibility requirements as outlined in subsection 22 CSR 10-2.020(2)(B) and is currently receiving a monthly retirement benefit from a retirement system listed in such rule.

C1.20 **RSMo (Revised Statutes of Missouri)** refers to the body of laws enacted by the Legislature, which govern the operations of all agencies of the State of Missouri. Chapter 103 of the statutes is the primary chapter governing the operations of MCHCP.

C1.21 **Shall** has the same meaning as the word must.

C1.22 **Should** means that certain feature, component and/or action is desirable but not mandatory.

C1.23 **Subscriber** means the person who elects coverage under the plan.

C2. GENERAL BIDDING PROVISIONS

C2.1 It shall be the bidder's responsibility to ask questions, request changes or clarification, or otherwise advise MCHCP if any language, specifications or requirements of an RFP appear to be ambiguous, contradictory, and/or arbitrary, or appear to inadvertently restrict or limit the requirements stated in the RFP to a single source. Any and all communication from bidders

regarding specifications, requirements, competitive procurement process, etc., must be directed to MCHCP via the messaging tool on the Direct Path web site, as indicated on the last page of the *Introduction and Instructions* document of the RFP. Such communication must be received no later than Friday, April 13 2018, 4 p.m. CT (5 p.m. ET).

Every attempt shall be made to ensure that the bidder receives an adequate and prompt response. However, in order to maintain a fair and equitable procurement process, all bidders will be advised, via the issuance of an amendment or other official notification to the RFP, of any relevant or pertinent information related to the procurement. Therefore, bidders are advised that unless specified elsewhere in the RFP, any questions received by MCHCP after the date noted above might not be answered.

It is the responsibility of the bidder to identify and explain any part of their response that does not conform to the requested services described in this document. Without documentation provided by the bidder, it is assumed by MCHCP that the bidder can provide all services as described in this document.

C2.2 Bidders are cautioned that the only official position of MCHCP is that position which is stated in writing and issued by MCHCP in the RFP or an amendment thereto. No other means of communication, whether oral or written, shall be construed as a formal or official response or statement.

C2.3 MCHCP monitors all procurement activities to detect any possibility of deliberate restraint of competition, collusion among bidders, price-fixing by bidders, or any other anticompetitive conduct by bidders, which appears to violate state and federal antitrust laws. Any suspected violation shall be referred to the Missouri Attorney General's Office for appropriate action.

C2.4 No contract shall be considered to have been entered into by MCHCP until the contract has been awarded by the MCHCP Board of Trustees and all material terms have been finalized. The contract is expected to be finalized and signed by a duly authorized representative of Contractor in less than fifteen (15) days from MCHCP's initial contact to negotiate a contract. An award will not be made until all contract terms have been accepted.

C3. PREPARATION OF PROPOSALS

C3.1 Bidders must examine the entire RFP carefully. Failure to do so shall be at the bidder's risk.

C3.2 Unless otherwise specifically stated in the RFP, all specifications and requirements constitute minimum requirements. All proposals must meet or exceed the stated specifications and requirements.

C3.3 Unless otherwise specifically stated in the RFP, any manufacturer's names, trade names, brand names, and/or information listed in a specification and/or requirement are for informational purposes only and are not intended to limit competition. Proposals that do not comply with the requirements and specifications are subject to rejection without clarification.

C4. DISCLOSURE OF MATERIAL EVENTS

C4.1 The bidder agrees that from the date of the bidder's response to this RFP through the date for which a contract is awarded, the bidder shall immediately disclose to MCHCP:

C4.1.1 Any material adverse change to the financial status or condition of the bidder;

C4.1.2 Any merger, sale or other material change of ownership of the bidder;

C4.1.3 Any conflict of interest or potential conflict of interest between the bidder's engagement with MCHCP and the work, services or products that the bidder is providing or proposes to provide to any current or prospective customer; and

C4.1.4 (1) Any material investigation of the bidder by a federal or state agency or self-regulatory organization; (2) Any material complaint against the bidder filed with a federal or state agency or self-regulatory organization; (3) Any material proceeding naming the bidder before any federal or state agency or self-regulatory organization; (4) Any material criminal or civil action in state or federal court naming the bidder as a defendant; (5) Any material fine, penalty, censure or other disciplinary action taken against the bidder by any federal or state agency or self-regulatory organization; (6) Any material judgment or award of damages imposed on or against the bidder as a result of any material criminal or civil action in which the bidder was a party; or (7) Any other matter material to the services rendered by the bidder pursuant to this RFP.

