Notice of Intent to Negotiate

THE CITY OF NEW YORK
OFFICE OF LABOR RELATIONS
EMPLOYEE BENEFITS PROGRAM
NEGOTIATED ACQUISITION 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

Basic Information

Negotiation Documents Due Date	January 11, 2021
Agency Contact Person	Georgette Gestely Title: Director, Employee Benefits Program Mailing Address: 22 Cortlandt Street, 12th Floor New York, NY 10007 Email: RPretax@nyceplans.org
Expression of Interest Instructions	Your organization has been selected by the Agency to enter into negotiations. If your organization is interested in continuing in the Negotiated Acquisition process to be considered for award, please electronically submit the Negotiation Documents, as defined below below (Please see Section 3 - Negotiation Documents Content & Instructions), addressed to the contact person above, via the secure method established by the Agency, as described below, no later than 4:30 P.M. E.D.T. on January 11, 2021. Electronic submission of the Negotiation Documents, via a secure site: Please be advised that all of the Negotiation Documents must be provided via electronic files to a secure file-sharing system. If your organization is submitting the Negotiation Documents, please contact Elizabeth Krupa at ekrupa@olr.nyc.gov (Monday through Friday 9am-5pm, excluding holidays) indicating your intent to submit the Negotiation Documents and provide the name and e-mail contact for the individual who will be uploading the files to the secure site. In a reasonable amount of time, a secure link will be

	generated (from the secure file-sharing system) and sent to the contact individual at your organization with instructions on how to upload your documents to the secure site. Please be advised, due to the current circumstances, please submit your Negotiation Documents timely. Please do NOT email any Negotiation Documents to ekrupa@olr.nyc.gov or RPretax@nyceplans.org. Any questions about the requirements of this Negotiated Acquisition or the documents contained therein should be emailed to the Agency Contact Person at RPretax@nyceplans.org. RESPONSES TO ALL QUESTIONS RECEIVED BY December 28, 2020 WILL BE POSTED BY December 30, 2020 IN THE FORM OF ADDENDAS TO THE NEGOTIATED ACQUISITION ON THE OLR WEBSITE.
Anticipated Contract Term	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. The contract shall also include three options to renew, beginning July 1, 2026 for two-years each. OLR reserves the right, prior to contract award, to determine the length of the initial contract term and the option to renew, if any.
Anticipated Number Contracts [& Competition Pools]	It is anticipated that the Agency will award one contract as a result of this procurement.
Anticipated Funding	It is anticipated that the annual funding for the contract awarded as a result of this procurement will be approximately $600M. The purpose of this procurement is to administer a health benefits program in the form of a Medicare Advantage plan in the most cost-effective manner that will lower the Health Benefits Program's overall costs while continuing to provide quality coverage and services to covered members.
Payment Structure	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.
Subcontracting (If applicable)	Subcontracting will be permissible under the awarded contract, subject to the approval of the Agency.

1. **<u>Program Background</u>**

   This Negotiated Acquisition (NA) is issued by the Mayor's Office of Labor Relations – Employee Benefits Program (OLR) on behalf of the Labor Management Health Insurance Policy Committee for the New York City Health Benefits Program. The purpose of this NA is to solicit responses from technically qualified vendors to provide health benefits services in the form of a Medicare Advantage plan under Medicare Part C for the Medicare eligible retirees and dependents of the City of New York who are eligible for the City's Health Benefits Program, on or about effective July 1, 2021. (Please see Section 3 - Negotiation Documents Content & Instructions)

   New York City Health benefits are determined through the collective bargaining process between the City and the Municipal Labor Committee (MLC), an umbrella organization to which the municipal unions belong. The City of New York currently provides many health plan options for Medicare eligible retirees and their Medicare eligible dependents. Through the HBP, the City provides coverage to approximately 245,000 Medicare eligible members and dependents as of December 31, 2019. The plan with the most membership (approximately 200,000 members) is the GHI/Empire Blue Cross Blue Shield Senior Care Plan (Senior Care). This is a comprehensive PPO medical plan

which is fully insured under a minimum premium arrangement. Facility coverage is administered separately from professional and other related services (coverage provided by Empire BCBS and GHI (Emblem), respectively.) The next most populated plan (approximately 30,000 members) is a Medicare HMO, insured and administered by HIP (Emblem). Both the Senior Care plan and the HIP HMO (VIP) are offered to participants and their dependents without any participant premium contribution requirements. The City offers various other plan options and prescription drug riders for Medicare eligible members and dependents.

