April 7, 2015

Reference Request for Proposals #800100-03132015 to provide Administrative Services Only (ASO) for Self Funded Medical Plans for the State of Louisiana, Office of Group Benefits which is scheduled to open at 5:00pm (CST) on April 20, 2015.

Addendum #2 provides clarifications to the RFP and includes responses to written inquiries received by the inquiry deadline date stated in the RFP.

THIS ADDENDUM IS HEREBY OFFICIALLY MADE A PART OF THE REFERENCED REQUEST FOR PROPOSAL

Amendments to RFP

Section Reference RFP 2.1 Term of Contract

Original Text:

The period of any contract resulting from this RFP is tentatively scheduled to begin on or about January 1, 2016 and to continue through December 31, 2016. The OGB has the right to contract for up to three years upon approval.

Revised Text:

The period of any contract resulting from this RFP will have an initial duration of three (3) years. With all proper approvals and concurrence with the successful contractor, OGB may also exercise an option to extend for up to twenty four (24) additional months at the same rates, terms and conditions of the initial contract term. Subsequent to the extension of the contract beyond the initial 36 month term, prior approval by the Joint Legislative Committee on the Budget (JLCB) or other approval authorized by law shall be obtained. Such written evidence of JLCB approval shall be submitted, along with the contract amendment to the Office of State Procurement to extend contract terms beyond the initial 3 year term. No contract/amendment shall be valid, nor shall the state be bound by the contract/amendment until it has first been executed by the head of the using agency, or designee, the contractor and has been approved by the Office of State Procurement. The term of the Contract with any extensions shall not exceed five (5) years.

Section Reference RFP 4.1 Proposal Submission

Original Text:

The OGB requests the following:

- Proposer should provide One (1) Original (clearly marked "Original") and Ten (10) numbered copies of the Technical proposal and One (1) Original and Two (2) copies of the Cost proposal to the OGB RFP Coordinator at the address specified. The original copy of the proposal shall contain original signatures of those company officials or agents duly authorized to sign proposals or contracts on behalf of the organization. A certified copy of a board resolution granting such authority should be submitted if proposer is a corporation. The copy of the proposal with original signatures will be retained for incorporation in any contract resulting from this RFP.
- Proposer should provide Two (2) CDs of the Technical proposal in PDF and Word Format and Two (2) CDs or Portable Drives of the Cost proposals in Word Format and a text file (tab-delimited format).

- If applicable, Proposer should also submit a redacted version of the proposal.

Revised Text:

The OGB requests the following:

- Proposer shall provide One (1) Original (clearly marked "Original") and should provide Ten (10) numbered copies of the Technical proposal and One (1) Original and Two (2) copies of the Cost proposal to the OGB RFP Coordinator at the address specified. The original copy of the proposal shall contain original signatures of those company officials or agents duly authorized to sign proposals or contracts on behalf of the organization. A certified copy of a board resolution granting such authority should be submitted if proposer is a corporation. The copy of the proposal with original signatures will be retained for incorporation in any contract resulting from this RFP.
- Proposer should provide Two (2) CDs of the Technical proposal in PDF and Word Format and Two (2) CDs or Portable Drives of the Cost proposals in Word Format and a text file (tab-delimited format).
- If applicable, Proposer should also submit a redacted version of the proposal per Section 3.9 of this RFP.

Section Reference RFP 5.4 Approach and Methodology

Original Text:

- Innovative concepts for services including, but not limited to Population Health Management, Creative Ideas, and/or cost-saving measures. The proposer should denote innovative concepts in the proposal. All services must be included in the proposed PEPM rate. (See Section 5.5 Administration Cost Information).

Revised Text:

- Innovative concepts for services including, but not limited to Population Health Management, Creative Ideas, and/or cost-saving measures. The proposer should denote innovative concepts in the proposal separate and apart from the minimum level of servcies cited in Attachment I: Scope of Services and standard services provided by the Proposer that are not included in the minimum services identifed by the OGB. All services must be included in the proposed PEPM rate. (See Section 5.5 Administration Cost Information).

Section Reference RFP 5.5 Administration Cost Information

Original Text:

The Proposer shall provide one total Per Employee Per Month (PEPM) cost proposals for providing all services proposed in order to provide Administrative Services Only (ASO) for Self-Funded Medical Plans offered by the Office of Group Benefits, including but not limited to:

- Medical Claims Third Party Administration, including network services
- Population Health Management, including, but not limited to, Disease Management
- Wellness Program

- Coordination of Health Reimbursement Account and Health Savings Account Services for respective plan offerings

This cost shall be inclusive of all services provided by the Proposer. The cost proposal shall not include any additional fees for service, other than the PEPM costs. The OGB shall not incur additional cost for use of innovative concepts proposed. Rates shall be guaranteed for term of the contract. The OGB has the right to contract for up to three years upon approval.

Note: The Contractor will be subject to performance standards for certain categories of service and required to put 25% of the total contracted Administrative fees at risk. Metrics of each category will be negotiated with the winning Proposer.

The proposed PEPM rate will be used to calculate score points using the formula specified in Section 6.5 Evaluation and Review.

Revised Text:

The Proposer shall provide one total Per Employee Per Month (PEPM) cost proposal for providing all services proposed in order to provide Administrative Services Only (ASO) for Self-Funded Medical Plans offered by the Office of Group Benefits, including but not limited to:

- Medical Claims Third Party Administration, including network services
- Population Health Management, including, but not limited to, Disease Management
- Wellness Program
- Coordination of Health Reimbursement Account and Health Savings Account Services for respective plan offerings

The PEPM shall be an all inclusive rate for all services, including innovative concepts.

For informational purposes only, the Proposer shall provide an itemized list of all services included in the proposed PEPM rate and detailed cost associated with each service. The PEPM rate proposed in response to this RFP shall be guaranteed for term of the contract which shall not exceed five (5) years. OGB desires the same rate for the entire contract term. The OGB has the right to contract for up to five (5) years upon approval.

Note: The Contractor will be subject to performance standards for certain categories of service and required to put 25% of the total contracted Administrative fees at risk. Metrics of each category will be negotiated with the winning Proposer.

The proposed total PEPM rate will be used to calculate score points using the formula specified in Section 6.5 Evaluation and Review.

<u>Section Reference RFP 5.5 Administration Cost Information</u>

Original Text:

Each Proposer will receive an electronic record containing redacted claims incurred by OGB members. The proposer shall utilize the redacted claims data to re-price the medical claims costs and determine provider network disruption. See Attachment VI for additional details about the re-pricing.

Evaluation will be based upon allowed amount per claim, not per claim line, where claim is identified by "Claim Header ID." Proposer shall provide a total cost for all claims after re-pricing. The total cost for all claims will be used to calculate the score points using the formula specified in Section 6.5 Evaluation and Review. **NOTE: The re-pricing shall be based upon the proposer's contracted pricing in effect on March 1, 2015. The redacted claims used for claims re-pricing include specification data furnished by the OGB's incumbent contractor, Louisiana Health Service & Indemnity d/b/a Blue Cross Blue Shield of Louisiana.**

Revised Text:

Each Proposer will receive an electronic record containing redacted claims incurred by OGB members. The proposer shall utilize the redacted claims data to re-price the medical claims costs and determine provider network disruption. See Attachment VI for additional details about the re-pricing. EVERY claim must be re-priced and sent back to OGB on a CD or portable drive (i.e., USB flash drive) in a text file (tab-delimited format).

Evaluation will be based upon allowed amount per claim, not per claim line, where claim is identified by "Claim Header ID." Proposer shall provide a total cost for all claims after re-pricing. The total cost for all claims will be used to calculate the score points using the formula specified in Section 6.5 Evaluation and Review. **NOTE: The re-pricing shall be based upon the proposer's contracted pricing in effect on March 1, 2015. The redacted claims used for claims re-pricing include specification data furnished by the OGB's incumbent contractor, Louisiana Health Service & Indemnity d/b/a Blue Cross Blue Shield of Louisiana.**

Section Reference RFP Attachment III: Sample Contract 2.1 Term of Contract

Original Text:

This Contract shall become effective on _____ and shall end on _____. OGB has the right to contract for up to a total of three (3) years with the concurrence of the Contractor and all appropriate approvals.

Notwithstanding any other provision of this Contract, this Contract and any amendments thereof shall not become effective until approved as required by statutes and regulations of the State of Louisiana.

Revised Text:

The period of any contract resulting from this RFP will have an initial duration of three (3) years. With all proper approvals and concurrence with the successful contractor, OGB may also exercise an option to extend for up to twenty four (24) additional months at the same rates, terms and conditions of the initial contract term. Subsequent to the extension of the contract beyond the initial 36 month term, prior approval by the Joint Legislative Committee on the Budget (JLCB) or other approval authorized by law shall be obtained. Such written evidence of JLCB approval shall be submitted, along with the contract amendment to the Office of State Procurement (OSP) to extend contract terms beyond the initial 3 year term. The term of the Contract with any extensions shall not exceed five (5) years.

Inquiry and Responses

No	Inquiry	Response
1	Would like to request a census that would include, at the minimum; Gender, Date of Birth, Zip Code and Benefit Tier.	All parties interested in obtaining this information may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm
2	Due to the highly competitive and proprietary information in the claims repricing and SSAE 16 report, would OGB and/or your consultant be willing to sign a non-disclosure agreement?	No, OGB and/or consultant(s) will not sign a non-disclosure agreement. However, see RFP, Section 3.9 - Proprietary Information.
3	Page 27, there's a statement that Contractor will need to accept OGB's standard file layout. Could you please supply this layout?	Please see attached file requirements and layout specifications currently used by OGB.
4	Page 28 - Provide administration and medical review for Over-Age Dependents – can we get details on what this means?	The successful proposer will be responsible for providing the administration and medical review of requests submitted by plan members for coverage on incapacitated dependents over the age of 26. Currently, OGB has approximately 200 dependents who fall into this category.
5	Page 49 /Q4 – "Does your claim processing system have the ability to accommodate and accurately process claims utilizing a multi-tiered network or special contracts negotiated by OGB?" Can we have some further clarification?	The purpose of this question is to determine whether the Proposer's claim processing system has the ability to process a third coinsurance or co-pay tier for a narrow preferred provider network. This network could be defined by OGB or by the carrier. Direct contracts with providers could be developed by OGB.
6	Would we be able to get full SPD's for each plan offered?	Schedules of Benefits for OGB's self-funded plans can be found at the following link: http://www.bcbsla.com/State/Pages/Benefits.aspx
7	Is there a specific spending target or percentage goal for the Veteran /Hudson initiative?	OGB will evaluate the Veteran and Hudson Initiatives in accordance with the standards stated within this RFP.

No	Inquiry	Response
8	In Section 3. Proposal Information, is it expected to respond to each point/subsection or to just acknowledge each point/subsection?	It is the Proposer's responsibility to ensure that their proposal contains sufficient information to meet or exceed any requirements set forth in this RFP. Please reference Section 3.11 Errors and Omissions in Proposal.
9	On page 53, question 4b, the question asks "Can you reduce this time to 102 days to stay actively engaged?" and then on Page 55, question 1b, almost the same question is asked "How many days at a time do you typically approve for an inpatient stay without additional documentation from the facility. Can you reduce this time to 1-2 days to stay actively engaged?" Which is accurate?	Page 53, 4b, should read as follows: b) How many days at a time do you typically approve for an inpatient stay without additional documentation from the facility? Can you reduce this time to 1-2 days to stay actively engaged? Note: Due to the correction of numbering in Attachment V: Technical Questionnaire, this question is now labeled #6b) of Section V by way of Addendum #1.
10	Is there any specific format you would like the ASO fees displayed?	OGB is requesting one total Per Employee Per Month (PEPM) rate. The PEPM shall be an inclusive rate for all services, including innovative concepts. For informational purposes only, the Proposer shall provide an itemized list of all services included in the proposed PEPM rate and cost associated with each service. The Proposer's submission for claims re-pricing shall include both the claim level detail provided on the data file and total cost for all claims after re-pricing.

No	Inquiry	Response
11	Which hospitals are included in their narrow network Magnolia Local Plan?	The following six (6) hospitals are a part of the Blue Cross and Blue Shield of Louisiana Community Blue network: •Baton Rouge General Medical Center (Florida Blvd.) •Baton Rouge General Medical Center (Picardy Ave.) •Christus Coushatta Health Care Center •Christus Highland Hospital •Christus Schumert Health System •West Feliciana Parish Hospital The following four (4) hospitals are a part of the Blue Cross and Blue Shield of Louisiana Blue Connect network: • Ochsner Baptist Medical Center • Ochsner Medical Center • Ochsner Medical Center – Westbank Campus • Ochsner Medical Center Kenner
12	With regard to the last paragraph within 7.4 Confidentiality, "Contractor shall not permit PHI to be disclosed to or used by any individual or entity outside of the territorial and jurisdictional limits of the fifty (50) United States of America", please confirm this is for direct OGB services and would not prohibit enterprise-wide IT and system support functions.	This requirement forbids enterprise-wide IT and system support functions that allow OGB PHI to depart the territorial and jurisdictional limits of the fifty (50) United States of America.
13	Could we get current enrollment per each for all employee/retirees enrolled in medical plans.	See attached Table #1
14	Page 29, under Population Health Management, monthly dashboard reporting, what types of data would be required for the dashboard?	OGB will work collaboratively with the successful Proposer to create the monthly dashboard, which should measure against a risk baseline determined on the population and also include statistics on any programs implemented to improve the health of the population.

No	Inquiry	Response
15	What is your definition of Health Informatics and what Health Informatics data OGB expects to have available to them?	OGB would like for the successful proposer to provide a web-based tool it can use to analyze the health status of its plan members, in order to better manage the health of its population so it can create programming collaboratively with successful proposer. Our incumbent Contractor, BCBSLA, currently uses Truven.
16	Page 29, under Wellness Program, there's a reference to a 24/7 online program for members and administration. What is meant by 24/7 online program for administration?	The Wellness Program should have an online portal available for members and administration to access 24 hours/day, 7 days/week.
17	Are the Mental Health and/or Behavioral Health currently carved-in and administered by Blue Cross? If so, are they included in the total medical administrative fee?	Yes, they are included in the total medical administrative fee.
18	Section 5.5 outlines that proposers shall provide one total Per Employee Per Month (PEPM) cost proposal, and Section 5.4 outlines that innovative programs must be included in the proposed PEPM rate. However, Question 50 in the Technical questionnaire states: "Please provide detail regarding any wellness offerings available to the OGB that are not included in the proposed fee and the additional cost associated with each service." Please clarify if Wellness, or any other services, can be broken out as separate line items (buy ups) from a base PEPM rate.	OGB is requesting one total Per Employee Per Month (PEPM) rate. The PEPM shall be an all inclusive rate for all services, including innovative concepts. For informational purposes only, the Proposer shall provide an itemized list of all services included in the proposed PEPM rate and cost associated with each service.