C4.1.4.1 For the purposes of this paragraph, "material" means of a nature, or of sufficient monetary value, or concerning a subject which a reasonable party in the position of and comparable to MCHCP would consider relevant and important in assessing the relationship and services contemplated by this RFP. It is further understood that in fulfilling its ongoing responsibilities under this paragraph, the bidder is obligated to make its best faith efforts to disclose only those relevant matters which come to the attention of or should have been known by the bidder's personnel involved in the engagement covered by this RFP and/or which come to the attention of or should have been known by any individual or office of the bidder designated by the bidder to monitor and report such matters.

C4.2 Upon learning of any such actions, MCHCP reserves the right, at its sole discretion, to either reject the proposal or continue evaluating the proposal.

C5. COMPLIANCE WITH APPLICABLE FEDERAL LAWS

C5.1 In connection with the furnishing of equipment, supplies, and/or services under the contract, the contractor and all subcontractors shall comply with all applicable requirements and provisions of the Health Insurance Portability and Accountability Act (HIPAA) and The Patient Protection and Affordable Care Act (PPACA), as amended.

C5.2 Any bidder offering to provide services must sign a Business Associate Agreement (BAA) (see Exhibit A-7) due to the provisions of HIPAA. Any requested changes shall be noted and returned with the RFP**. The changes are accepted only upon MCHCP signing a revised BAA after contract award.**

C5.3 Upon awarding of the contract by the Board, the BAA shall be signed by both parties within five (5) working days of the request to sign, or the award of the contract may be rescinded.

ATTACHMENT 1
LAYOUT FOR MCHCP ENROLLEE FILE

Field Name	Description
Random Number	Random number assigned by MCHCP
Relationship	Identifies if member is subscriber, spouse, or child 01 – subscriber 02 – spouse
Plan Type	Identifies plan type member is enrolled PPO 300 – PPO 300 Plan PPO 600 – PPO 600 Plan Rx – Medicare Prescription Drug Only Plan
Medical Tier	Identifies subscriber's level of coverage MI – Employee Only MS – Employee and Spouse MC – Employee and Child(ren) MF – Employee, Spouse, and Child(ren) SC – Surviving Child
Status	Identifies status of member RTN – Retired Employee DSB – Participant on Long Term Disability SVR – Survivor VES – Vested Participant
Medicare	Indicates if subscriber is on Medicare P – Subscriber does have Medicare S – Spouse of Subscriber has Medicare B – Subscriber and Spouse both have Medicare
Zip Code	Zip code corresponding to the members' residence.
YOB	Year of birth
Gender	M – Male F – Female

Attachment 3
Provider File Layouts

Provide comma separated text files listing physicians and facilities in your network as of January 1, 2018. Limit your network files to Missouri providers. If a provider has more than one office location, provide a record for each address. Provide a crosswalk for provider specialty. The following file layout should be used:

Physician File Layout

1. Missouri License Number
2. Out of State License Number
   (if applicable and only if no Missouri License Number)
3. Last Name
4. First Name
5. Middle Initial
6. Title (MD, DO, PHD, DSS, etc.)
7. Role 1 (PCP or SPEC)
8. Role 2 (PCP or SPEC)
9. Provider Specialty (Family Practice, Urology, OB/GYN, etc.)
10. Accepting New Patients (Y or N)
11. Accepts Medicare Assignment (Y or N)
12. Street 1 (street address, no P.O. Box)
13. Street 2 (suite number, etc.)
14. City
15. State
16. Zip
17. Phone (area code & 7 digits)
18. County

Facility File Layout

1. Tax Identification Number
2. Facility Name
3. Type of Facility (Hospital, Surgery Center, DME Supplier, Home Health, etc.)
4. Street 1 (street address, no P.O. Box)
5. Street 2 (suite number, etc.)
6. City
7. State
8. Zip
9. Phone (area code & 7 digits)
10. County