This NA requests an extended service area (ESA) or passive PPO Medicare Advantage product (i.e. cost sharing for the member at any willing Medicare provider would be the same).

The City does not provide prescription drug coverage to its members; coverage is available through either an optional rider at full cost to the members, or through union-sponsored benefit programs. Although prescription drug coverage is not the focus of this NA, we are asking respondents to include in their expression of interest a Medicare prescription drug optional rider for those members who choose to elect the rider. (Currently, 6,300 members elect this optional rider).

The City also currently offers a 365-day hospital rider that provides for coverage beyond the standard Medicare days. Respondents are requested to include this benefit as part of the standard offering and as an optional rider to be voluntarily purchased by the participant.

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.

A significant number of members and dependents reside in the five boroughs of New York City and the surrounding counties, so it is important that the available network of hospitals and physicians be strong in New York City. However, as Medicare eligible members are scattered across the United States, national availability of providers is required.

The City and the MLC desire to select a vendor that will ensure its healthcare benefit program delivers to its Medicare eligible members and dependents a positive member experience and comprehensive, cost effective, quality healthcare choices. We expect the selected vendor to provide de-identified detailed claim data to the City, specific to its members, as well as to offer data management and analytics to support informed City decision-making. Additionally, the selected vendor is expected to provide care management and clinical coaching support that is specifically geared to the Medicare-eligible population, as well as to provide information and tools to help Medicare eligible members and dependents make appropriate medical purchase decisions and create the potential for them to lead longer and healthier lives. The City and its Unions also have significant expectations of savings from this program, including multi-year rate guarantees, and as such will be more likely to adopt a construct that maximizes those savings.

The Health Benefits Program is currently administered in accordance with the present plan provisions and program description as indicated in New York City Summary Program Description - Health Benefits Program located on the OLR website at:
http://www1.nyc.gov/site/olr/health/summaryofplans/health-full-spd-page.page

2. Program Requirements

A. Agency Goals and Objectives for this NA

- Enhance quality of care
    - Clinical Quality
        - Improve clinical outcomes and member quality of life
        - Improve quality of network(s) and the providers within them
        - Ensure quality and effectiveness of wellness/disease management and utilization programs specific to an older population, as well as to an under 65, disabled population
    - Service Quality
        - For members: Optimize member service experience; empower them to make high value, high quality choices; and leveraging technology to provide senior-appropriate information to do that
        - For the City: Coordinate and collaborate with the City and share/report appropriate data to enable fact-based decision-making
- Maximize the value of care received by the enrollees and services provided by the vendor to the City
    - Maximized CMS Star quality rating and efforts to improve Star rating
    - Provide competitive network discounts and fees, based on provider payment structures that reward appropriate care and improvement of health status
    - Provide compelling approach for managing cost trajectory (e.g., through utilization management, population health management, or shifting to lower-cost, higher-quality settings of care)
    - Share perspectives on new provider payment and care delivery models (e.g., ACOs)
- Optimize network access and performance
    - Ensure sufficient breadth of network(s) to provide coverage across specialties and services that meet the City's geographic access requirements
    - Ensure an approach to mitigate disruption to members currently on a different plan