No	Inquiry	Response
19	Please describe your current Case Management and Disease Management offering in greater detail. What is the prevalence rate by disease state? What is your reach/engagement rate?	Information regarding OGB's case management and disease management programs offered to members enrolled in its self-funded plans can be found at the links below: http://www.bcbsla.com/State/Pages/DiseaseManagement.aspx http://www.bcbsla.com/State/Pages/CaseManagement.aspx 6% of OGB members are identified for the Disease Management program based on claims; 84% of eligible identified members are participating. • Asthma: 1137 • COPD: 305 • Coronary artery disease: 1694 • Diabetes: 5419 • Heart failure: 430
20	What percent of members with a chronic illness are identified as high risk, moderate risk and low risk? Of those, what percent are engaged telephonically?	The breakout provided below categorizes risk levels for the member population with chronic illness. In crisis: 9% Struggling: 19% At risk: 23% Stable: 22% Healthy: 27% Please reference the response to Inquiry #19 for participation.
21	Please provide the current ROI attained as well as a list of clinical care and utilization improvement statistics by disease state and case management.	This information cannot be provided at this time.
22	Please provide additional insight into what is working well in Case Management and Disease Management and what you would like to see improved.	The identified member engagement and experience has been positive; however, true results and achieving goals is limited. OGB is seeking stronger outcomes that can be tangibly tracked and reported.
23	Please describe your current wellness offering in greater details. What lifestyle management programs are currently offered?	See Table #2

No	Inquiry	Response
24	Do you currently incent members for participation in your wellness programs? If so, please describe your current incentive plan. Also please define your incentive strategy for 2016.	Those members enrolled in one of OGB's offered self-funded medical plans who participate in the Live Better Louisiana wellness program by completing the Personal Health Assessment (PHA) and undergo a preventative onsite health checkup by August 15, 2015 will receive a $10.00 per month premium credit, beginning January 2016. The program is not open to dependents at this time. Those members enrolled in one of OGB's offered self-funded medical plans who participate in the InHealth: Blue Health Services disease management program receive prescription drug incentives: • $0 Copayment for certain Generic Prescription Drugs approved by the U. S. Food and Drug Administration (FDA) for any of the 5 chronic health conditions. • $20 Copayment (31 day supply), $40 Copayment (62 day supply) or $50 Copayment (93 day supply) for certain Preferred Brand-Name Prescription Drugs. • $40 Copayment (31 day supply), $80 Copayment (62 day supply) or $100 Copayment (93 day supply) for certain Non-Preferred Brand-Name Prescription Drug. Non-Preferred drugs typically have lower cost alternatives available in the same drug class. •If an OGB Plan Participant chooses a Brand-Name Drug for which an FDA-approved Generic version is available, the OGB Plan Participant pays the difference between the Brand-Name and Generic cost, plus a $40 Copayment for a 31 day supply. Those eligible members who participate in the smoking cessation program offered by the Smoking Cessation Trust receive (free of charge) access to the following: • Telephone quit lines • Certain smoking cessation medications and products • Certain physician, psychologist, social worker (MSW/LCSW), or nurse practitioner services
25	What percent of members complete the Health Assessment each year? Of those that complete a Health Assessment, what percent participate in lifestyle	To date, 7,772 members have completed the health assessment. Of the 703 members that applied, 603 have been accepted to the OMADA program and 420 have enrolled.

No	Inquiry	Response
	modification programs?	
26	What percent of members are outreached to by a Health Coach for telephonic counseling and what percent perform their lifestyle modification programs online?	OGB attempts to reach 100% of the members telephonically in the disease management program. Lifestyle modification programs are offered online to members that complete the wellness screening and identified as being pre-diabetic. The lifestyle modification programs are intended to prevent members from becoming participants in the disease management program.
27	Do you perform biometric screenings on site each year? If so, how many locations are they held at and how many people participate? How many people complete screenings via alternative methods, such as an MD form?	The Live Better Louisiana wellness program began in May 2014. As of 4/6/15, 411 onsite clinics have been held throughout the state of Louisiana; 11,075 members have been screened at on-site clinics and less than 50 members have submitted a MD form from their primary care physician.
28	Are there any case management, disease management, wellness services being delivered on site today? If so, please describe in detail to include service type, frequency, number of staff delivering, number of locations being delivered at and perceived benefit or actual benefit.	Onsite wellness screenings are available to those members enrolled in one of OGB's offered self-funded medical plans through an in-network provider of the incumbent contractor using regional teams that service locations throughout the state of Louisiana.
29	What results have been achieved with your Wellness programs: risk reduction improvement, improvements in lifestyle modifications?	While some improvement in chronic conditions have been observed, due to the newness of OGB's wellness initiatives, return on investment measures are still under development.
30	How many onsite seminars do you currently offer annually? Please provide sample topics for these seminars and additional detail on the support you would like provided.	Although not typical, OGB held 160 onsite meetings last year. The successful Proposer may be required to potentially provide onsite support at all meetings to include, but not limited to preparing and printing materials (OGB approval required prior to distribution), presentation of benefit offerings and subsequent questions and answers.

No	Inquiry	Response
31	Do you currently have an onsite clinic? If so, how do the Wellness and clinical programs integrate with clinic personnel?	OGB does not have a permanent medical clinic available to its members. OGB currently offers the nearly 400 OGB-participating agencies the ability to host preventative health screening at their locations through the Live Better Louisiana program. The onsite preventative health screening clinics are operated by Catapult Health.
32	If you have an onsite clinic, please describe in greater detail your current on-site clinic design, philosophy, approach, and future vision.	Please see response to question #31.
33	Is there a managed behavioral program in place today? If so please describe in detail (is an Autism benefit state mandated and included in the current managed behavioral offering). Is it being delivered by BCBS of LA today? If not please describe and identify the vendor delivering the services.	Standard behavioral health programs are provided to OGB's self-funded plan members by a subcontractor of BCBSLA.
34	Is there an Employee Assistance Program in place today? If so please describe in detail including the visit model being used, training hours included, CISD's delivered, DOT evaluations etc. and if is it being delivered by BCBSLA today. If not please describe and identify the vendor.	OGB does not currently offer its member's access to an Employee Assistance Program. As OGB's members are associated with nearly 400 state agencies, school boards, charter schools, and certain local government entities, it is unknown if any OGB members have such access directly through their employing entity, and if so, who the vendors of such programs are.
35	The term "Innovative Concepts" is referenced in several places (Section 6.5: evaluation/scoring will consider "Creativity and feasibility of innovative concepts proposed…"; Section 5.4: bidders should describe "Innovative concepts for services including, but not limited to… proposer should denote innovative concepts in the proposal. All services must be included in the proposed	•Innovative concepts are considered as anything not included in the minimum service level defined in Attachment 1: Scope of Services and not considered as a standard service by the Proposer. •The proposer should denote innovative concepts in the proposal separate and apart from the minimum level of services cited in Attachment I: Scope of Services and standard services proposed by the Proposer that are not included in the minimum

No	Inquiry	Response
	PEPM rate"; Section 5.5: the single PEPM fee "shall be inclusive of all services provided….the OGB shall not incur additional cost for use of innovative concepts proposed.") Please clarify OGB's instructions and intent around "innovative concepts": • Please provide a definition of "innovative concepts." Are these pilot programs? • How should such concepts be denoted in proposals (per instructions in 5.4)? • If we are proposing the use of innovative services or technology, should those costs be included in the single PEPM rate? If not, and bidders are to be scored on the inclusion of such concepts, is it the OGB's intent that these services be provided free of charge?	services identified by the OGB. •The PEPM shall be an all inclusive rate for all services, including innovative concepts.
36	Please clarify instructions for Performance Standards. Has the OGB identified Performance Standard Categories will require the selected vendor to meet? Should bidders submit their proposed Performance Standards for consideration?	OGB intends to negotiate performance guarantees with the successful Proposer.
37	Are wellness programs offered to just employees or also to spouses and dependents age 18 and over?	The Live Better Louisiana program is not open to dependents at this time. ● The InHealth:Blue Health Services disease management program is open to qualified enrollees and their dependents. ● The Smoking Cessation Trust is open to qualified enrollees and their dependents. ● The Healthy Blue Beginnings maternity support program is open to qualified enrollees and their dependents.
38	What fulfillment type do you prefer for incentives (ex. gift cards, HSA/HRA deposits, premium reductions)?	At this time, the only financial incentive OGB provides to its members is the ability to qualify for a premium discount through the Live Better Louisiana program.

No	Inquiry	Response
39	Does OGB have an incentive budget?	At this time, the only financial incentive OGB provides to its members is the ability to qualify for a premium discount through the Live Better Louisiana program. Through this program, plan members who complete both the Personal Health Assessment and undergo a preventative onsite health checkup by August 15, 2015 will receive a $10.00 per month premium discount, beginning in January 2016.
40	For approximately what percentage of employees/spouses does the OGB have accurate contact information?	OGB has mailing addresses for its plan member households. OGB has email addresses for some of its members, but cannot confirm how many of the email addresses it has on record are current or valid.
41	Can OGB estimate what percentage of employees have access to a computer and/or email while at work? Will OGB provide member email addresses to the successful vendor? What is the average tenure of an OGB employee?	As OGB's members are associated with nearly 400 state agencies, school boards, charter schools, and certain local government entities, OGB cannot provide an estimate of the percentage of plan members who have access to a computer and/or email while at work, nor can it provide information regarding the average tenure of plan members. OGB will provide the successful proposer the email addresses of those plan members for which it has such information.
42	Are there any restrictions in place on outreach to OGB employees/spouses/ dependents (telephone, mail, email)?	OGB requires all Contractor communications to OGB plan members and/or their dependents to be approved by OGB prior to dissemination. Further, state and/or federal law (e.g. HIPAA) may restrict outreach.
43	What is the average tenure of an OGB employee?	As OGB's members are associated with nearly 400 state agencies, school boards, charter schools, and certain local government entities, OGB cannot provide information regarding the average tenure of its plan members.

No	Inquiry	Response
44	On Pg. 5 the RFP states “Disease Management is currently offered on an opt-in model for non-Medicare eligible members for the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Chronic Heart Failure, Asthma, and Coronary Artery Disease.” Please clarify how the current program is operated: • Is there different types for programming for different acuity levels? • Do potential DM enrollees need to opt-in (agree) to receive communications/mailers about their condition, or just to engage in telephonic coaching?	Please see response to question #19.
45	If a Health Assessment or Survey has been used, what have been the results/insights?	The analysis is currently underway and results are not available.
46	Please provide OGB’s top 20 locations by employee population.	See attached Table #3 for a list of the top 20 zip codes by OGB self-funded plan member population.
47	What model of utilization management does OGB currently have (e.g., medical necessity)?	Utilization management is currently based on medical and financial necessity. Claim dollar amounts or physician referral can trigger case or disease management.
48	When does OGB anticipate next soliciting bids for Pharmacy Benefit Management services?	OGB intends to do a new procurement so as to have a new contract in place for January 1, 2017, and that the timeline for issuance of the new Request for Proposal will provide all required procurement notices, etc. but has not yet been established.
49	Is it OGB’s intent to select a single medical carrier, or to select multiple carriers?	It’s OGB's intent to contract with a single medical carrier for it administrative services only for self-funded medical plans.

No	Inquiry	Response
50	What biometric screening method of screening has been used (finger stick, blood draw, fasting/non-fasting)?	Onsite preventative health screenings are operated by Catapult Health. Screenings involve finger pricks to draw approximately 0.1cc's of blood for lab-accurate analysis of common health indicators, including glucose, cholesterol, and triglycerides. Patients are instructed to fast for at least eight (8) hours prior to their scheduled appointment. In addition to the blood lab analysis performed, technicians chart each patient's blood pressure, height, weight and abdominal circumference, and asks each patient to complete a brief health history/questionnaire.
51	If OGB does not have onsite facilities or clinics (health clinics, exercise facilities, etc.), has the implementation of any such facilities been explored or considered? What were the insights or decisions made?	OGB does not have a permanent medical clinic available to its members. As OGB's members are associated with nearly 400 state agencies, school boards, charter schools, and certain local government entities, it is unknown if any of these entities provide onsite exercise facilities to their employees, retirees and dependents. OGB will consider the implementation of such facilities if presented.
52	Does the OGB currently have any of its own staff delivering care management or wellness services (promotion, coaching, nursing consultation, etc.)? Please describe.	No, OGB doesn't have any of its own staff delivering care management or wellness services.
53	Because the contract starts on 01/01/2016, would we need the performance bond issued 10 days after the contract start or is there an alternative solution?	Section 7.3.1 of this RFP requires that “the performance bond be provided within 10 working days from request.” The performance bond is required to be effective 01/01/2016 and remain in effect for the full contract term which shall not exceed five (5) years.
54	Do you have a specific bond form for us to use on the performance bond? If so, please provide.	No, OGB does not require a specific bond form. However, the performance bond must name the “State of Louisiana, Division of Administration, Office of Group Benefits” as payee of the bond’s sum in the event the Contractor fails to perform according to the terms and conditions of the contract.