Attachment 4

Claims experience

Subsets	Members with Medicare	
State or Public Entity	State	
Time Period: Incurred Plan Year	Jan 2016 - Dec 2016	Jan 2017 - Nov 2017
Allowed Amount IP Acute Fac	$35,296,555.51	$33,689,291.65
Net Pay IP Acute Fac	$3,466,676.75	$3,207,357.18
Allowed Amount IP Non Acute Fac	$22,100.02	$0.00
Net Pay IP Non Acute Fac	$10,463.26	$0.00
Allowed Amount IP LTC Fac	$10,418,517.18	$8,821,949.18
Net Pay IP LTC Fac	$1,727,719.71	$1,602,494.77
Allowed Amount OP Fac Med	$37,760,518.16	$36,598,019.50
Net Pay OP Fac Med	$5,148,120.80	$4,553,595.37
Allowed Amount OP Prof Med	$41,770,275.57	$40,017,091.19
Net Pay OP Prof Med	$8,525,689.54	$7,971,782.34
Allowed Amount IP Acute Prof	$5,907,059.82	$5,603,267.03
Net Pay IP Acute Prof	$894,271.51	$853,073.90
Allowed Amount IP Non Acute Prof	$33,558.06	$37,616.58
Net Pay IP Non Acute Prof	$4,865.16	$4,953.54
Allowed Amount IP LTC Prof	$761,123.42	$719,938.11
Net Pay IP LTC Prof	$126,318.41	$132,366.23
Allowed Amount Med	$131,969,707.74	$125,487,450.07
Net Pay Med	$19,904,125.14	$18,325,635.72