B. Agency Assumptions Regarding Contractor Experience

- As of April 2020 the Proposer had at least five (5) years of experience providing health benefit services in the form of a Medicare advantage plan under Medicare Part C;
- Show and experience as a firm in providing Medicare Advantage programs, particularly to employer groups
- The Proposer should have experience in providing a Medicare advantage plan under Medicare Part C of similar size and scale to the Senior Care plan;
- Preferred experience in providing a Medicare advantage plan under Medicare Part C with a demonstrated capability of managing large employer plans

C. Agency Assumptions Regarding Organizational Capability

- As of December 31, 2019, the Proposer had membership in their Medicare Advantage HMO/PPO plan(s) of 250,000 or more in the Greater New York area;

- As of December 31, 2019, the Proposer had a minimum of five (5) public sector employers and/or unions participating in their Medicare Advantage Plan;
- As of December 31, 2019, the Proposer had at least one client with 50,000 employees and at least one other client with 50,000 members;
- Provide a Medicare prescription drug optional rider;
- Maintain a strong network of hospitals and physicians in New York City. However, as Medicare eligible members are scattered across the United States, national availability of covered providers is required.

D. Agency Assumptions Regarding Contractor Approach

The prospective respondent will be expected to perform the following services at a minimum:

1. Respondent will act as plan fiduciary.

2. Assign a team of appropriately trained personnel, dedicated to the City

3. The Respondent must meet with the City and its representatives as necessary.
4. When requested, the Respondent shall provide, at no cost to the City, staff to participate in meetings, conference calls, etc., to support management of the Medicare Advantage plan including, but not limited to those responsible for the:
    a. Management of the account
    b. Management of claims processing and medical services
    c. Recruitment and retention of providers
    d. Development and implementation of medical policy
    e. Dedicated Medical Director(s) and clinical staff
    f. Management information systems and member relations
    g. Support of other benefit programs provided by the City or its unions
    h. Strategic planning
5. The Respondent must assist in preparing and providing electronic print-ready Summary Program Descriptions and other formal plan documents, brochures, advisory letters, and communication materials at no cost to the City. Notwithstanding CMS requirements, the City requires complete flexibility to review and edit all communication materials.
6. The Respondent must assist in assessing the fiscal and policy impacts of legislation and regulations at the state and federal level, including any potential direct or indirect impact upon the City's health plans.
7. With reasonable notice by the City, the Respondent agrees to the City's right to modify benefits, number, and type of plans offered, employer contribution, and scope of services to be provided during the contract period.
8. The Respondent must agree to coordinate as necessary with other City vendors to provide information and reporting to the City.
9. Respondent must have full HIPAA, Electronic Data Interface (EDI), and Privacy compliance. All City member data will be maintained in accordance with applicable federal, state, and local regulations to ensure protection and confidentiality.
10. Respondent must have strict policies and procedures for the protection of client and member Personal Health Information (PHI) and avoidance of security breaches under HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH). The Respondent must have breach notification procedures in the event of a release of PHI.
11. Respondent is required to assist the City in any and all reporting and compliance efforts related to local, state, and federal legislation, such as New York Health Care Reform Act (HCRA), creditable coverage requirements, and so forth.
12. The Contractor(s) will not in any way charge, and the City will not pay, commissions to insurance agents or brokers.

13. The Proposer's administrative expense charges and premium rates cover all of the required activities and materials of this contract.