No	Inquiry	Response
55	Is a Bid Bond required with this RFP proposal?	A bid bond is not required to accompany a proposal in response to this RFP.
56	Does your current carrier release weekly claim payments once funding is received from OGB? If yes, how long after receiving funds are payments released? If current carrier releases before funding is received, please advise how long before.	OGB's current carrier submits a weekly invoice, with an accompanying check register (claim disbursements) for reimbursement of claim payments made on behalf of OGB. It should be noted that all of OGB's accounts payable activities are performed by the Division of Administration (DOA) Office of Finance and Support Services (OFSS). Typically, OGB submits the invoices to OFSS the following day, assuming the totals on file and invoice match, for payment. OFSS processes the wire transfer within 48 hours after receipt of an approved invoice from OGB. Exceptions occur when there are banking or state holidays and/or if OFSS identifies errors in an approved invoice during payment processing. In the case of errors, payment processing would be halted until discrepancies are resolved.
57	When OGB funds its current carrier for weekly claims invoiced, is OGB aware of the current carrier's cash flow timing for the use of OGB funds, i.e. what % are check payments and what is their average clearing time to deplete the cash received from OGB?	OGB reimburses the current carrier for claim payments made on behalf of OGB on a weekly basis.
58	What is the percent of electronic payments made by the current carrier and how does the current carrier's cash flow demonstrate the use of OGB funds for such electronic payments, i.e. when after receipt of OGB funds is the NACHA batch file sent to the bank and when does the carrier provide funds to the bank to electronically ACH credit the payee?	The current carrier submits a weekly invoice, with an accompanying check register (claims disbursements), for reimbursement of claim payments made on behalf of OGB.
59	Does OGB's current carrier segregate funds of OGB from all other customer funds or are funds co-mingled, i.e. can OGB funds be used to fund any other customer's claim liability?	OGB reimburses the current carrier for claim payments made on behalf of OGB via wire transfer payments.

No	Inquiry	Response
60	Please confirm your schedule to pay the monthly administration fees. For example, if the March invoice is released mid-February and the payment due date is 3/1, when would we receive payment?	OGB shall render payment within thirty (30) days of invoice approval as stated in Section 7.2 Billing and Payment. Exceptions occur when there are banking or state holidays and/or if OFSS identifies errors in an approved during payment processing. In the case of errors, payment processing would be halted until discrepancies are resolved.
61	Section 1 General Information, Subsection 1.1, p.4 - OGB is seeking a contract with a proposer/Contractor that will partner with the agency to provide innovative solutions for medical program management. Regarding Innovative Programs, should we distinguish between those that are currently active in the State of Louisiana versus elsewhere?	The partnership is not required to match programs currently offered, but is expected to propose innovative solutions available in order to effectively manage the health of OGB's population today and in the future.
62	Section 1 General Information, Subsection 1.2, p.5 - Disease management is currently offered on an opt-in model for non-Medicare eligible members for the following conditions: Chronic Obstructive Pulmonary Disease, Diabetes, Chronic Heart Failure, Asthma, and Coronary Artery Disease. Does OGB want the RFP bid based on a Disease Management opt-in or opt-out model or both?	Concerning Disease Management, the RFP bid should be based on an opt-out model.
63	Section 3 Proposal Information, 3.7 Subcontracting Information, p. 10 - Information required for the proposer under the terms of this RFP shall also be required for each subcontractor. What specific information is required on subcontractors?	Information required of the proposer under the terms of this RFP shall also be required for each subcontractor, as stated in Section 3.7 Subcontracting Information.

No	Inquiry	Response
64	Section 5 Proposal Content, 5.2 Corporate Background, Financial Condition and Experience, p.14 - The OGB will require the Contractor and/or subcontractors to obtain an independent annual SSAE 16 engagement resulting in a SOC I, Type II Report. Please confirm that the SOC 1 requirement, as stated in Section 5.2 of the RFP, pertains only to the subcontractors performing key delegated functions under the contract.	The services detailed in this RFP are considered as outsourcing of a key internal control function for OGB. Therefore, any contractor and/or subcontractor performing key delegated functions under the OGB contract will be required to comply with the requirement to obtain an annual SSAE16 engagement resulting in a Soc 1, Type II report.
65	Section 5 Proposal Content, 5.4 Approach and Methodology, p. 18 - Provide samples of the following: 1) Communication Campaign; 2) Annual Strategic Calendar; 3) Claims Reporting; 4) Utilization report with executive dashboard; 5) Population Health Reporting; 6) Explanation of Benefits; and 7) Service Agreement. Does OGB want a sample of bidder's standard ASO Agreement?	Yes, OGB would like to see a sample of the Proposer's standard ASO agreement. Please reference Section 5.1 Executive Summary.
66	Section 5 Proposal Content, 5.4 Approach and Methodology, p. 18 -Approach and ability to interface with State payroll systems as well as individual department and/or separate entities, as needed. Can you provide the name and quantity of your State payroll systems?	Currently, OGB interfaces with LaGov HCM which consists of all paid agencies under the umbrella of the Office of State Uniform Payroll. Once this interfaces, the LaGov HCM agencies use the OGB eEnrollment system to enroll and make changes for plan members. OGB currently receives an 834 file from Louisiana State University. The remaining departments/entities do not interface with OGB but fully use the eEnrollment system which then interfaces with IMPACT.
67	Section 5 Proposal Content, 5.4 Approach and Methodology, p. 18 - Approach and ability to partner with benefit enrollment systems, and/or any restrictions Proposer has regarding file feeds and programming. Can you provide the name and quantity of your enrollment systems?	The OGB eEnrollment system interfaces directly with the IMPACT system. An 834 file is received from LSU to update the IMPACT system directly.

No	Inquiry	Response
68	Section 5 Proposal Content, 5.4 Approach and Methodology, p. 18 - Approach and ability to partner with benefit enrollment systems, and/or any restrictions Proposer has regarding file feeds and programming. Would the enrollment system include integration with all OGB vendors including but not limited to Medical, Pharmacy and Voluntary Benefits?	The request for approach and ability to partner with benefit enrollment systems is in anticipation for upcoming changes to technology currently utilized within OGB. Currently, there is a system in place that supports eligibility and enrollment, but does not support self-service enrollment. It would be expected that any current and future systems would continue to include integration with OGB vendors, including but not limited to Medical, Pharmacy and Voluntary Benefits.
69	Section 5 Proposal Content, 5.4 Approach and Methodology, p. 18 - Approach and ability to partner with benefit enrollment systems, and/or any restrictions Proposer has regarding file feeds and programming. Would the benefit enrollment systems be used by agencies and members?	Yes, benefit enrollment systems will be used by agencies and members.
70	Section 5 Proposal Content, 5.4 Approach and Methodology, p. 18 - Approach and ability to partner with benefit enrollment systems, and/or any restrictions Proposer has regarding file feeds and programming. What enrollment system will be utilized to cover OGB open enrollment for 2016 coverage?	The current enrollment process includes access to an in-house developed online self-enrollment portal or paper enrollment submission form for processing by OGB. These current systems are anticipated to be utilized during the 2016 plan year annual enrollment period.
71	Section 5 Proposal Content, 5.5 Administration Cost Information Approach and Methodology, p. 18 - Rates shall be guaranteed for the term of the contract. The OGB reserves the right to contract for up to three years upon approval. Does "term of the contract" refer to the initial one year term or does it apply to the maximum three years?	The term of the Contract with any extensions shall not exceed five (5) years. Please reference amendments to RFP included in this addendum.

No	Inquiry	Response
72	Attachment III: Sample Contract, Article 1.1, p.31- references a Concise Description of Services as an Attachment; however, the attachment is not included (See article 1.2) in this document. Does the OGB intend to negotiate the list of services to be included here once the Notice of Intent Letter is issued or should the proposer create the Attachment and submit it along with its response?	OGB intends to negotiate deliverables, timelines, performance guarantees and metrics among other requirements to be provided under the Contract resulting from this RFP with the successful Proposer.
73	Attachment III: Sample Contract, Article 1.2, p.31 - Article 1.2, references a Statement of Work as an Attachment; however, the attachment is not included in this document. Does the OGB intend to negotiate a Statement of Work after the Notice of Intent Letter is issued, or will the proposer be provided with the Statement of Work prior to the issuance of the Notice of Intent Letter?	Attachment I of the RFP includes a list of the minimum services the successful Proposer will be responsible for providing under the contract resulting from this RFP. OGB intends to negotiate deliverables, timelines, performance guarantees and metrics among other requirements to be provided under the Contract resulting from this RFP with the successful Proposer.
74	Attachment III: Sample Contract, Article 1.4, p.31 - Article 1.4, references Performance Measures as an Attachment; however, the attachment is not included in this document. Does the OGB intend to negotiate the specific performance standards and metrics once the Notice of Intent Letter is issued or should the proposer submit a list of specific proposed performance standards and metrics along with its response?	OGB intends to negotiate deliverables, timelines, performance guarantees and metrics among other requirements to be provided under the Contract resulting from this RFP with the successful Proposer.
75	Attachment III: Sample Contract, Article 2.2, p. 32 - Article 2.2, references OGB Furnished Resources as an Attachment; however, the attachment is not included in this document. Does the OGB intend to provide a list of those items once the Notice of Intent Letter is issued or prior to the issuance of the Notice of Intent Letter?	OGB intends to negotiate deliverables, timelines, performance guarantees and metrics among other requirements to be provided under the Contract resulting from this RFP with the successful Proposer.

No	Inquiry	Response
76	Attachment III: Sample Contract, Article 2.4, Payment Terms, references a maximum fee of _____ for the Term of the Contract. Our assumption is that the Term of the Contract would be January 1, 2016 – December 31, 2016. Is it the intent of the OGB to insert the monthly administrative service fee (i.e., PEPM) in this section once the contract is awarded? If so, what about the monthly administrative service fee in subsequent optional contract years. In addition, will there be a maximum amount payable under the contract reflected in the final ASO agreement?	OGB will negotiate terms of the maximum amount payable with the successful Proposer. The Per Employee Per Month (PEPM) rate shall be in effect and guaranteed for term of the contract which shall not exceed five (5) years.
77	Attachment V: Technical Questionnaire, I. Medical Claims Administration, p. 49 - 12. Please provide your call center service hours for the following: a. Providers b. Members c. Account Management d. Nurseline The Nurseline referenced here, does this apply to the Prior Auth phone line manned by nurses or the Disease Management phone line used for DM outreach?	The Nurseline referenced applies to prior authorization; however, call hours should be listed for the disease management phone line used for outreach services.
78	Attachment V: Technical Questionnaire, V. Overall Administration, p. 52 - 3. Please confirm you are able to administer the plan designs as outlined in Attachment VIII. Will Attachment VIII be provided?	Plan information should be obtained by accessing www.bcbsla.com/ogb and www.groupbenefits.org. Clarification was issued by way of Addendum# 1.

No	Inquiry	Response
79	5 PROPOSAL CONTENT, Section 5.5 Administration Cost Information, p. 18 - The Proposer shall provide one total Per Employee Per Month (PEPM) cost proposals for providing all services proposed in order to provide Administrative Services Only (ASO) for Self-Funded Medical Plans offered by the Office of Group Benefits, including but not limited to:..... This cost shall be inclusive of all services provided by the Proposer. The cost proposal shall not include any additional fees for service, other that the PEPM costs. Conflicting statements from underlined statement in section 5.5 "inclusive of all services" versus pages 50 and 52. Is OGB requesting an itemized list of services within the PEPM cost?	OGB is requesting one total Per Employee Per Month (PEPM) rate. The PEPM shall be an all inclusive rate for all services, including innovative concepts. For informational purposes only, the Proposer shall provide an itemized list of all services included in the proposed PEPM rate and cost associated with each service.
80	Attachment V: Technical Questionnaire, I. Medical Claims Administration, p. 50 - 17. Please indicate if additional services may be provided that are not included in the proposed fee, and what the additional cost for each service would be. Conflicting statements from underlined statement in section 5.5 "inclusive of all services" versus pages 50 and 52. Is OGB requesting an itemized list of services within the PEPM cost?	OGB is requesting one total Per Employee Per Month (PEPM) rate. The PEPM shall be an all inclusive rate for all services, including innovative concepts. For informational purposes only, the Proposer shall provide an itemized list of all services included in the proposed PEPM rate and cost associated with each service.
81	Attachment V: Technical Questionnaire, V. Overall Administration, p. 52 - 3. Please confirm you are able to administer the plan designs as outlined in Attachment VIII. A. Please include the cost to the OGB to eliminate any of the programs included in the proposal. Conflicting statements from underlined statement in section 5.5 "inclusive of all services" versus pages 50 and 52. Is OGB requesting an itemized list of services within the PEPM cost?	OGB is requesting one total Per Employee Per Month (PEPM) rate. The PEPM shall be an all inclusive rate for all services, including innovative concepts. For informational purposes only, the Proposer shall provide an itemized list of all services included in the proposed PEPM rate and cost associated with each service.

No	Inquiry	Response
82	ATTACHMENT VI: Claims Re-Pricing, The claim record must be expanded to include two fields. One field is an indicator that identifies in-network, participating non-network and out-of-network or non-participating providers based on your contracted network in effect on March 1, 2015. Will you provide an example of a participating non-network provider?	An example of a non-participating non-network provider would be any leased or wrap network providers that allow for some discounts and members are protected from balanced billing.
83	Since data was just released on 3/26 – we wanted to confirm if there will be a deadline extension available?	Per Addendum #1 of this RFP, the deadline for receipt of written inquires has been changed to April 1, 2015 by 5:00 PM Central Standard Time. No other changes have been made to the Schedule of Events.
84	Please clarify submission requirements for the claims repricing component of the RFP. Section 5.6 of the NIC states that Proposer shall provide a total cost for all claims after repricing. Yet, within the claims data file instructions, there is an indication that Proposers must provide claim-level detail. While claims will of course be repriced at the claim line level, it is our assumption that our final submission to OGB will be at the summary level, including total charges and associated allowed amounts by claim type.	The Proposer's submission for claims re-pricing should include both the claim level detail provided on the data file and total cost for all claims after re-pricing. The total cost for all claims will be used to calculate the score points using the formula specified in Section 6.5 Evaluation and Review
85	Please clarify the date range of claims data provided.	Please re-price the claims as though admit date or service date is March 1, 2015. The sample data was selected from 2014 and 2015 dates of service and, where possible, updated to current diagnosis coding parameters.

No	Inquiry	Response
86	Please provide a copy of the current Administrative Agreement including fees paid to current vendor.	All parties interested in obtaining a copy of the current Administrative Agreement including fees paid to current vendor may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm
88	Please confirm we may submit electronic copies via USB instead of CD-ROM.	Submission of the technical and cost proposals via USB flash drives instead of CD-ROMs is acceptable.
89	In an effort to be conscious of our environment and reduce printing may we submit GEO, disruption and repricing summary via hard copy and submit full reports in the electronic submission? These reports are usually over 1,000 pages.	Yes, full detail reports and supporting information may be provided on the CDs or USB flash drives to be submitted that are to contain the cost proposal. A hard copy summary should also be provided in accordance with requirement set forth in Section 4.1 of the RFP.
90	In Section 2.1, the NIC states that the period of any contract is tentatively scheduled to begin on or about January 1, 2016 and continue through December 31st , 2016 and that OGB has the right to contract for up to three years upon approval. Under Section 6.5, Phase 3: Cost Proposal contemplates a possible score of 130 with the proposer with the lowest total administrative cost receiving 130 points. Will only year one be utilized in the scoring? If not, how will OGB score the value of a multi-year proposals? As an example, in the following scenario how would each proposer be scored? **Proposer 1:** Admin Year One - $20.00 Admin Year Two - $22.00 Admin Year Three - $24.20 **Proposer 2:** Admin Year One - $21.00 Admin Year Two - $21.00 Admin Year Three - $21.00 **Proposer 3:** Admin Year One - $18.00 No guarantee for year two or three	The Proposer shall provide one total Per Employee Per Month (PEPM) cost proposal. The PEPM rate shall be guaranteed and in effect for the full contract which shall not exceed five (5) years.

