

To: Anthem, Accolade, Cigna, Optima

Good Morning,

We have received several more questions about the current exercise. The following questions and answers are provided as clarification. The due date remains unchanged. All submissions should be in electronic format and may be e-mailed to Dan.Hinderliter@DHRM.Virginia.Gov or delivered to:

Dan Hinderliter
DHRM, 12th Floor
101 N. 14th Street
Richmond, VA 23219

If you are providing the information via disk, we request seven (7) copies. Our intent is to post the submissions for public review, so if you are including proprietary information, please provide a separate redacted version for this purpose. Financial information must be provided in Excel format.

1. (Two similar questions)

What codes are being used for the service categories? We know how we define the categories and want to make sure we are grouping the services the same.

The Financial Analysis Worksheet has summarized claims across settings (IP Fac, OP Fac, Prof, MH/Sub, Rx) and service categories within each setting. Please supply the logic or criteria used to segment claims into the service categories.

Answer: The service category is a required field on the claims reporting specifications currently used by the Commonwealth's vendors to submit claims data. This field is assigned each carrier using their internal coding definition logic. This field is provided for informational purposes only as we would expect each proposer to use their own service category definitions as part of their analytical process.

2. What does Payment 9 mean on the pharmacy? We understand Tier 1, 2, 3.

Answer: Payment Tier value of 9 is an unknown tier code associated with an unknown plan code being reported by the current pharmacy vendor.

3. Is therapy code the same as drug provider specialty?

Answer: Yes. The codes listed in the layout as Drug Provider Specialty are the therapy codes and also are populated in the Provider Specialty field with a "D" prefix for pharmacy claims.

4. How can we find/identify outpatient surgery?

Answer: We would expect each proposer to use their own service category definitions to identify Outpatient Surgery.

5. Would it be possible to get member months tied back to the claims data provided.

Answer: 1,986,633

6. Members are all listed as “active” in their status. Please clarify the date(s) that the members included were deemed active. It could be across the entire 24 month span, as of the date the data was pulled, as of the last date of the incurred period, or some other time frame.

Members were determined to be active based on status codes submitted by the carriers on the claims files. These status codes were determined by the carrier based on member eligibility as of the claim incurred date. These status codes submitted by the carriers were not verified against the COVA eligibility files. For analysis purposes, assume all were active for the entire period.

7. The percentage of members incurring claims that are age 65+ appears substantive for a population that is supposed to contain only active employees. Do all members included in the data set have primary coverage through the health plan, and not Medicare primary?

Members were determined to be active based on status codes submitted by the carriers on the claims files. These status codes were determined by the carrier based on member eligibility as of the claim incurred date. These status codes submitted by the carriers were not verified against the COVA eligibility files. For analysis purposes, assume all are active.

Regards,

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