Enrollment and Eligibility

14. At no additional cost to the City, the Respondent must support the annual open enrollment period established by the City. The support includes assistance with plan design changes and materials, including health benefit plan documents. All materials provided must be approved by the City and the MLC prior to distribution.
15. At no additional cost to the City, the Respondent agrees to accept Medicare Advantage enrollment and disenrollment in conjunction with the Special Election Period. This enrollment is not restricted to Medicare annual open enrollment and is determined by the member's last enrollment decision. Currently, a member can change his or her enrollment election at any time, so long as twelve months have passed since the previous election. The City is considering alternative requirements for enrollment election.
16. The Contractor(s) will maintain subscriber eligibility files for entities that control their own payrolls, and will provide reporting as requested by the City.
17. The Contractor(s) will be responsible for all direct and associated costs of the production and mailing/electronic communications of: subscriber certificates of insurance, directories of participating providers, transfer period materials and activities, Summary Program Descriptions, direct notification of benefit modifications, and other necessary subscriber materials, after review and approval of their content by the City.
18. The Contractor(s) will be directly responsible for all start-up and acquisition costs for the administration of the contract(s).
19. The Respondent must securely transmit the necessary and appropriate information to any other organization that the City has contracted with to perform any services applicable to the provision of benefits under the plan as approved by the City.
20. The Respondent must have the ability to terminate coverage for retirees and their dependents immediately, except for termination due to divorce which takes effect the day after divorce, and at the age of 26 which terminates at the end of the month.
21. The Respondent must store historical information by member with the Social Security number (SSN) and retiree identification number as an access key for at least ten years.
22. The Respondent must support retroactive enrollments and terminations of up to one year for members in situations allowable under the Affordable Care Act and CMS rules.
23. The Respondent must store dependent information as sent by the City and only pay claims for those dependents actively enrolled.
24. The Respondent must ensure that only City-originated eligibility information and changes will be reflected on the plan records contained in the Contractor's files and that discrepancies between City-originated eligibility information and information contained in the vendor's systems are reported on within 72 hours following successful upload of eligibility files.
25. The Respondent must provide edits/security to ensure the integrity of the data on the Respondent files.
26. The Respondent must accept alternative sequence numbers in lieu of actual SSNs for newborns and foreign nationals.

Reporting

27. The Respondent must conform to standards for data interoperability, and must be willing to share data proactively and collaboratively with the City and other vendors, such that care coordination is not hindered. Typical information required would be claims data such as utilization, diagnostics, etc.

28. The Respondent will provide detailed claim data on all products and plans applicable to City members in detail, including individual claim line data, detailed information on plan expenses, CMS funding, and all details available.

Financial

29. The Respondent will never charge the City for any payment that is greater than the actual amount paid by the Contractor.
30. The Respondent must submit to the City on an annual basis or upon request a summary of the gross claims, CMS subsidies received, and any other fees and expenses (including but not limited to administrative fees and fees related to the ACA) incurred by the Plan.
31. The Respondent must provide financial reporting 45 days (under no circumstances to exceed 60 days) following the end of each quarter.

Technical Resources/Communications

32. The Respondent must resolve/accommodate all data processing problems/changes within a reasonable time period mutually agreed upon, and the required changes must be implemented in a timely manner. The City will identify how the technical priorities will be set.
33. The Contractor's staff will be required to participate in IT system status meetings on at least a semiannual basis. This would include but not be limited to, the Account executive, IT, Eligibility, and Claims Managers. The meetings will focus on open IT problems/changes and any issues associated with them.
34. All changes (City or Respondent generated) must be tested between the City and the Respondent prior to implementation.
35. The Respondent shall immediately notify the City of technical problems that impact the website availability or any other service that impacts the member or the City.

Record Keeping

36. Subject to legal requirements, the Respondent must have no interest in, nor have any obligation to provide, any aggregate claim or payment data maintained or copied by the Respondent for its own uses outside of the scope of this Contract. Such information may not be used for any purposes which may be detrimental to the City.
37. All Claims Records and other records possessed by the Respondent as claims administrator under this Contract ("Records") must be retained in accordance with applicable federal and City record retention requirements, but in any case will be kept and retrievable for no less than ten (10) years. Records must be retained for two (2) years online from the date of service or from the date final payment is made on the claim, whichever is later.
38. All data records will be maintained by the administrator but will be the property of the City of New York (or another party designated by the City) within 30 days of notification of termination and without cost.
39. If a claim becomes the subject of litigation, the Respondent must provide the City all claim information related to that claim as necessary for litigation purposes and participate as fact or expert witnesses. In the case where an expert witness is necessary, one must be provided at a reasonable and customary fee. This provision will survive termination of this Contract.
40. The Contractor(s) will be required to provide the City with copies of their statutory quarterly and annual statement and other filings required by the New York State Insurance Department or applicable State Agency (including special New York Supplements and experience reporting) within 30 days of the date such material is actually filed.
41. The Contractor(s) will also provide audited financial reports, including auditors' opinions and related footnotes. If the Respondent has a parent company, the above reports must also be

provided for the parent company. If affiliated companies are providing coverage for certain benefits, the above reports must also be provided for those affiliated companies.