No	Inquiry	Response
91	Confirm they agree that their Inpatient Data Layout is different than the actual inpatient data file, there were a number of additional fields included in the data file than on the layout.	The data file contains additional secondary diagnosis and procedure codes.
92	Confirm the control totals that I have listed below to ensure that we have all of the data incorporated into the analysis. <u>Inpatient Data File</u> Claim Count – 14,650 Claim Line Count – 215,862 Line Charge Total – $570,381,983.34 <u>Outpatient Data File</u> Claim Count – 378,357 Claim Line Count – 1,724,790 Line Charge Total – $931,289,872.86 <u>Physician Data File</u> Claim Count – 554,516 Claim Line Count – 1,217,478 Physician Charges Total – $214,056,130.85	The listed control totals are correct.
93	Confirm the time period of the data that was provided; i.e. 24 months, 12 months, 6 months, etc	Inpatient/Outpatient data was provided for a 12 month period (calendar year 2014). Professional data was provided for a 3 month period (November 2014 through January 2015).
94	All it says in the census is the count of subscribers by zip code, please send overall membership	Full census data is not required for the response. Zip code counts have been provided.
95	Please provide the average network discounts achieved with the BC/BS network on the ASO membership: • Inpatient Providers • Outpatient Providers • Physicians • Other	OGB does not have achieved average network discounts for the BC/BS network on the ASO membership.

No	Inquiry	Response
96	Please provide the average network discounts achieved with the BC/BS network on the ASO membership: • Bed Days per 1,000 • Average Length of Stay • Admissions per 1,000 • Payment Per Admissions	Please see response to question #95.
97	For the past 12 months what % of submitted charges were identified as "ineligible" by BC/BS of LA?	OGB does not have the percentage for submitted charges identified as "ineligible" by BCBS of LA for the past 12 months.
98	Are there any anticipated benefit changes effective for the proposed effective date of 1/1/2016? If so please provide details.	While OGB does not anticipate making any medical benefit changes to its self-funded health plans for the 2016 plan year (beginning January 1, 2016), it reserves the right to make such medical benefit changes as deemed necessary.
99	Please provide the current plan year and prior plan year's Aggregate report (or similar).	The total claims expenditures (accrual) for OGB's self-funded medical plans for the 2014 plan year was $923,042,526. The total claims expenditures (accrual) for OGB's self-funded medical plans for the current plan year (January 2015 through February 2015) is $152,852,349.
100	Over the past 12 months, what is the average number of medical claims processed each month for ASO services in connection with this bid?	Average monthly claims for 2014 were 31,530 outpatient claims per month, 1,221 inpatient claims per month. For the most recent 3 months period physician claims averaged 184,831 per month.
101	Please provide the current performance measures that are in-force and the associated penalties for the performance measures not being met?	All parties interested in obtaining a copy of the current Administrative Agreement including fees paid to current vendor may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm

No	Inquiry	Response
102	For the past 12 months, please provide a list of the performance measures that have not been met by BC/BS of LA and the amount of penalties that have been imposed.	All parties interested in obtaining a copy of the current Administrative Agreement including fees paid to current vendor may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm
103	How will enrollment changes be submitted? Approximately how many employee coverage status changes occur each month?	Enrollment changes are currently entered into OGB's eEnrollment using the 834 file from LSU and changes in IMPACT are sent by a daily file to the vendor. OGB experienced an average of 4,100 changes per month from January 2014 to June 2014 which includes annual enrollment 2014 changes. These changes take into account retiree changes, waiver of coverage, new hires, terms, coverage level changes, etc.
104	How many participants are on COBRA currently?	As of April 1, 2015, there were 417 COBRA enrollees.
105	How many Cobra qualifying events occur monthly?	The average number of COBRA qualifying events that occurred each month for the period of January 01, 2014 through December 31, 2014 was 1,525.
106	Please provide details relating to the number of accounts (or similar) for which there may be separate invoicing related to administration fees, reinsurance premiums or other invoicing or payments made in connection with the OGB plan?	Separate administrative fee invoices for each entity participating in OGB offered health plans are not required. Separate administrative fee invoices will need to be provided for each self-funded plan offered.
107	Please provide a summary of the type of reports that are currently provided to the Office of Group benefits (monthly, semi-annually, annually etc).	All parties interested in obtaining this information may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm

No	Inquiry	Response
108	What % of calls are answered within 30 seconds by BC/BS of LA?	All parties interested in obtaining this information may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm
109	What is the current customer call abandonment rate % and approximately how many calls does BC/BS of LA receive each month regarding the ASO services?	All parties interested in obtaining this information may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm
110	What is the % of accuracy related to claims processing by BC/BS of LA for the following categories over the past 12 months? • Procedural: • Financial:	All parties interested in obtaining this information may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm
111	Please provide a copy of the Plan Document that governs the self-funded plan administered by BC/BS of LA.	Schedules of Benefits for OGB's self-funded plans can be found at the following link: http://www.bcbsla.com/State/Pages/Benefits.aspx
112	When “out of network” services are provided, what is the fee charged to Office of Group Benefits for when a discount may apply to out of network services?	All parties interested in obtaining this information may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm
113	What is the access fee charged to OGB when a member receives care outside of LA though another BC/BS provider located in another state, and for the past 12 months?	All parties interested in obtaining a copy of the current Administrative Agreement including fees paid to current vendor may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm

No	Inquiry	Response
114	How much did OGB pay in network access fees for BC/BS providers located outside of LA?	All parties interested in obtaining a copy of the current Administrative Agreement including fees paid to current vendor may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm
115	What is the fee charged to the Office of Group Benefits for when a claim is audited?	All parties interested in obtaining a copy of the current Administrative Agreement including fees paid to current vendor may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm
116	Who currently provides services in connection with Subrogation, and what is the fee for services?	OGB's incumbent contractor is responsible for subrogation efforts on behalf of OGB. The fee is a part of the monthly administrative fee charge per employee per month.
117	Does the Office of Group Benefits retain 100% of the Pharmacy rebates in connection with the Rx plan? If not, what % of the rebates are kept by the PBM, or BC/BS of LA?	PBM proposals will not be considered in connection with this RFP.
118	Will OGB consider a PBM proposal in connection with this ASO bid?	PBM proposals will not be considered in connection with this RFP.
119	Will OGB allow the ASO Company providing a proposal to make any modifications to the Protected Health Information Addendum/HIPAA BAA, Sample Contract?	Please reference Section 5.1 Executive Summary

No	Inquiry	Response
120	Please provide a complete listing of all fees (PEPM, % of Savings, etc) charged by BC/BS of LA in connection with the ASO services provided.	All parties interested in obtaining a copy of the current Administrative Agreement including fees paid to current vendor may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm
121	Please describe the process and frequency for which eligibility is exported to BC/BS of LA and the number of systems for which eligibility files are extracted.	The file is sent electronically using File Transfer Protocol (FTP) and encrypted using PGB (Pretty Good Privacy). This file shall be received during the evening of every work day by the contractor and posted to their system before the next day. Eligibility data is extracted on from one (1) system, Impact.
122	Are there any anticipated changes to systems relative to eligibility exports between the Office of Group Benefits and the chosen ASO provider in the next 12 months?	OGB does not anticipate any changes outside of typical updates and maintenance of the system.
123	Please provide the eligibility file layout/specifications that would be apply as of the effective date of this contract.	Please see attached file requirements and layout specifications currently used by OGB.
124	Please provide the file layout specifications for any other files as mentioned on page 28 of the RFP.	Please see attached file requirements and layout specifications currently used by OGB. Any file requirement and layout specification not attached require development by OGB and will be provided to the successful Proposer.
125	Please provide the last plan participant survey results relating to satisfaction of service relating to the ASO plan.	All parties interested in obtaining this information may do so by filing a public records request with the State of Louisiana Division of Administration. Information on how to submit such a request can be found at the website below: http://www.doa.louisiana.gov/DOA/ContactInfo.htm
126	Who is the claim fiduciary for the self-funded plan?	The successful Proposer will be the claim fiduciary for OGB's self-funded plans.

No	Inquiry	Response
127	Please confirm that there are approximately 125,000 covered subscribers within the ASO plan and that subscribers is the equivalent of Employees & Retirees?	As of April 1, 2015, there were 124,972 subscribers enrolled in the self-funded health plans offered by OGB. This count consists of employees, retirees, COBRA participants, and Surviving Spouses.
128	7-Successful Contractor Requirements, 7.3.1 Performance Bond, p.24 - Contractor shall provide a performance bond (surety) bond in the amount of 100% of the annual contracted administrative cost to insure the successful performance under the terms and conditions of the Contract. Please confirm the surety bond percentage requirement of 100%.	The performance bond percentage is 100% of the annual contracted administrative cost.
129	ADDENDUM 1, RFP Attachment V: Technical Questionnaire, p.9, Section V, Overall Administration Question #5. Please confirm that Question 5 should read 5c. and 5d.	Question #5 should read 5a and 5b.

Table 1 – 2015 Plan Year Enrollment

2015 Plan Year Enrollment*	Actives	Retirees	Total
Magnolia Open Access	8,638	23,799	32,437
Magnolia Local	399	206	605
Magnolia Local Plus	64,725	24,786	89,511
Pelican HRA 1000	4,455	924	5,379
Pelican HSA 775	2,200	0	2,200
Vantage MHHP	3,082	569	3,651
OneExchange	12	408	420
Peoples Health HMO 65	96	1,608	1,704
Vantage HMO 65	210	1,315	1,525
Vantage Zero 65	10	188	198
LSU First	5,873	2,775	8,648
All Plans	89,700	56,578	146,278

*Enrollment data as of 3/11/2015; does not include dependents.

Table 2- Wellness Offerings

Initiative	Objective	Targeted	Population-Based	Target Participation	Incentive
Catapult Screenings	Educate employees about their current health status and steer them to available programs and initiatives to help them prevent & manage chronic conditions.		x	25%	$10 per month on 2016 premium contributions (for PHA + screenings)
BCBS Personal Health Assessment	Educate employees about their current health status and steer them to available programs and initiatives to help them prevent & manage chronic conditions.		x	25%	$10 per month on 2016 premium contributions (for PHA + screenings)
Pennington Heads Up Program	Lottery-based Medical Weight Loss program that includes a liquid diet and/or surgical intervention. 5-year grant with 2 years remaining. Are in the process of seeking another grant.	x		200 for surgery 500 for liquid diet	none
Omaha Prevent Program	Virtual diabetes prevention program where employees qualify through screenings if pre-diabetes is identified.	x		2,000 have qualified through screenings	none
YMCA Diabetes Prevention Program	Onsite diabetes prevention program. *Currently unavailable because BCBS cannot bill as a claim, but they are looking into it.*	x			
Tobacco Cessation	BCBS program available to all members and Louisiana.		x		
	Smoking Trust available to all Louisiana residents who began smoking prior to 1988.	x			
	Quit with Us Louisiana is a program available to all residents of Louisiana. Online or telephonic support available.		x		
	Tobacco-Free campus implementation.		x		

Quality Blue Primary Care	Team-based delivery care model to help members manage conditions effectively through support provided to physicians and members in the Quality Blue network.		x		
BCBS Disease Management Program	Proactive outreach to identified members to help them chronic conditions	x			none
BCBS Case Management		x			

Table 3 - Top 20 Zip Codes by Employee Location

Zip Code	City	Members
70726	Denham Springs	4,664
71360	Pineville	3,602
71457	Natchitoches	2,834
70810	Baton Rouge	2,814
70570	Opelousas	2,813
71270	Ruston	2,605
71291	West Monroe	2,578
70808	Baton Rouge	2,563
70816	Baton Rouge	2,445
70817	Raton Rouge	2,399
71203	Monroe	2,353
70791	Zachary	2,322
70072	Marrero	2,299
70785	Walker	2,235
70301	Thibodaux	2,130
70454	Ponchatoula	2,083
70706	Denham Springs	2,054
70403	Hammond	1,983
71303	Alexandria	1,970
70769	Prairieville	1,939
Total		50,685

File Requirements and Layout Specifications

Files to be Sent to OGB by Contractor:

All files shall be sent electronically using FTP (File Transfer Protocol) and must be encrypted using PGP (Pretty Good Privacy). File format is flat ascii text unless otherwise specified.

1. **Medical Claims File (Appendix A-1) –**This file includes all claims for which EOBs (Explanations of Benefits) or checks were sent or issued to the provider and/or claimant during a month. This is a file of records containing claim charge lines or service lines for a physician claim (CMS-1500), facility claim (UB-92), or a dental claim (ADA-1500) that has been received and processed. No claims in process are included.

2. **Provider File (Appendix A-2) -** This is a file of medical service providers for which checks and EOBs were issued in (1) above. This will include, for example, physicians, hospitals, urgent care facilities, and physician groups. The file will also contain separate records relevant to the entity paid for a provider's services.

3. **Check Register File (Appendix A-3) -** This file will contain one record for each check issued during the month. The amount of money reflected on this file should match the invoice sent to OGB for payment each month. Check numbers shall correspond to checks referenced in the paid claims provided in (1) above.

4. **Pharmacy Claims File (Appendix A-4)** This file shall contain Pharmacy Claims data paid on behalf of High Deductible Plan members during the period. The file contains multiple records types.

5. **Disease Management Participation File (Appendix A-5)** This file shall contain all Disease Management participants for the month just ended. The data will serve two purposes. It will determine which participants are invoiced for the month and who will receive reduced pharmacy co-pay incentive for the following 90 days.