2017 Claims experience represent claims incurred through Nov. 2017 and paid through Feb. 2018.

Attachment 4

Claims experience by service category

State

Subsets	Members with Medicare					
Time Period: Incurred Plan Year	Jan 2016 - Dec 2016			Jan 2017 - Nov 2017		
Service Category	Patients Med	Allowed Amount Med	Net Pay Med	Patients Med	Allowed Amount Med	Net Pay Med
Facility Inpatient Long Term Care	558	$9,935,701.55	$1,646,449.31	482	$8,517,074.21	$1,564,547.02
Facility Inpatient Maternity				2	$23,062.72	$21,971.84
Facility Inpatient Medical	2,339	$16,457,968.17	$2,509,668.97	2,249	$16,891,280.50	$2,391,476.92
Facility Inpatient Non Acute	8	$22,100.02	$10,463.26	3	$0.00	$0.00
Facility Inpatient Surgical	943	$18,307,694.62	$866,193.34	867	$16,500,738.34	$741,324.40
Facility Outpatient DME	14	$46,478.41	$38,208.95	33	$61,080.49	$39,463.35
Facility Outpatient Diagnostic Services	3,439	$521,831.19	$63,406.31	2,123	$558,306.87	$59,204.53
Facility Outpatient Dialysis	73	$57,560.61	$2,037.92	58	$23,112.92	$6,697.44
Facility Outpatient ER	3,106	$3,416,671.99	$516,971.99	1,189	$866,026.39	$93,663.68
Facility Outpatient Home Health	945	$55,088.16	$5,795.74	110	$41,541.57	$6,579.22
Facility Outpatient Other	8,788	$20,806,755.79	$2,748,144.41	9,621	$29,527,597.68	$3,626,797.17
Facility Outpatient PT, OT, Speech Therapy	2,225	$462,723.63	$52,796.98	834	$392,363.13	$43,329.11
Facility Outpatient Pharmacy	3,337	$209,613.27	$44,190.42	1,192	$468,689.20	$117,459.91
Facility Outpatient Specialty Drugs	579	$81,615.44	$16,396.84	284	$79,478.90	$16,211.44
Facility Outpatient Supplies and Devices	1,383	$65,698.76	$17,519.91	526	$67,892.36	$12,004.29
Facility Outpatient Surgery	3,397	$10,821,206.72	$1,426,922.56	1,481	$3,451,659.06	$385,013.38
Facility Outpatient Transportation	290	$70,124.54	$13,123.05	117	$79,127.88	$11,750.21
Laboratory Outpatient Chemistry Tests	4,748	$184,214.71	$51,766.49	3,204	$176,337.08	$53,090.51
Laboratory Outpatient Other	5,658	$100,333.58	$26,283.65	4,307	$121,366.30	$32,510.29
Laboratory Outpatient Pathology	3,716	$712,029.92	$102,902.45	3,544	$680,659.75	$102,116.69
Mental Health Inpatient	364	$1,134,519.96	$189,973.97	309	$679,960.60	$105,727.61
Mental Health Office Visits	1,178	$238,798.84	$27,441.97	1,163	$223,337.49	$24,881.16
Mental Health Other Outpatient	1,178	$776,074.09	$111,134.30	1,133	$654,921.48	$85,711.73
Physician Non-Specialty ER	1,133	$165,085.00	$23,237.71	1,165	$180,558.10	$24,240.07
Physician Non-Specialty Inpatient	2,164	$1,575,475.68	$242,620.46	2,116	$1,455,281.73	$215,338.70
Physician Non-Specialty Office Visits	10,956	$3,642,287.63	$504,403.87	10,893	$3,366,483.71	$426,236.95
Physician Non-Specialty Outpatient Other	3,833	$486,606.13	$99,787.27	3,615	$398,653.46	$59,644.03
Physician Non-Specialty Outpatient Surgery	598	$298,703.20	$38,447.77	453	$207,857.38	$25,912.27
Physician Specialty ER	3,197	$713,359.29	$105,662.76	2,990	$680,017.82	$101,829.49
Physician Specialty Inpatient	2,859	$4,260,252.77	$628,781.54	2,767	$4,016,522.67	$593,483.92
Physician Specialty Office Visits	10,918	$3,966,762.94	$474,279.23	11,080	$3,779,976.03	$439,592.01
Physician Specialty Outpatient Other	8,322	$2,465,777.82	$305,160.65	8,240	$2,378,919.86	$277,367.60
Physician Specialty Outpatient Surgery	4,421	$3,570,990.23	$470,842.57	4,315	$3,521,591.81	$467,145.89
Professional Chiropractic Services	1,244	$459,272.88	$104,307.94	1,253	$424,281.21	$92,162.33
Professional DME	2,388	$4,030,855.64	$2,324,778.23	2,210	$3,449,369.39	$2,097,914.62
Professional Diagnostic Services	8,666	$1,649,632.75	$195,565.99	8,473	$1,529,851.32	$174,553.61
Professional Dialysis	87	$166,768.15	$29,593.34	79	$148,734.29	$25,663.06
Professional Home Health	304	$263,806.92	$178,205.94	281	$203,380.89	$151,951.51
Professional Injections	3,552	$1,061,728.24	$267,679.90	3,597	$1,160,161.17	$294,597.84
Professional Office Visits	5,761	$919,523.36	$121,392.86	6,126	$989,930.68	$116,871.39

Time Period: Incurred Plan Year	Jan 2016 - Dec 2016			Jan 2017 - Nov 2017		
Service Category	Patients Med	Allowed Amount Med	Net Pay Med	Patients Med	Allowed Amount Med	Net Pay Med
Professional PT, OT, Speech Therapy	1,339	$992,844.25	$244,497.09	1,309	$974,790.84	$238,026.84
Professional Services Other	7,628	$3,587,884.45	$526,819.17	7,684	$3,789,447.95	$575,552.25
Professional Specialty Drugs	841	$6,549,349.36	$1,212,361.36	858	$6,254,489.27	$1,155,092.33
Professional Supplies and Devices	3,740	$2,330,541.17	$562,047.03	3,527	$2,278,295.97	$543,208.54
Professional Transportation	1,426	$1,495,555.83	$333,490.75	1,290	$1,441,426.73	$309,771.45
Radiology Outpatient CAT Scans	2,402	$415,745.85	$58,903.21	2,332	$442,721.29	$55,930.05
Radiology Outpatient MRIs	1,883	$501,582.73	$85,028.94	1,829	$482,742.42	$60,174.77
Radiology Outpatient Mammograms	1,033	$82,310.03	$9,295.77	931	$110,225.49	$11,866.40
Radiology Outpatient Nuclear Medicine	1,116	$190,380.40	$28,750.28	941	$187,496.35	$21,156.10
Radiology Outpatient Other	1,319	$259,100.65	$34,853.12	1,319	$250,929.99	$32,916.22
Radiology Outpatient Therapeutic Radiology	147	$595,894.82	$102,138.28	143	$581,604.91	$107,232.40
Radiology Outpatient Ultrasounds	2,210	$246,891.48	$28,781.53	2,068	$212,937.15	$25,555.34
Radiology Outpatient X-Rays	6,249	$485,301.10	$65,806.59	6,099	$445,475.16	$55,597.27
Substance Abuse Inpatient	9	$40,831.85	$6,111.69	7	$35,720.03	$4,057.49
Substance Abuse Office Visits	17	$3,127.21	$521.93	26	$3,470.83	$303.34
Substance Abuse Other Outpatient	26	$10,673.96	$2,177.58	17	$18,489.25	$3,157.74