42. Rate/fee changes may occur at contract anniversary or concurrent with benefit change(s). All rate changes will be required to be provided to the City a minimum of 105 days before the anticipated effective date and will be subject to agreement by the City.

Medical Management

43. The Respondent must provide proven effective, patient-oriented medical management services for a retiree-only population. Special consideration will be given to Medicare Advantage plans that:
    - Improve the quality of care and quality of life for our retiree population
    - Educate our retiree population about the benefits, programs and assistance available in innovative and highly effective ways
    - Engage retirees in case management and disease management programs that improve member health status, close gaps in care, and reduce unnecessary high cost utilization
    - Educate our retiree population
    - Assist our retiree population with navigating the healthcare system and complying with recommended treatment plans
44. The Respondent must compile and submit to the City quarterly reports on the medical management activities it has undertaken, results, and subsequent actions. The report is to be provided no later than 60 days after the close of the quarter.

Coordination of Benefits (COB)

45. The Respondent must inquire as to the existence of other group medical, Veterans Administration benefits, federal low income subsidy or Medicaid coverage and coordinate payment of claims with other payers.

Required Claim Administration Services

46. The Respondent will provide the City, where applicable, with electronic access to aggregate claims data containing information on utilization.
47. The Respondent must process claims for services incurred on or after the effective date of coverage.
48. The Respondent must maintain current complete and accurate records of all claims and correspondence associated with each claim. Each claim will, upon receipt, be immediately assigned an appropriate tracking number, which will remain with the claim until it can be reviewed for completeness before adjudication.
49. The Respondent must request in writing from the provider, the City, or, if appropriate, the member, whatever additional information is necessary for the appropriate disposition of the claim if it finds during the adjudication process that information essential to the accurate coding and subsequent determination of benefits has not been provided.
50. The Respondent must maintain and utilize a nationally recognized software for purposes of determining usual, reasonable, and customary allowance.
51. The Respondent must maintain and utilize software containing edits to identify and track members by services received, level of care assigned, and conditions treated.
52. The Respondent must maintain and utilize software containing edits to identify and track providers by services rendered and claim dollars received.
53. The Respondent must maintain appropriate systems edits and critically examine charges for all services that appear aberrant, excessive, or fraudulent. The Respondent should examine such services with the provider, when necessary and appropriate.