6. **DHH-LaCHIP Financial Report (Appendix A-6)**
   Medical Claims Payer shall produce Financial Report listing paid amounts associated with Medical Claims. This report will accompany the associated money request. The report will be in the format as described in Appendix-6. Delivery method will be in PDF format via email to addressees provided by OGB Fiscal Department. The descriptions and qualifying criteria contain information on how OGB produced this report and is included here for illustration purposes. This report must match the invoice.

7. **Bancorp Enrollment Account File for HSA accounts (Appendix A-12)**
   This file shall contain all Enrollment Account Information each month. File shall be a flat text file. This file will allow OGB to update participant's Enrollment and Bank Records based on the information in the file. It will be in the format as described in Appendix-7.

Files to be sent to the contractor by OGB:

The contractor shall receive the following two files from OGB. Both files shall be constructed using strictly the layout as described in Appendix A-5, and A-6. Both files shall be sent electronically using FTP (File Transfer Protocol) and MUST be encrypted using PGP (Pretty Good Privacy).

8. **Eligibility File (Appendix A-7)**
   This file shall be received the evening of every work day by the contractor and posted to their system before the next day. It will contain the contractor's entire membership plus any terminations that have been done in the last two months.

9. **ASO Administrative Fee Billing file(Appendix A-8)**
   This file shall be received monthly by the contractor and will contain the amount per contract holder that OGB will pay the ASO for administrative fee. OGB will pay the ASO based on this file. This file will contain adjustments to prior months billing resulting from retro terms and enrollment.

10. **Claims Paid By Contractor After Termination or Stop Payment(Appendix A-9)**
    This file shall be received monthly by the contractor and will contain the claims paid in error after the termination or stop payment date.

11. **Eligibility file for Bancorp of All members Eligible for HSA Accounts(Appendix-10)**
    File contains those members that are eligible for HSA Accounts. File will be in format described in Appendix-10. File is sent to Bancorp monthly.

12. **Eligibility TERMS that are identified upon load process for Bancorp(Appendix-11)**
    File is created when the Enrollment file from Bancorp is processed. If any potential participant has information or a lack thereof the keeps OGB from being able to update and open that participant's record in OGB's system, they are returned to Bancorp via this term file. File format is as described in Appendix-11. File is sent monthly.

REQ: * indicates a required field **TYPE**: A/N – Alphanumeric (or text) N – Numeric D - Date

Medical Claims File (Appendix A-1)

Prior to any transmission of claims data from the Contractor, OGB must have an understanding of the Contractor's procedures for processing, paying and adjusting claims so that the financial and clinical care of our members can be accurately reflected in our data warehouse. Information provided to OGB is also transmitted to our Living Well Louisiana health management program for management of ongoing health conditions, including diabetes, heart disease, heart failure, asthma, and chronic obstructive pulmonary disease (COPD). To clarify OGB needs, the following will apply to all claims:

1. **Only processed claims –** Transmit all paid and denied claims as indicated above for which bills were submitted for our members. Claim transmissions will include detail for each charge or service line on the patient's bill. All coding in each line will adhere to standard medical coding procedures.
2. **Adjusted Claims –** Claims that are reprocessed and subsequently adjusted, whether for financial reasons or for changes related to services provided, will include a reference to the original or preceding claim in all claim lines. OGB must be able to reconstruct a representative processing history for each claim through final disposition.
3. **Provider recognition –** Each provider must be clearly identified by their purpose in the data provided, specifically, service providers and "pay-to" providers must be distinguished from each other. Where possible, relationships between facilities, physician groups, physicians, and other ancillary service providers as it applies to patient care should be made available whenever possible.
4. **Non-standard codes –** Codes and their meaning or description used to represent Contractor's processing data for which an industry standard does not exist will be transmitted to OGB separately from the monthly transmission, beginning with contract initiation. Any changes to these codes will be transmitted to OGB prior to transmission of claim records with these codes being used. Examples of these codes include but are not limited to Contractor's physician specialty codes and denial codes.
5. **Data standards –** Numeric data will be right-justified and zero-filled. Money amounts will be 15 digits including an explicit decimal point and accurate to two decimal places (**000009999999.99**). Negative amounts will have a minus sign as the first character (**-00009999999.99**). Dates will be formatted **CCYYMMDD** and valid. All text will be left-justified and space-filled. All SSN's, ICD-9 codes, phone numbers, NDC's and zip codes will be left-justified, with no dashes, commas, decimals or other formatting.

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: The Claim ID is Contractor's distinct identifier for all charges and services associated with a patient bill. Whenever OGB contacts Contractor relevant to information on a medical claim, this identifier will be used as reference to the specific claim.						
1	*	CLAIM ID	A/N	40	1-40	CONTRACTOR'S UNIQUE IDENTIFIER FOR THIS CLAIM.
Field 2: A service line references a discrete charge or service in a submitted claim. OGB uses service line detail for its reporting for the State of Louisiana whenever we are asked to study the potential effects of a change to existing benefits, whether financial or clinical.						
2	*	CLAIM LINE ID	A/N	40	41-80	CONTRACTOR'S IDENTIFIER FOR A PARTICULAR CHARGE OR SERVICE LINE.
Fields 3-4: Service Dates apply to the claim line, not the duration of the stay referenced for inpatient facility claims.						

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
3	*	FROM SERVICE DATE	D	8	81-88	THE START DATE OF SERVICE REFERENCED ON THIS LINE. **FORMAT- CCYYMMDD**
4	*	THRU SERVICE DATE	D	8	89-96	THE LAST/FINAL DATE OF SERVICE. **FORMAT- CCYYMMDD**
Field 5: For keyed claims, the date received, not the date keyed. For electronic claims, the date Contractor received the transmission.						
5	*	RECEIVED DATE	D	8	97-104	THE DATE THE CLAIM WAS RECEIVED BY CONTRACTOR **FORMAT- CCYYMMDD**
6	*	CLAIM SOURCE	A/N	1	105	"K": KEYED INPUT "A": AUTOMATIC/ELECTRONIC INPUT
7	*	SYSTEM ENTRY DATE	D	8	106-113	THE DATE CONTRACTOR FIRST ENTERED THE CLAIM INTO THE CLAIM PAYMENT SYSTEM **FORMAT- CCYYMMDD**
Field 8: For each action affecting the payment status or clinical information on a claim, the date that action was taken.						
8	*	ADJUDICATION DATE	D	8	114-121	THE DATE CONTRACTOR PROCESSED AN ORIGINAL CLAIM. FOR ADJUSTMENTS, THE DATE REPROCESSED **FORMAT- CCYYMMDD**
9	*	PAID DATE	D	8	122-129	THE DATE THE PROCESSED CLAIM WAS PAID OR ADJUSTED. FOR DENIED CLAIMS, THE DATE DENIED. **FORMAT- CCYYMMDD**
10	*	MEDICAL CLAIM DOC TYPE	A/N	10	130-139	THE TYPE OF DOCUMENT SUBMITTED, EITHER THE HCFA OR UB DESIGNATION.
11		SUBMITTED DRG	A/N	20	140-159	FOR INPATIENT CLAIMS, THE V25 DRG CODE THAT WAS SUBMITTED ON THE CLAIM
Field 12: Revenue code is required for UB-92 claims. OGB will calculate the patient's length of stay for our data warehouse reports based on revenue coding.						
12		REVENUE CODE	A/N	10	160-169	THE 3 CHARACTER REVENUE CODE USED ON UB92 CLAIM FORMS.
Field 13: The original billed charge for each claim line will be provided on all activity affecting the claim or claim line.						
13	*	CHARGE AMOUNT	N	15	170-184	THE DOLLARS BILLED/CHARGED BY THE PROVIDER FOR THIS CLAIM LINE.
Field 14: For in-network providers, the allowed amount is determined after repricing and applying rate tables. For out-of-network providers, the allowed amount is determined from Contractor's fee schedule for that service.						

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
14	*	ALLOWED AMOUNT	N	15	185-199	THE AMOUNT THAT IS ALLOWED PER THE PROVIDERS PRICING CONTRACT OR FOR OUT-OF-NETWORK PROVIDERS
Field 15: Copay is a fixed component of the member's cost share to be paid to the provider by or for the member directly and separately from other claim payments. Copays are established by the state and are listed in the plan benefits of the HMO plan.						
15	*	COPAY AMOUNT	N	15	200-214	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER AT THE TIME OF SERVICE SEPARATE FROM THE AMOUNT PAID BY CONTRACTOR.
Field 16: Coinsurance is a variable component of the member's cost share to be paid to the provider by or for the member directly and separately from other claim payments. This value is normally zero except for out-of network providers.						
16	*	COINSURANCE AMOUNT	N	15	215-229	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER, BUT NOT BY CONTRACTOR DUE TO THE MEMBER'S COINSURANCE ARRANGEMENTS.
Field 17: The deductible is a component of the member's cost share to be paid to the provider by or for the member directly and separately from other claim payments. This value is normally zero except for out-of network providers for which the member is subject to an annual limit.						
17	*	DEDUCTIBLE AMOUNT	N	15	230-244	THE AMOUNT THAT WOULD NORMALLY BE PAYABLE TO THE PROVIDER, BUT NOT BY CONTRACTOR BASED ON PLAN BENEFITS.
18	*	COB PAID AMOUNT	N	15	245-259	THE AMOUNT PAID BY ANOTHER INSURER AGAINST THE MEMBER'S CLAIM, (COORDINATION OF BENEFITS)
19	*	WITHHELD AMOUNT	N	15	260-274	THE AMOUNT WITHHELD FROM PAYMENT DUE TO TERMS OF THE PROVIDER'S CONTRACT OR ACCOUNT.
20	*	PROVIDER PAID AMOUNT	N	15	275-289	THE NET AMOUNT THAT WAS EVENTUALLY PAID DIRECTLY BY CONTRACTOR TO THE PAY-TO PROVIDER FOR THIS CLAIM LINE.
21	*	MEMBER PAID AMOUNT	N	15	290-304	THE NET AMOUNT THAT WAS EVENTUALLY PAID DIRECTLY BY CONTRACTORTO THE MEMBER, SUBSCRIBER OR EMPLOYEE FOR THIS CLAIM LINE.
Field 22: The net paid amount must equal the total of the provider paid amount and the member paid amount.						
22	*	NET PAID AMOUNT	N	15	305-319	THE NET AMOUNT THAT WAS PAID IN TOTAL FOR THIS CLAIM LINE BYCONTRACTOR.

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
23	*	TRANSACTION TYPE	A/N	20	320-339	THE TRANSACTION TYPE (OUTCOME). SPECIFICALLY, 'APPROVED', 'DENIED', 'DUPLICATE', 'REVERSED', 'REVERSAL', 'ADJUSTMENT'.
Field 24: This field is blank for the first activity or transaction against a patient's bill, the "original claim". Depending on Contractor procedures, for reprocessed claims this field will either contain the claim number of the original transaction or the claim number of the immediately prior transaction against the originally submitted claim. OGB will use this field to reconstruct a transaction history against the original claim. Note: Claim Line IDs remain the same throughout the transaction history of a member's claim (see Field 2 above).						
24		ADJUSTED FROM CLAIM ID	A/N	40	340-379	IF THIS CLAIM IS A REPROCESSING OF A MEMBER'S CLAIM, THIS FIELD WILL CONTAIN THE CLAIM ID OF THE PRIOR CLAIM.
Field 25: Contractor will provide OGB a file of their denial codes and the corresponding descriptions for the reasons a claim may be denied, thus eliminating the NIC requirement for a separate DENIED REASON NAME field. Codes provided on denied claims will exist in the list provided, and any changes to the list will be provided to OGB in a timely manner. All denial reasons will be clear and accurately reflect the actual condition causing the denial. Note: The denial reason code is required for all denied claims						
25		DENIED REASON	A/N	20	380-399	IF DENIED, THE REASON CODE FOR THIS DENIAL.
26		BILL TYPE CODE	A/N	3	400-402	CREATED BY HCFA AND PROVIDES THREE SPECIFIC PIECES OF INFORMATION. THE FIRST CHARACTER IDENTIFIES THE TYPE OF FACILITY. THE SECOND CLASSIFIES THE TYPE OF CARE. THE THIRD INDICATES THE SEQUENCE OF THIS BILL IN THIS PARTICULAR EPISODE OF CARE.
27	*	PLACE OF SERVICE	A/N	20	403-422	THE HCFA STANDARD PLACE OF SERVICE CODE
28	*	TYPE OF SERVICE	A/N	20	423-442	THE HCFA STANDARD TYPE OF SERVICE CODE ON THE CLAIM.
29	*	SERVICE UNITS COUNT	N	11	443-453	THE NUMBER OF UNITS OF SERVICE DESCRIBED BY THE PROCEDURE REFERENCED ON THIS CLAIM LINE.
30		ANESTHESIA MINUTES	N	11	454-464	WHEN APPROPRIATE, THIS CLAIM LINE LISTS THE NUMBER OF MINUTES OF ANESTHESIA THAT WAS RENDERED.
Fields 31-36: Employee refers to the contract holder (subscriber), identified as relation = '01' in the State of Louisiana's eligibility file provided to Contractor in a daily transmission.						