2017 Claims experience represent claims incurred through Nov. 2017 and paid through Feb. 2018.

Attachment 4

MC state members by month

State

Subsets	Members with Medicare			
Time Period: Incurred Month	Members Med	Allowed Amount Med	Net Pay Med	Third Party Amt Med
Dec 2015	14,021	$12,020,566.78	$2,111,727.41	$9,417,257.49
Jan 2016	13,980	$10,658,577.93	$1,098,107.44	$7,221,461.55
Feb 2016	14,005	$10,440,178.59	$1,235,821.15	$7,605,970.10
Mar 2016	14,040	$11,241,361.08	$1,614,329.40	$8,373,811.43
Apr 2016	14,078	$10,982,816.38	$1,526,191.64	$8,438,872.29
May 2016	14,114	$10,386,884.03	$1,536,383.86	$8,028,750.54
Jun 2016	14,162	$10,475,331.96	$1,731,913.35	$7,996,621.79
Jul 2016	14,211	$10,236,891.14	$1,630,550.94	$8,007,503.62
Aug 2016	14,279	$11,610,165.34	$1,875,399.37	$9,083,422.99
Sep 2016	14,327	$10,664,588.88	$1,716,395.67	$8,406,544.46
Oct 2016	14,393	$11,926,673.22	$1,976,527.87	$9,403,824.67
Nov 2016	14,435	$11,569,309.24	$1,856,478.99	$9,212,965.59
Dec 2016	14,473	$11,776,929.95	$2,106,025.46	$9,164,893.38
Jan 2017	14,470	$11,886,066.26	$1,179,285.25	$8,240,429.48
Feb 2017	14,512	$10,984,967.37	$1,289,788.88	$8,100,455.44
Mar 2017	14,549	$11,780,736.34	$1,497,515.35	$8,920,090.06
Apr 2017	14,597	$10,856,002.90	$1,503,324.29	$8,326,025.20
May 2017	14,638	$11,357,690.80	$1,674,525.17	$8,783,194.90
Jun 2017	14,714	$11,753,105.71	$1,889,636.48	$9,072,613.75
Jul 2017	14,778	$10,774,913.38	$1,708,360.73	$8,424,705.42
Aug 2017	14,853	$11,970,362.87	$1,886,952.91	$9,395,737.72
Sep 2017	14,913	$11,009,374.74	$1,832,254.27	$8,619,455.41
Oct 2017	14,967	$12,005,805.70	$1,968,224.64	$9,475,003.57
Nov 2017	14,994	$11,108,424.00	$1,895,767.75	$8,700,340.69

Attachment 4

Utilization

State

Subsets	Members with Medicare	
Time Period: Incurred Plan Year	Jan 2016 - Dec 2016	Jan 2017 - Nov 2017
Patients Admit	2,386	2,285
Admits	2,902	2,682
Days Admit	14,289	12,266
Admits Per 1000 Acute	204.25	198.69
Days Per 1000 Adm Acute	1,005.70	908.68
Visits Office Med	151,601	142,661
Visits Per 1000 Office Med	10,670.05	10,568.46
Visits ER	8,171	2,270
Visits Per 1000 ER	575.10	168.16
Svcs OP Lab	111,637	45,978
Svcs Per 1000 OP Lab	7,857.29	3,406.09
Svcs OP Rad	73,317	51,628
Svcs Per 1000 OP Rad	5,160.23	3,824.65