54. The Respondent must investigate claims and medical services to determine medical necessity, appropriateness of care, over- and under-utilization of medical services, and the existence of other coverage.
55. The Respondent must verify member eligibility before paying claims.
56. The Respondent must review and process all claims submitted and issue reimbursement as per contract design and an Explanation of Benefits (EOB), as appropriate.
57. The Respondent must issue electronic funds transfers, benefits checks to contracted providers and facilities as appropriate and to non-contracted providers and facilities or members in a timely manner.
58. The Contractor's participating providers must be prohibited from balance-billing members for charges for periods of confinement that were not approved by the Contractor.
59. As required by the City, the arrangement would be that contracted hospitals and the Respondent will perform preadmission/precertification review, concurrent review, discharge planning, and retrospective review. The existence of concurrent review, discharge services, and retrospective review will be transparent to the member.
60. The Respondent must notify claimants of denied claims and the reason for the denial, and also provide an explanation of the benefit and appeal process.
61. The Respondent must review denied claims that are appealed by a member to the Respondent in accordance with standards established by the City or by law. In order to do so, the City delegates to the Respondent the authority, responsibility, and discretion to initially interpret and construe the provisions of the plan, as necessary to reach factually supported conclusions and to make a full and fair review of each claim, and to notify each member in writing of each claim that has been denied.
62. The Respondent must make a reasonable effort to recover claim amounts overpaid or paid in error and refund the recoveries to the City or credit these recoveries against any amounts payable by the City. The Respondent may pursue the overpayment with the provider and/or member. Except as prohibited by CMS, recoupment of monies tied to Respondent errors cannot be contingent on the Respondent recovering it from the parties that are overpaid
63. The Respondent must make all reasonable efforts to recover claims paid in error when the member has been involved in a workplace accident. Reasonable efforts include: asserting liens, appearing in workers' compensation court to recover liens, and all correspondence with the member's attorney.
64. With regard to recovery of overpayment to members, the Respondent must never pursue legal remedies such as placing liens for overpayment without first advising the City. After reasonable attempts are made to recover the overpayment, the Respondent may deduct the overpayment from future payments to the member. If the overpayment was the result of an error of the Contractor, the overpayment will be immediately absorbed by the Respondent and will not be charged to the City or to the member.
65. The Respondent must disclose and fully account to the City any and all funds received by it as a recovery of an overpayment or incorrect payment. Reports are to be provided quarterly.
66. Monies recovered such as subrogation outside of New York of a claim or lien must be fully disclosed and accounted for and credited to the City's claims account. Reports are to be provided quarterly.
67. Administrative charges must be on a mature basis; no additional fees will be charged at plan termination to administer claim runout.

Fraud

68. The Respondent must develop procedures to audit the plan experience and identify providers and/or members who appear to be committing fraud and work with the City and appropriate law enforcement agencies to pursue prosecution. In addition, when notified by the City that a member or provider is being investigated or prosecuted, the Respondent must provide all claim information and participate as a fact or an expert witness as necessary.

Subrogation

69. The Respondent must inquire of the member whether a third party may be liable for the cost of the care received and, if yes, request that the identity of the third party be provided for purposes of instituting subrogation.
70. The Respondent must actively pursue the City's right of subrogation to recover claim payments from third parties, including pursuing payments made when there is a work-related accident or illness.

Mental Health/Substance Abuse

71. The Respondent will be responsible for the provision and administration of all covered mental health, and substance abuse services to all eligible enrollees, as well as to maintain programs designed to identify potential abuse issues in the Medicare population
72. The Respondent must support the City in compliance with all requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

73. The Respondent must be able to coordinate with services provided by the City's EAP, which is available to retirees.

Network Access and Network Management

74. The Respondent must provide for access to medical care and health services that satisfy all applicable requirements of the federal and City statutes and regulations pertaining to medical care and services.
75. In the performance of its network management duties, the Respondent must verify initially and routinely (at least every three years) thereafter that all contracted facilities are appropriately licensed by the city in which they operate.
76. The Respondent must in the performance of its network management duties verify initially and routinely thereafter (at least every three years) professional education, training, quality of care, licenses and other credentials and where applicable the admitting and other privileges granted by a facility to each network provider.
77. The Respondent must require that each and every licensed network provider contracted in connection with this Agreement maintain professional liability (medical malpractice) insurance with limits of at least $1 million for each occurrence and $3 million in the aggregate except where, in any identified geographic area, other professional liability coverage limits are appropriate and usual for the network provider's clinical specialty and/or services in that network provider's geographic area. It is the Contractor's responsibility to ensure that the insurance is valid at the time of credentialing and recheck credentials routinely thereafter in accordance with the National Committee for Quality Assurance (NCQA) standard.
78. Respondent must confirm that administration will include monitoring, evaluating, and taking action to address improvements in the quality of healthcare delivered by all network providers through the implementation of a continuous quality assurance program.
79. Respondent must provide at least 60 days' advanced notice on provider disruption that impacts more than 500 members.
80. Respondent will not charge access fees as part of claim charges. All access fees must be included within administrative fees or as a retention item for insured plans.