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
31	*	EMPLOYEE SSN	A/N	11	465-475	THE CONTRACT HOLDER'S SOCIAL SECURITY NUMBER - LEFT JUSTIFIED AND FILLED WITH SPACES TO THE RIGHT. NO DASHES. THE FOREIGN WORKER NUMBER, WHEN APPROPRIATE.
32	*	EMPLOYEE ID QUALIFIER	A/N	1	476	INDICATES THE TYPE/ORIGIN OF THE IDENTIFYING NUMBER FROM THE BILL USED TO DETERMINE ELIGIBILITY: 'S'=SSN; 'P'=MEMBER ID OF THE CONTRACT HOLDER
33	*	EMPLOYEE LAST NAME	A/N	40	477-516	THE LAST NAME OF THE CONTRACT HOLDER.
34	*	EMPLOYEE SEX	A/N	1	517	THE GENDER OF THE CONTRACT HOLDER. 'F' = FEMALE; 'M' = MALE; 'U' = UNKNOWN
35	*	EMPLOYEE DATE OF BIRTH	D	8	518-525	THE CONTRACT HOLDER'S DATE OF BIRTH **FORMAT- CCYYMMDD**
36	*	EMPLOYEE ZIP CODE	A/N	9	526-534	THE CONTRACT HOLDER'S FULL ZIP CODE, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
Fields 37-46: Member refers to the patient for whom the charge or service was provided. For a claim to be paid, a member must be eligible as of the date of the service. Member information must correspond to OGB's eligibility transmission.						
37	*	UNIQUE MEMBER ID	A/N	8	535-542	THE MEMBER'S UNIQUE IDENTIFIER FROM THE STATE OF LOUISIANA'S ELGIBILITY FEED.
38		MEMBER SSN	A/N	11	543-553	THE MEMBER'S SOCIAL SECURITY NUMBER - LEFT JUSTIFIED AND FILLED WITH SPACES TO THE RIGHT. NO DASHES. THE FOREIGN WORKER NUMBER, WHEN APPROPRIATE.
39	*	MEMBER FIRST NAME	A/N	40	554-593	THE FIRST NAME OF THE MEMBER (PATIENT)
40	*	MEMBER LAST NAME	A/N	40	594-633	THE LAST NAME OF THE MEMBER (PATIENT)
41	*	MEMBER SEX	A/N	1	634	THE GENDER OF THE MEMBER. 'F' = FEMALE; 'M' = MALE; 'U' = UNKNOWN
42	*	MEMBER DATE OF BIRTH	D	8	635-642	THE MEMBER'S DATE OF BIRTH. **FORMAT- CCYYMMDD**
43	*	MEMBER ZIP CODE	A/N	9	643-651	THE MEMBER'S FULL ZIP CODE, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
Field 44: The relationship code will be consistent with that provided to Contractor in the daily eligibility transmission.						

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
44	*	RELATIONSHIP TO EMPLOYEE	A/N	2	652-653	THE RELATIONSHIP THIS MEMBER HAS TO THE CONTRACT HOLDER. '01 = EMPLOYEE/CONTRACT HOLDER '02' = SPOUSE '03' = OTHER DEPENDENTS
Fields 45-46: The following should relate directly to a check written to a member in the check register transmitted along with the month's claim file.						
45		MEMBER CHECK NUMBER	A/N	10	654-663	FOR PAID CLAIMS, THE NUMBER OF THE CHECK USED TO PAY THE MEMBER
46		MEMBER CHECK AMOUNT	N	15	664-678	THE AMOUNT ON THE MEMBER'S CHECK
FIELDS 47-57 AND 61-66: DIAGNOSIS AND PROCEDURE CODING WILL ADHERE TO ICD-9 STANDARD CODING. ONCE A PLAN AND SCHEDULE FOR TRANSITION TO ICD-10 CODING IS ESTABLISHED, DIAGNOSIS CODES AND PROCEDURE CODES WILL BE REVISITED TO PROVIDE OGB WITH AN ACCURATE REPRESENTATION OF THE CLINICAL ASPECTS OF THE CLAIM.						
47	*	PRIMARY DIAGNOSIS CODE	A/N	10	679-688	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE PRIMARY DIAGNOSIS FOR THE SERVICE PROVIDED
48		DIAGNOSIS CODE 2	A/N	10	689-698	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE SECOND DIAGNOSIS FOR THE SERVICE
49		DIAGNOSIS CODE 3	A/N	10	699-708	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE THIRD DIAGNOSIS FOR THE SERVICE
50		DIAGNOSIS CODE 4	A/N	10	709-718	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE FOURTH DIAGNOSIS FOR THE SERVICE
51		DIAGNOSIS CODE 5	A/N	10	719-728	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE FIFTH DIAGNOSIS FOR THE SERVICE
52		DIAGNOSIS CODE 6	A/N	10	729-738	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE SIXTH DIAGNOSIS FOR THE SERVICE
53		DIAGNOSIS CODE 7	A/N	10	739-748	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE SEVENTH DIAGNOSIS FOR THE SERVICE
54		DIAGNOSIS CODE 8	A/N	10	749-758	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE EIGHTH DIAGNOSIS FOR THE SERVICE
55		DIAGNOSIS CODE 9	A/N	10	759-768	THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE NINTH DIAGNOSIS FOR THE SERVICE

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
56		ADMIT DIAGNOSIS CODE	A/N	10	769-778	FOR INPATIENT CLAIMS, THE ICD-9-CM DIAGNOSIS CODE THAT IDENTIFIES THE ADMIT DIAGNOSIS FOR THIS CLAIM
57	*	PROCEDURE CODE	A/N	10	779-788	THE ACTUAL PROCEDURE PERFORMED: - THE CPT PROCEDURE CODE ON HCFA FORMS - THE HCPCS PROCEDURE CODE ON UB92 FORMS - THE ADA PROCEDURE CODE ON DENTAL FORMS.
58		MODIFIER CODE 1	A/N	5	789-793	THE FIRST MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
59		MODIFIER CODE 2	A/N	5	794-798	THE SECOND MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
60		MODIFIER CODE 3	A/N	5	799-803	THE THIRD MODIFIER CODE ASSOCIATED WITH THE CPT/HCPC CODE ON A HCFA1500 CLAIM FORM
61		ICD9 PROCEDURE CODE 1	A/N	10	804-813	THE PRIMARY ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
62		ICD9 PROCEDURE CODE 2	A/N	10	814-823	THE SECOND ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
63		ICD9 PROCEDURE CODE 3	A/N	10	824-833	THE THIRD ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
64		ICD9 PROCEDURE CODE 4	A/N	10	834-843	THE FOURTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
65		ICD9 PROCEDURE CODE 5	A/N	10	844-853	THE FIFTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
66		ICD9 PROCEDURE CODE 6	A/N	10	854-863	THE SIXTH ICD9 PROCEDURE CODE ORIGINATING FROM A UB92 CLAIM (HEADER LEVEL)
67		RX DRUG CODE	A/N	11	864-874	FOR DRUGS ADMINISTERED, THE PRESCRIPTION DRUG CODE (NDC) FOR THE CLAIM LINE, FORMATTED 542, NO DASHES
Fields 68-69: The service provider must exist in the provider file transmitted along with the month's claim file.						
68	*	SERVICE PROVIDER ID	A/N	20	875-894	THE UNIQUE ID OF THE SERVICE PROVIDER ASSIGNED IN CONTRACTOR CLAIMS PROCESSING SYSTEM.
69	*	NPI	A/N	10	895-904	THE SERVICE PROVIDER'S NPI
Fields 70-74: The pay-to provider must exist in the provider file transmitted along with the month's claim file.						

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
70	*	PAY-TO PROVIDER ID	A/N	20	905-924	THE UNIQUE ID OF THE PAY-TO PROVIDER ASSIGNED IN CONTRACTOR CLAIMS PROCESSING SYSTEM. THIS MAY BE THE SAME ID LISTED FOR THE SERVICE PROVIDER IF A SEPARATE PAYMENT ENTITY IS NOT ESTABLISHED.
71	*	NETWORK INDICATOR	A/N	1	925	AT THE TIME OF SERVICE, THE PROVIDER'S STATUS: 'I' = IN NETWORK; 'O' = OUT OF NETWORK
72		PAY-TO TAX ID	A/N	10	926-935	THE TAX ID NUMBER FOR THE PAY-TO ENTITY FOR THIS PROVIDER
Fields 73-74: The following should relate directly to a check written to a provider in the check register transmitted along with the month's claim file.						
73		PROVIDER CHECK NUMBER	A/N	10	936-945	FOR PAID CLAIMS, THE NUMBER OF THE CHECK USED TO PAY THE PROVIDER
74		PROVIDER CHECK AMOUNT	N	15	946-960	THE AMOUNT ON THE PROVIDER'S CHECK
75		OVERRIDE CODE	A/N	3	961-963	IDENTIFIES THAT THE APPROVER OVERRODE THE SYSTEM-GENERATED PAYMENT AMOUNT. IDENTIFIES THE REASON THE APPROVER OVERRODE THE SYSTEM (CLAIM RELATED TO DETOXIFICATION, PAY BENEFIT FROM CREDIT-RESERVE, REJECTED LINE ITEM. ETC.)
76		BENEFIT LEVEL CAUSE CODE	A/N	2	964-965	IDENTIFIES THE REASON THE PATIENT SOUGHT MEDICAL CARE BLANK=N/A 0=GENERAL SICKNESS 1=PSYCHIATRIC 2=NORMAL MATERNITY 3=EMERGENCY ILLNESS 4=ROUTINE CARE 5=COMPLICATIONS OF PREGNANCY 6=ALCOHOLISM AND DRUG ADDICTION A=ACCIDENT

Appendix A-1 Medical Claims File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
77		DISCHARGE STATUS CODE	A/N	2	966-967	IDENTIFIES THE STATUS OF THE MEMBER'S INPATIENT STAY AS OF THE LAST SERVICE DATE ON THE CLAIM, RIGHT JUSTIFIED AND PREFIXED WITH ZERO

Appendix A-2 Provider File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: To simplify references, a provider may have more than one entry in the provider file. Specifically, a provider must be identified by services performed but may be paid as a separate entity from its identity as a service provider. Multiple entries may be caused by different addresses, tax requirements, and/or contractual responsibility to a group. Service providers are referenced in Fields 68 and 69 of Appendix A-1, Medical Claims File. Pay-to providers are referenced in Fields 70 through 74 of Appendix A-1.						
1	*	PROVIDER INTERNAL ID	A/N	20	1-20	THE UNIQUE ID FOR A SERVICE OR PAY-TO PROVIDER ASSIGNED BY CONTRACTOR IN CLAIMS PROCESSING
2	*	PROVIDER TAX ID	A/N	10	21-30	TAX ID OF THIS PROVIDER
3	*	NPI	A/N	10	31-40	THIS PROVIDER'S NATIONAL PROVIDER IDENTIFIER
4	*	PROVIDER DEA ID	A/N	10	41-50	THE FEDERAL DEA NUMBER OF THIS PROVIDER
Fields 5-8: A provider may refer to a physician, a facility, or another care provider. Either an office (Field 8) or a person (Fields 5-7) or both must be named in the following 4 fields.						
5		PROVIDER LAST NAME	A/N	40	51-90	THE LAST NAME FOR THIS PROVIDER
6		PROVIDER FIRST NAME	A/N	40	91-130	THE FIRST NAME FOR THIS PROVIDER
7		PROVIDER MIDDLE INITIAL	A/N	1	131	THE MIDDLE INITIAL FOR THIS PROVIDER
8		PROVIDER OFFICE NAME	A/N	40	132-171	THE OFFICE NAME, CORPORATION NAME, OR LOCATION NAME OF THE OFFICE THIS PROVIDER OFFERS SERVICES.
9	*	PROVIDER ADDRESS LINE1	A/N	40	172-211	LINE 1 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
10		PROVIDER ADDRESS LINE2	A/N	40	212-251	LINE 2 OF THE STREET ADDRESS PORTION OF THIS PROVIDER'S ADDRESS.
11	*	PROVIDER CITY	A/N	40	252-291	THE CITY PORTION OF THIS PROVIDER'S ADDRESS
12	*	PROVIDER STATE	A/N	2	292-293	THE STATE PORTION OF THIS PROVIDER'S ADDRESS
13	*	PROVIDER ZIP	A/N	9	294-302	THE ZIPCODE OF THIS PROVIDER'S ADDRESS, 5 OR 9 DIGITS AS AVAILABLE, NO DASHES.
14		PROVIDER UPIN	A/N	20	303-322	THE UNIVERSAL PROVIDER IDENTIFICATION NUMBER FOR THIS PROVIDER
15		PROVIDER MEDICARE ID	A/N	20	323-342	THE MEDICARE IDENTIFIER FOR THIS PROVIDER
Fields 16-19: Contractor will send initially and keep current a file of specialty codes and descriptions used in their claims processing to OGB						
16	*	PROVIDER SPECIALTY	A/N	10	343-352	THE CODE FOR THE PROVIDER'S PRIMARY SPECIALTY FROM THE CONTRACTOR SYSTEM.

Appendix A-2 Provider File						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
17		PROVIDER SPECIALTY 2	A/N	10	353-362	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR SYSTEM.
18		PROVIDER SPECIALTY 3	A/N	10	363-372	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR SYSTEM.
19		PROVIDER SPECIALTY 4	A/N	10	373-382	A CODE FOR A PROVIDER'S SECONDARY SPECIALTY FROM THE CONTRACTOR SYSTEM.
20	*	PROVIDER TYPE	A/N	1	383	**"F" – FACILITY, "P" – PHYSICIAN, "O" – OTHER, "Y" – PAY-TO, "G" - GROUP**

Appendix A-3 Check Register						
FIELD	**REQ**	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
Field 1: The check number should relate directly to the check number in the claim or claims paid by this check. This assumes that all claims for OGB members are paid from the same checking account. If this is not so, a separate account field will be required.						
1	*	CHECK NUMBER	A/N	10	1-10	THE NUMBER PRINTED ON THE CHECK
2	*	CHECK ISSUE DATE	A/N	8	11-18	DATE THE CHECK WAS ISSUED AS PAYMENT **FORMAT- CCYYMMDD**
Field 3: The amount of the check should equal the sum of the amounts on the claim or claims paid to the provider or member paid by this check.						
3	*	CHECK ISSUE AMOUNT	N	15	19-33	AMOUNT PAID BY THIS CHECK
4	*	PAYEE TYPE	A/N	1	34	'P' – PROVIDER, 'M' – MEMBER, 'O' - OGB
Field 5: If the check is to a provider, the provider ID must exist in Contractor provider file transmitted with the check register. If the check is written to a member, the member ID must correspond to OGB's member ID provided in the related eligibility transmission to Contractor. Financial adjustments to payments from OGB to Contractor may or may not reference a distinct claim transaction. Payments to OGB by Contractor, if any, should reference the relevant line on the Contractor invoice.						
5	*	PAYEE ID	A/N	20	35-54	PROVIDER ID OR MEMBER ID TO WHOM THE CHECK WAS PAID. INVOICE LINE IF PAID TO OGB.