2017 Claims experience represent claims incurred through Nov. 2017 and paid through Feb. 2018.

Attachment 4

Definitions

Measure	Definition
Allowed Amount IP Acute Fac	The amount of submitted charges eligible for payment for inpatient acute facility services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay IP Acute Fac	The net amount paid for inpatient acute facility services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount IP Non Acute Fac	The amount of submitted charges eligible for payment for inpatient non-acute care facility services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts. Inpatient non-acute care settings include hospices and inpatient rehabilitation facilities.
Net Pay IP Non Acute Fac	The net amount paid for inpatient non-acute care facility services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted. Inpatient non-acute care settings include hospices and inpatient rehabilitation facilities.
Allowed Amount IP LTC Fac	The amount of submitted charges eligible for payment for inpatient long term care facility services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay IP LTC Fac	The net amount paid for inpatient long term care facility services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount OP Fac Med	The amount of submitted charges eligible for payment for outpatient facility services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay OP Fac Med	The net amount paid for outpatient facility services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount OP Prof Med	The amount of submitted charges eligible for payment for outpatient professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay OP Prof Med	The net amount paid for outpatient professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount IP Acute Prof	The amount of submitted charges eligible for payment for inpatient acute professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay IP Acute Prof	The net amount paid for inpatient acute professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.

Measure	Definition
Allowed Amount IP Non Acute Prof	The amount of submitted charges eligible for payment for inpatient non-acute care professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts. Inpatient non-acute care settings include hospices and inpatient rehabilitation facilities.
Net Pay IP Non Acute Prof	The net amount paid for inpatient non-acute care professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted. Inpatient non-acute care settings include hospices and inpatient rehabilitation facilities.
Allowed Amount IP LTC Prof	The amount of submitted charges eligible for payment for inpatient long term care professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay IP LTC Prof	The net amount paid for inpatient long term care professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Allowed Amount Med	The amount of submitted charges eligible for payment for facility and professional services provided under medical coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.
Net Pay Med	The net amount paid for facility and professional services provided under medical coverage. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.
Patients Admit	The unique count of members who were admitted to an inpatient acute or non-acute facility. Patients are included in this count if they received facility or professional services included in an admission.
Admits	The number of acute and non-acute admissions.
Days Admit	The number of days from admissions. The number of days is assigned during Admission Build. It is based on the days that were reported on those facility claims containing room and board services that are included in the admission.
Admits Per 1000 Acute	The average number of acute admissions per 1000 members with medical coverage per year.
Days Per 1000 Adm Acute	The average number of days from acute admissions per 1000 members with medical coverage per year.
Visits Office Med	The number of professional visits provided in an office setting under medical coverage. The number of visits is based on the count of unique patient, service date, and provider combinations.
Visits Per 1000 Office Med	the average number of professional office visits provided under medical coverage, per 1000 members with medical coverage per year. The number of visits is based on the count of unique patient, service date, and provider combinations.
Visits ER	The number of emergency room facility visits provided under medical coverage. The number of visits is based on the count of unique patient and service date combinations. This includes both ER visits that resulted in an admission and those that did not.
Visits Per 1000 ER	The average number of emergency room facility visits provided under medical coverage, per 1000 members with medical coverage per year. The number of visits is based on the count of unique patient and service date combinations.

Measure	Definition
Svcs OP Lab	The sum of the Service Count field for outpatient facility and professional laboratory and pathology services provided under medical coverage. The Service Count field typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the Service Count is set to 1 (one).
Svcs Per 1000 OP Lab	The average number of outpatient laboratory and pathology services provided under medical coverage, per 1000 members with medical coverage per year. The Service Count field typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the Service Count is set to 1 (one).
Svcs OP Rad	The sum of the Service Count field for outpatient facility and professional radiology and imaging services provided under medical coverage. The Service Count field typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the Service Count is set to 1 (one).
Svcs Per 1000 OP Rad	The average number of outpatient radiology and imaging services provided under medical coverage, per 1000 members with medical coverage per year. The Service Count field typically represents the units submitted on the claim. However, for certain services such as anesthesia, blood, medical supplies, injections, and ambulance services, the Service Count is set to 1 (one).