Quality Management Programs

81. The Respondent must monitor, evaluate, and take action to address improvements in the quality of healthcare delivered by all network providers through the implementation of a continuous

quality assurance program. The Respondent must provide the Director of the Employee Benefits Program with all updates to its quality management program.

Compliance With Labor Law

82. In implementing a wellness program, the Respondent must (i) comply with relevant requirements as stated in New York Labor Law Section 201-d; and (ii) assist the City in complying with any relevant requirements of Section 201-d.

Reporting of Changes to Law

83. Within 30 days of any changes to Federal, State, City and local laws that impact the City's Medicare Advantage plan, the Respondent will provide the City a summary update in writing that would include coverage changes, and cost or other implications, if any.

84. Show evidence of preparedness to proactively address potential changes to CMS requirements, funding and compliance requirements

Transition/Implementation

85. Provide ability to implement and transition members seamlessly (if applicable) and manage the ongoing administration of the account with excellence
86. Respondent's database(s) for any new health plan that covers City employees and retirees must be able to meet the programming requirements for communicating/exchanging data with the City's NYCAPS/NYCAPS-R enrollment database.
87. Respondent must also be able to accept both paper and electronic enrollments from non-NYCAPS agencies and databases.
88. Respondent must also accommodate the coverage classes that they City currently uses unless the City decides to change the premium payment calculations. There are 5 coverage classes:
    - Individual, non-Medicare (1 person, non-Medicare)
    - Individual, Medicare (1 person, Medicare)
    - Family, non-Medicare (2 persons non-Medicare & 0, 1 or more Medicare persons)
    - Family, Medicare (2 persons Medicare & 0, 1 non-Medicare)
    - Medicare-split (1 person Medicare, 1 non-Medicare)

3. <u>Negotiation Documents Content & Instructions</u>

Your organization has been selected by the Agency to enter into negotiations. If your organization is interested in being considered for award, please electronically submit the Negotiation Documents addressed to the contact person above, via the secure method established by the Agency, as described above, no later than 4:30 P.M. E.D.T. January 11, 2021.

The "Negotiation Documents" should include the following:

A. LETTER OF TRANSMITTAL

A transmittal letter, on the respondent's business stationery, binding the respondent to all statements contained in the Negotiation Documents, including those regarding services and the representations related to the respondents' operations. The letter shall contain, but not be limited to, the following information:

1. Name of the organization submitting the Negotiation Documents, date of submission, and title: "Negotiated Acquisition 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"

2. The respondent's legal status (i.e., corporation, partnership, etc.), date and place of organization and/or incorporation, and the state(s) in which it is authority to do business.

3. A statement indicating the names of all entities related to the respondent including, but not limited to, all companies, parent company, subsidiaries and affiliated entities and the relationships between each of the entities and the respondent.

4. A statement including the names of all the principals and members of the respondent's team who would be servicing this contract.

5. The name, title, address, telephone number, email address and facsimile number of the person(s) authorized to discuss the Negotiation Documents with the City and to bind the respondent to the terms of such discussions and to enter into a written agreement with the City.

6. Confirmation that the Negotiation Documents are being submitted by the respondent in conformity with the specifications contained in this Notice of Intent.

7. In reference to Section 3(B), for each of the options (A,B and C) listed in Attachment A, please provide a proposed implementation process and timeline, for the services to be provided as set forth in Section 2(D).

8. The respondent's narrative with respect to any confidentiality issues with regard to its proposal package.

B. Medicare Advantage Price Questionnaire

As part of the Negotiation Documents, respondent shall include its signed responses, representing respondent's binding offer to the financial terms set forth in the Medicare Advantage Price Questionnaire. (ATTACHMENT A attached to the email along with this Notice of Intent to Negotiate.)

In order to complete the Medicare Advantage Price Questionnaire, respondent will need to refer to the following document:

-Medicare Advantage Financial Exhibits (ATTACHMENT C attached to the email along with this Notice of Intent to Negotiate.)