Appendix A-4 Drug Claims File					
No	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD IDENTIFIER	N	1	001-001	0=PROCESSOR RECORD
2	PROCESSOR NUMBER	N	10	002-011	THIS NUMBER IS ASSIGNED BY NCPDP TO IDENTIFY THE SOURCE OF THE TAPE, I.E. PHARMACY, WHOLESALER, HOSPITAL, SERVICE BUREAU, ETC.
3	BATCH NUMBER	N	5	012-016	THIS NUMBER IS ASSIGNED BY THE PROCESSOR. FORMAT=YYDDD YY=YEAR DDD=JULIAN DATE I.E. 92252=SEPT. 8, 1992
4	PROCESSOR NAME	A/N	20	017-036	PROCESSOR NAME
5	PROCESSOR ADDRESS	A/N	20	037-056	PROCESSOR ADDRESS
6	PROCESSOR LOCATION CITY	A/N	18	057-074	PROCESSOR CITY
7	PROCESSOR LOCATION STATE	A/N	2	075-076	PROCESSOR STATE
8	PROCESSOR ZIP CODE	A/N	9	077-085	PROCESSOR ZIP CODE, EXPANDED
9	PROCESSOR TELEPHONE NUMBER	N	10	086-095	TELEPHONE NUMBER FORMAT=AAAEEENNNN AAA=AREA CODE EEE=EXCHANGE CODE NNNN=NUMBER
10	RUN DATE	A/N	8	096-103	DATE ON WHICH TAPE WAS GENERATED BY CARRIER FORMAT=CCYYMMDD
11	THIRD PARTY TYPE	A/N	1	104-104	TYPE OF CLAIM M=GOVERNMENT P=PRIVATE
12	VERSION/RELEASE NUMBER	N	2	105-106	A NUMBER TO IDENTIFY THE FORMAT OF THE TRANSACTION SENT OR RECEIVED
13	EXPANSION AREA	A/N	187	107-293	RESERVED FOR FUTURE NCPDP CONTINGENCIES
14	UNIQUE FREE FORM	A/N	415	294-708	FILLER

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD IDENTIFIER	N	1	001-001	2=PHARMACY RECORD
2	PROCESSOR NUMBER	N	10	002-011	THIS NUMBER IS ASSIGNED BYNCPDP TO IDENTIFY THE SOURCE OF THE TAPE, I.E. PHARMACY, WHOLESALER, HOSPITAL, SERVICE BUREAU, ETC.
3	BATCH NUMBER	N	5	012-016	THIS NUMBER IS ASSIGNED BY THE PROCESSOR. FORMAT=YYDDD YY=YEAR DDD=JULIAN DATE I.E. 92252=SEPT. 8, 1992
4	PHARMACY NUMBER	A/N	12	017-028	ID ASSIGNED TO A PHARMACY
5	PHARMACY NAME	A/N	20	029-048	NAME OF PHARMACY
6	PHARMACY ADDRESS	A/N	20	049-068	ADDRESS OF PHARMACY
7	PHARMACY LOCATION CITY	A/N	18	069-086	CITY OF PHARMACY
8	PHARMACY LOCATION STATE	A/N	2	087-088	STATE OF PHARMACY
9	PHARMACY ZIP CODE	A/N	9	089-097	ZIP CODE OF PHARMACY EXPANDED
10	PHARMACY TELEPHONE NUMBER	A/N	10	098-107	TELEPHONE NUMBER OF PHARMACY
11	EXPANSION AREA	A/N	211	108-318	RESERVED FOR FUTURE NCPDP CONTINGENCIES
12	UNIQUE FREE FORM	A/N	390	319-708	FILLER

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD IDENTIFIER	N	1	1-1	4=CLAIM RECORD
2	PROCESSOR NUMBER	N	10	2-11	THIS NUMBER IS ASSIGNED BY NCPDP TO IDENTIFY THE SOURCE OF THE TAPE, I.E. PHARMACY, WHOLESALER, HOSPITAL, SERVICE BUREAU, ETC.
3	BATCH NUMBER	N	5	12-16	THIS NUMBER IS ASSIGNED BY THE PROCESSOR. FORMAT=YYDDD YY=YEAR DDD=JULIAN DATE I.E. 92252=SEPT. 8, 1992
4	PHARMACY NUMBER	A/N	12	17-28	ID ASSIGNED TO A PHARMACY
5	PRESCRIPTION NUMBER	A/N	7	29-35	
6	DATE FILLED	A/N	8	36-43	DISPENSING DATE OF RX **FORMAT=CCYYMMDD**
7	NDC NUMBER	N	11	44-54	FOR LEGEND COMPOUNDS USE: 99999999999 SCHEDULE II: 99999999992 SCHEDULE III: 99999999993 SCHEDULE IV: 99999999994 SCHEDULE V: 99999999995 COMPOUNDS: 99999999996
8	DRUG DESCRIPTION	A/N	30	55-84	LABELNAME
9	NEW/REFILL CODE	N	2	85-86	00=NEW PRESCRIPTION 01-99=NUMBER OF REFILLS
10	METRIC QUANTITY	N	6	87-92	NUMBER OF METRIC UNITS OF MEDICATION DISPENSED (LEADING SIGN IF NEGATIVE)
11	DAYS SUPPLY	N	4	92-96	ESTIMATED NUMBER OF DAYS THE PRESCRIPTION WILL LAST
12	BASIS OF COST DETERMINATION	A/N	2	97-98	01=AWP (contracted network discount) 06=MAC 07=USUAL AND CUSTOMARY

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					Required field when not an adjustment
13	INGREDIENT COST	N	10	99-108	COST OF THE DRUG DISPENSED. FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as “0000123.45” -123.45 would be expressed as “-000123.45”
14	DISPENSING FEE SUBMITTED	N	10	109-118	FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as “0000123.45” -123.45 would be expressed as “-000123.45”
15	CO-PAY AMOUNT	N	10	119-128	CORRECT CO-PAY FOR PLAN BILLED FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as “0000123.45” -123.45 would be expressed as “-000123.45”
16	SALES TAX	N	10	129-138	SALES TAX FOR THE PRESCRIPTION DISPENSED FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as “0000123.45” -123.45 would be expressed as “-000123.45”
17	AMOUNT BILLED	N	10	139-148	THE PROVIDER’S USUAL AND CUSTOMARY AMT FORMAT-All financial fields should be 10

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as “0000123.45” -123.45 would be expressed as “-000123.45”
18	PATIENT FIRST NAME	A/N	12	149-160	FIRST NAME OF PATIENT
19	PATIENT LAST NAME	A/N	15	161-175	LAST NAME OF PATIENT
20	DATE OF BIRTH	A/N	8	176-183	DATE OF BIRTH OF PATIENT **FORMAT=CCYYMMDD**
21	SEX CODE	A/N	1	184-184	0=NOT SPECIFIED 1=MALE 2=FEMALE
23	EMPLOYEE SSN	A/N	9	185-193	
24	OGB Internal Id-	A/N	8	194-201	See Appendix E (Eligibility File) Field number-33
25	FILLER	A/N	1	202-202	
26	RELATIONSHIP CODE	A/N	1	203-203	1=CARDHOLDER 2=SPOUSE 3=CHILD 4=OTHER
27	GROUP NUMBER	A/N	15	204-218	ID ASSIGNED TO CARDHOLDER GROUP OR EMPLOYER GROUP
28	PRESCRIBER ID	A/N	10	219-228	IDENTIFICATION ASSIGNED TO THE PRESCRIBER
29	DIAGNOSIS CODE	A/N	6	229-234	ICD-9 STANDARD DIAGNOSIS CODES
30	Document number	A/N	15	235-249	
30	FILLER	A/N	12	250-261	
31	RESUBMISSION CYCLE COUNT	A/N	2	262-263	0 = ORIGINAL SUBMISSION 1 = FIRST RE-SUBMISSION 2 = SECOND RE-SUBMISSION

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
32	DATE PRESCRIPTION WRITTEN	A/N	8	264-271	DATE PRESCRIPTION WAS WRITTEN
33	DISPENSE AS WRITTEN (DAW)/PRODUCT SELECTION CODE	A/N	1	272-272	0 = NO PRODUCT SELECTION INDICATED 1 = SUBSTITUTION NOT ALLOWED BY PRESCRIBER 2 = SUBSTITUTION ALLOWED - PATIENT REQUESTED PRODUCT DISPENSED 3 = UBSTITUTION ALLOWED PHARMACIST SELECTED PRODUCT DISPENSED 4 = SUBSTITUTION ALLOWED - GENERIC DRUG NOT IN STOCK 5 = SUBSTITUTION ALLOWED - BRAND DRUG DISPENSED AS A GENERIC 6 = OVERRIDE 7 = SUBSTITUTION NOT ALLOWED - BRAND DRUG MANDATED BY LAW 8 = SUBSTITUTION ALLOWED - GENERIC DRUG NOT AVAILABLE IN MARKETPLACE 9 = OTHER
34	ELIGIBILITY CLARIFICATION CODE	A/N	1	273-273	CODE INDICATING THAT THE PHARMACY IS CLARIFYING ELIGIBILITY BASED ON DENIAL 0 = NOT SPECIFIED 1 = NOT OVERRIDE 2 = OVERRIDE 3 = FULL TIME STUDENT 4 = DISABLED DEPENDENT 5 = DEPENDENT PARENT
35	COMPOUND CODE	A/N	1	274-274	CODE INDICATING WHETHER OR NOT THE PRESCRIPTION IS A COMPOUND

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					0=NOT SPECIFIED 1=NOT A COMPOUND 2=COMPOUND
36	NUMBER OF REFILLS AUTHORIZED	N	2	275-276	NUMBER OF REFILLS AUTHORIZED BY PRESCRIBER
37	DRUG TYPE	A/N	1	277-277	CODE TO INDICATE THE TYPE OF DRUG DISPENSED (Must be specified (1-3) if an amount is paid) 0=Not Specified 1=SINGLE SOURCE BRAND 2=BRANDED GENERIC 3=GENERIC 4=O.T.C. (OVER THE COUNTER)
38	PRESCRIBER LAST NAME	A/N	15	278-292	PRESCRIBER LAST NAME
39	POSTAGE AMOUNT CLAIMED	N	4	293-296	DOLLAR AMOUNT OF POSTAGE CLAIMED FORMAT- Field should be 4 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 1.23 would be expressed as “01.23” -1.23 would be expressed as “-1.23”
40	UNIT DOSE INDICATOR	A/N	1	297-297	CODE INDICATING THE TYPE OF UNIT DOSE DISPENSING DONE 0=NOT SPECIFIED 1=NOT UNIT DOSE 2=MANUFACTURER UNIT DOSE 3=PHARMACY UNIT DOSE
41	OTHER PAYOR AMOUNT	N	6	298-303	DOLLAR AMOUNT OF PAYMENT KNOWN BY THE PHARMACY FROM OTHER SOURCES FORMAT=positive 123.56 negative -12.45
42	FILLER	A/N	35	304-338	RESERVED FOR FUTURE NCPDP CONTINGENCIES

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
43	CONTRACT SSN	A/N	9	339-347	(Contract Holder's SSN)
44	COVERED AMOUNT	N	10	348-357	FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "0000123.45" -123.45 would be expressed as "-000123.45"
45	PAID AMOUNT	N	10	358-367	FORMAT-All financial fields should be 10 characters long, zero filled, with an explicit decimal point and leading sign only when negative Example: 123.45 would be expressed as "0000123.45" -123.45 would be expressed as "-000123.45"
46	PAID DATE	A/N	8	368-375	Date of payment FORMAT = CCYYMMDD
47	FILLER	A/N	2	376-377	Spaces
48	Prescribe First Name	A/N	15	378-392	
49	Prescribe Last Name	A/N	25	393-417	
50	Prescribe MI	A/N	1	418-418	
51	Prescribe Address-1	A/N	55	419-473	
52	Prescribe Address-2	A/N	55	474-528	
53	Prescribe City	A/N	20	529-548	
54	Prescribe State	A/N	2	549-550	
55	Prescribe Zip Code	A/N	10	551-560	
56	GPI Number	N	14	561-574	
57	Care Facility	A/N	6	575-580	
58	Care Qualifier	A/N	10	581-590	
59	Care From Date	N	7	591-597	
60	Care Thru Date	N	7	598-604	
61	Family ID	A/N	20	605-624	
62	Alternate Insurance ID	A/N	10	625-634	
63	Submitted PA Type	N	1	635-635	

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
64	Submitted PA Number	A/N	11	636-646	
65	Member PA Number	A/N	11	647-657	
66	Member PA Reason Code	A/N	2	658-659	
67	Therapeutic Class Code	N	6	660-665	
68	Therapeutic Class Name	A/N	25	666-690	
69	RxClaim #	N	15	691-705	
70	Claim Sequence #	N	3	706-708	
71	Medicare D Eligible Indicator	A/N	1	709-709	Y = Medicare D eligible N = NOT Medicare D eligible
72	Date Processed	N	8	710-717	Format YYYYMMDD
73	Time Processed	N	6	718-723	Format HHMMSS
74	Diabetic Sense Vendor Indicator	A/N	1	724-724	
75	Mail Order Indicator	A/N	1	725-725	If Mail Order then Y, else N
76	Brand/Generic Indicator	A/N	1	726-726	M=multi-source brand no generic equivalent O=multi-source brand generic equivalent avail. N=single-source brand Y=generic
77	Brand/Generic Override	A/N	1	727-727	M=multi-source brand no generic equivalent O=multi-source brand generic equivalent avail. N=single-source brand Y=generic
78	Claim Origin	A/N	1	728-728	values T = Electronic B = Batch M = Manual
79	Retrospective DUR Program	A/N	1	729-729	Run-time parameter: values Y/N
80	Quantity Limit Program	A/N	1	730-730	Run-time parameter: values Y/N
81	Prior Authorization Program	A/N	1	731-731	Run-time parameter: values Y/N
82	Therapeutic	A/N	1	732-732	Run-time parameter: values Y/N

Appendix A-4 Drug Claims File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
	Interchange Program				
83	Decimal Qty	N	13	733-745	Format -9.999;
84	Cost Type Unit Cost	N	14	746-759	Format 9.99999; will contain unit cost or cost type (AWP, MAC)
85	Cost Basis	A/N	10	760-769	values SD = Submitted Drug Cost SM = Submitted Amount Due U = Usual and Customary AWP = Average Wholesale Price HCFA = HCFA MAC MAC* = Catalyst RX MAC price
86	Avg Wholesale Price Unit	N	14	770-783	Format 9.99999
87	DMR Method/Cust Location	A/N	2	784-785	Added to indicate if DMR pricing is used: 91 indicates DMR is submitted value less copay, 94 indicates adjustment, 93 indicates pass thru rate less copay