-Medicare Advantage Technical Questionnaire (Please refer to the Medicare Advantage Technical Questionnaire, located on the RFP Page under Additional downloads on the OLR website.

C. Medicare Advantage Performance Guarantees

As part of the Negotiation Documents, respondent shall include its signed responses, representing respondent's binding offer to the performance guarantees terms set forth in the Medicare Advantage Performance Guarantees. (ATTACHMENT B attached to the email along with this Notice of Intent to Negotiate.)

D. Medicare Advantage Agreement (also referred to herein as "Contract" or "the Contract")

As part of the Negotiation Documents, respondent shall include a proposed binding Contract that includes all the services, agreed to be provided, as set forth in Section 3 - Program Requirements of this Notice of Intent. The terms of Contact shall be subject to negotiation with the City.

The Contract submitted to the City, as part of the Negotiation Documents, must include the following provision:

In the event of any express or implied conflict between the provisions of this Contract and Appendix A, the following order of priority shall govern: (1) first, the body and exhibits of this Agreement shall govern; (2) thereafter, the General Provisions listed in Appendix A;

In order to complete the Medicare Advantage Agreement, respondent will need to refer to the following documents:

Appendix A – General Provisions Governing Contract for Consultants, Professional, Technical Human, and Client Services (Please refer to Appendix A, located on the RFP Page under Additional downloads on the OLR website.)

As part of the Negotiation Documents, respondent shall include a binding Appendix A. The respondent's included Appendix A may include any edits or comments, if any. The edits or comments, if any, must be incorporated into respondent's Contract, as referenced above. For example, if respondent wishes to delete a provision of Appendix A, the respondent's Contract must include an underlined provision that states, "Section 0.0 of Appendix A is hereby deleted". Please do not redline Appendix A.

E. Minority and Women-Owned Business Enterprise (M/WBE) Utilization Plan

New York City's M/WBE program, established in 2005, was designed to promote government contracting opportunities for certified M/WBEs. Accordingly, the Department of Small Business Services (SBS) built a program dedicated to promote fairness and equity in accessing contracting opportunities for City procurement. In 2013, Local Law 1 was enacted to help strengthen the M/WBE Program. Pursuant to Local Law 1 agencies are required to establish M/WBE participation requirements in the procurement based upon the type of contract as well as the availability of certified M/WBEs with the capacity to perform the specific types and scale of work anticipated in such procurements.

Please be advised this NA has been determined to be exempt from the Local Law 1 M/WBE participation requirements.

However, the Agency still seeks to promote government contracting opportunities for certified M/WBEs through the implementation of a voluntary M/WBE Utilization Plan. Respondents are required to include in the Negotiated Documents their responses to the below questions. This is a material requirement of this solicitation.

Please provide your plan for utilizing the services of City-certified M/WBEs:

1. To the fullest extent possible, provide specific quantitative goals for the utilization of minority- and women-owned business enterprises if awarded the contract. (Include time period, goal, scope and dollar amount)

2. To the fullest extent possible, provide a detailed plan for your company to enter into partnering or subcontracting agreements with New York City certified minority- and women-owned business enterprises if awarded the contract.

4. Basis for Contract Award and Procedures

A. Negotiation Documents Evaluation

The Evaluation Committee will be comprised of a minimum of eight (8) persons including, but not limited to, employees of the Office of Labor Relations, Office of Management and Budget and members of the Municipal Labor Committee.

All Negotiation Documents received in the manner set forth above will be reviewed by the Evaluation Committee.

B. Negotiations & Contract Award

Your organization has been selected by the Agency to enter into negotiations based on the above factors. A contract will be awarded to the responsible vendor whose offer is determined to be the most advantageous to the City, taking into consideration technical expertise/Program Requirements, price, contract terms and the other factors set forth in this solicitation.

OLR reserves the right to request additional information and conduct site visits, to conduct interviews, or to request that organizations make presentations, as deemed applicable and appropriate.