A-5 Disease Management Participation All data left justified				
NO	**FIELD NAME**	**LEN**	**LOC**	**DESCRIPTION**
1	Patient Record ID	08	01-08	OGB Member Internal ID (1-8)
2	filler	42	09-50	Spaces
3	Relation Code	02	51-52	Relationship to Subscriber 01 – subscriber 02 – spouse 03 – dependent
4	filler	28	53-80	Spaces
5	Birth Date	08	81-88	Birth Date (CCYYMMDD)
6	Gender	01	89-89	Gender Code M – Male F – Female
7	First Name	15	90-104	Patient First Name
8	filler	35	105-139	Spaces
9	Middle Initial	01	140-140	Patient Middle Initial
10	Filler	49	141-189	Spaces
11	Last Name	20	190-209	Patient Last Name
12	Product Type	30	210-239	HMO, PPO, etc
13	Last Coaching Date	08	240-247	CCYYMMDD
14	Heart Disease	01	248-248	Condition Indicator
15	Diabetes	01	249-249	Condition Indicator
16	CHF	01	250-250	Condition Indicator
17	COPD	01	251-251	Condition Indicator
18	Asthma	01	252-252	Condition Indicator
19	File Creation Date	08	253-260	CCYYMMDD

APPENDIX-6 DHH-LACHIP Financial Report			
Line No	**REPORT HEADING**		**DESCRIPTION**
Line 1.C	**Gross Premiums Paid**		**OGB will administer**
Line 1.C.1	**Administration Fees**		**OGB will administer**
Line 2.	**Inpatient Hospital Services - Regular Payments**		**Facility Claims**
	Qualifying Criteria	Document Type	U
		DRG Code	Not Null
Line 3.	**Inpatient Mental Health Facility Services - Regular Payments**		**UBH Claims**
	Qualifying Criteria	Specialty	HOS
		Bill Type	I
Line 4.	**Nursing Care Services**		**Outpatient Facility Claims**
	Qualifying Criteria	Document Type	H
		Specialty	NPR, MID, DBE, CNS
Line 5.	**Physician and Surgical Services**		**Inpatient And Outpatient Claims**
	Qualifying Criteria	Specialty (All MD and OD)	ANS, CVA, CVT, DC, DER, DPM, EMR, END, ENT, FLY, GAS, GRM, HBM, HEM, HNS, INF, INT, MAS, MAX, MIC, NEO, NEP, NES, NEU, OBG, OD, ONC, OPH, ORT, PAT, PED, PES, PHM, PLS, PMG, PST, PUL, RAD, RDO, RHM, SOM, SUR
Line 6.	**Outpatient Hospital Services**		**Facility Claims**
	Qualifying Criteria	Document Type	U
		DRG Code	Null
Line 7.	**Outpatient Mental Health Facility Services - Regular Payments**		**UBH Claims**
	Qualifying Criteria	Specialty	HOS
		Bill Type	O
Line 8.	**Prescription Drugs**		**OGB will administer Catalyst Drug Claims**
	Qualifying Criteria	CPT	All But Family Planning Drugs (Omit Catalyst GPI Codes For Family Planning)
		Omit Catalyst GPI Coding	Data Warehouse Table - CATALYST_FAMILY_PLANNING
Line 8.A.1.	**Drug Rebate Offset - National Agreement**		**Separate Reporting**

APPENDIX-6 DHH-LACHIP Financial Report			
Line No	**REPORT HEADING**		**DESCRIPTION**
	Qualifying Criteria	Per Tommy Teague	Calculated Catalyst Rebate From Member List
Line 9.	**Dental Services**		**Medical Claims**
	Qualifying Criteria	Specialty	DDS, All 1st Letter D
Line 10.	**Vision and Hearing Services**		**Vision And Hearing Aids When Billed By The Physician**
	Qualifying Criteria	CPT	Data Warehouse Table - HEARING_AIDS
Line 11.	**Other Practitioners**		**Non-MD/OD, Non Facility Claims**
	Qualifying Criteria	Specialty	AUD, PAS
			Social Workers, Licensed Professional Counselors, Doctor of Social Work
		Specialty	4, 5, 16 (UBH)
Line 12.	**Clinic Services**		**Rural Health Clinic Services**
	Qualifying Criteria	Document Type	U
		POS	72
			Mental Health Clinic Services
		Specialty	61 (UBH)
Line 13.	**Therapy Services**		**Physical/Occupational Therapy**
	Qualifying Criteria	Specialty	PHY
		POS	Not 12 Or 34
Line 14.	**Laboratory and Radiological Services**		**Inpatient And Outpatient Claims**
Qualifying Criteria		Document Type	H
		Specialty	Exclude DDS
		CPT	Starting With 7 Or 8
Line 15.	**Durable and Disposable Medical Equipment**		**Inpatient And Outpatient Claims**
	Qualifying Criteria	Specialty	DME
		CPT	Data Warehouse Table - DME_CODES
Line 16.	**Family Planning**		**Inpatient And Outpatient Claims**
	Qualifying Criteria	Therapeutic Class	

APPENDIX-6 DHH-LACHIP Financial Report			
Line No	**REPORT HEADING**		**DESCRIPTION**
		Catalyst GPI Coding	**OGB will administer Catalyst Drug Claims** Data Warehouse Table - CATALYST_FAMILY_PLANNING
		CPT	All Family Planning Drugs
		CPT/HCPCS (Seek Code)	J1055-J1056, J7300-J7302, 58300-58301, 57170
Line 18.	**Screening Services**		**Periodic Screenings**
			Health And Developmental History
			Comprehensive Unclothed Physical Exam
			Interperiodic Screenings
			Laboratory Tests
			Health Education
	Qualifying Criteria	CPT/HCPCS	99381-99385, 99391-99395 (TS Modifier Is Interperiodic)
			Appropriate Immunizations
		CPT	Data Warehouse Table - IMMUNIZATIONS
Line 19.	**Home Health Services**		**Nursing Services, Supplies, and Therapy**
	Qualifying Criteria	Document Type	H
		POS	12
		Specialty	HMH, PHY
			OR
	Qualifying Criteria	Document Type	U
		CPT	Data Warehouse Table - HOME_HEALTH_BILL_TYPES
Line 22.	**Hospice Care Services**		**Inpatient Claims**
	Qualifying Criteria	Document Type	H
		POS	34
		Specialty	HMH, PHY
			OR
	Qualifying Criteria	Document Type	U
		Bill Type	810 thru 82A
Line 25.	**Other Services**		**Skilled Nursing Facility, Rehab Facility, Other**
	Qualifying Criteria	Specialty	SKN
			OR

APPENDIX-6 DHH-LACHIP Financial Report			
Line No	**REPORT HEADING**		**DESCRIPTION**
	Qualifying Criteria	Document Type	U
		Specialty	RHB, LTA
		OR	
			All Other Charges Not Attributed To Any Of The Above
Line 26.	**Total**		**Sum of Lines 1-25.**

Appendix A-7 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	Contract Holder's SSN	A/N	9	001-009	Holder SSN
2	Member Last Name	A/N	20	010-029	Member Last Name
3	Member First Name	A/N	15	030-044	Member First Name
4	Member Middle Initial	A/N	1	045-045	Member Middle Initial
5	Address 1	A/N	35	046-080	Address Line 1
6	Address 2	A/N	35	081-115	Address Line 2
7	City	A/N	30	116-145	City
8	State	A/N	2	146-147	State
9	Zip Code	A/N	13	148-160	Zip Code
10	Birth Date	A/N	8	161-168	CCYYMMDD
11	Plan Effective Date	A/N	8	169-176	CCYYMMDD- earliest effective date of uninterrupted Coverage within Contractor
12	Termination Date	A/N	8	177-184	CCYYMMDD- Blank if active
13	Client / Agency Code	A/N	8	185-192	Code Client /Agent
14	Sub Client / Section of Agency	A/N	4	193-196	Sub Client or Section Agency
15	Type of Coverage	A/N	1	197-197	"e" – member only "c" – member and child(ren) "s" – member and spouse "f" – family (Populated on all records)
16	Medicare A Primary Effective Date	A/N	8	198-205	CCYYMMDD(can be blank)
17	Medicare B Primary Effective Date	A/N	8	206-213	CCYYMMDD(can be blank)
18	Sex Code	A/N	1	214-214	Male or Female(M/F)
19	Student Date	A/N	8	215-222	BLANK
20	Relation Code	A/N	2	223-224	01 – Enrollee 02 – Spouse 03 – Children 04 – Student
21	Transaction Date	A/N	8	225-232	CCYYMMDD
22	Agency Employment Date	A/N	8	233-240	CCYYMMDD

Appendix A-7 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
23	Portability Date	A/N	8	241-248	CCYYMMDD- Pre-existing Condition Ending
24	Member Phone Number	A/N	12	249-260	(Populated on all records)
25	Retirement Indicator	A/N	1	261-261	03/01/2015 Retirement Indicator 'A'-Retired Before 03/01/2015 'B'-Retired 03/01/2015 or After Blank- Not Retired
26	Handicapped indicator	A/N	1	262-262	"Y" = Yes "N" = No
27	Marriage Date	A/N	8	263-270	CCYYMMDD(can be blank)
28	HIC Number	A/N	12	271-282	Medicare card number.
29	COB DATE	A/N	8	283-290	CCYYMMDD- Beginning coverage by other carrier not including Medicare.
30	Medicare Primary	A/N	1	291-291	"Y" = Yes "N" = No
31	Member SSN	A/N	9	292-300	Member SSN
32	Filler	A/N	1	301-301	Blanks
33	Agency Change Date	A/N	8	302-309	CCYYMMDD- earliest effective date of uninterrupted Coverage within Agency
34	Member Record-ID	A/N	8	310-317	OGB Internal id
35	Billing Rate Table(On Subscriber Only)	A/N	2	318-319	AC – active CB - cobra CD - cobra disability CP - cobra part-time CS – cobra subsidy

Appendix A-7 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					D1 – Sponsored Dependent 1 on Medicare DN – Sponsored Dependent No Medicare R1 - retired Medicare 1 R2 - retired Medicare 2 RN - retired no Medicare E1 – Early Retirement 1 On Medicare E2 – Early Retirement 2 On Medicare EN – Early Retirement None On Medicare This Field is always blank for dependents
36	Shared Accumulator OGB Record ID	A/N	9	320-328	Contains the 8 digit Record ID for Shared Accumulators
37	Claim Payment Stop Date	A/N	8	329-336	CCYYMMDD
38	Lifetime Accum	N	10	337-346	9999999.99 Leading spaces: Sum of Drugs, Medical, Mental Health & DME claims paid
39	Drug Accum	N	10	347-356	9999999.99 Leading spaces: Sum of Drug clain paid Included in Lifetime accum
40	Mental Health Accum	N	10	357-366	9999999.99 Leading spaces: Sum of Mental Health claims paid. Included in Lifetime accun
41	Country Code	A/N	2	367-368	Values: available on request
42	Pre-existing Start Date	A/N	8	369-376	CCYYMMDD- Pre-existing Condition Start Da
43	Coverage Level Effective Date	A/N	8	377-384	CCYYMMDD- Earliest Eff Date of Uninterrup CoverageWithin Contractor/Coverage Level
44	Rate Table Effective Date	A/N	8	385-392	CCYYMMDD- Earliest Eff Date of Uninterrup CoverageWithin Contractor/Rate Table
45	Product	A/N	5	393-397	Magnolia Local New Orleans- MAGBC Magnolia Local Baton Rouge- MAGCB

Appendix A-7 Eligibility File					
NO	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
					Magnolia Local Shreveport- MAGCB Magnolia Local Plus-HMO Magnolia Open Access- PPO Pelican HAS 775- CDHP Pelican HRA 1000- HRA
46	Retiree 100 Effective Date	A/N	8	398-405	Retiree 100 Effective Date (CCYYMMDD)
47	Retiree 100 Termination Date	A/N	8	406-413	Retiree 100 Termination Date (CCYYMMDD)
48	Medicare A Effective Date	A/N	8	414-421	CCYYMMDD(can be blank)
49	Medicare A Termination Date	A/N	8	422-429	CCYYMMDD(can be blank)
50	Medicare B Effective Date	A/N	8	430-437	CCYYMMDD(can be blank)
51	Medicare B Termination Date	A/N	8	438-445	CCYYMMDD(can be blank)
52	Medicare A Primary Termination Date	A/N	8	446-453	CCYYMMDD(can be blank)
53	Medicare B Primary Termination Date	A/N	8	454-461	CCYYMMDD(can be blank)
54	Survivor Type	A/N	2	462-463	SP(Spouse) DP(Dependent). This field applies t Survivors- R??SV in Client OR 95 in Sub Client

APPENDIX A-8 ASO ADMINISTRATIVE FEE BILLING FILE					
No	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	**Invoice Date**	N	8	001-008	CCYYMMDD
2	Enrollee SSN	N	9	009-017	SOCIAL SECURITY NUMBER
3	Enrollee Last Name	A	20	018-037	Last Name
4	Enrollee First Name	A	20	038-057	First Name
5	Enrollee Middle Initial	A	1	058-058	Initial
6	Enrollee Coverage Type	A	2	059-060	"EE" -Employee Only "ES"-Employee and Spouse "EC"-Employee and Child(ren) "FM"-Family
7	Rate Table Code	A	2	061-062	"AC"- Active "CB"- Cobra "CD"- Cobra Disability "CP"- Cobra Part-Time "R1" - Retired Medicare 1 "R2"- Retired Medicare 2 "RN"- Retired No Medicare This Field is always blank for dependents
8	Billing OR Coverage	N	8	063-070	CCYYMMDD
9	Premium Amount	N	10	071-080	Administrative Fee Amount
10	Record ID	N	8	081-088	OGB Internal Record ID
11	Product	N	5	089-094	PPO=PPO, HMO=HMO, OGBMOA=MAGNO OPEN, OGBML=MAGNO-LOCAL, OGBML=MAGNO-PLUS, OGBHSA=HAS, OGBHRA=HRA

APPENDIX A-9 CLAIMS PAID AFTER TERMED OR STOP PAYMENT DATE					
No	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	CLAIM NUMBER		15	001-015	
2	Total Charge		10	016-025	Decimal + 2 decimal places. If negative the sign will be immediately to the left of the number
3	Total Paid Amount		10	026-035	Decimal + 2 decimal places. If negative the sign will be immediately to the left of the number
4	Provider Name		30	036-065	
5	Date of Service From		8	066-073	CCYYMMDD
6	Term/Stop Sent Date		8	074-081	CCYYMMDD
7	Paid Date		8	082-089	CCYYMMDD
8	Family SSN		9	090-098	
9	Relation Code		2	099-100	01Enrollee 02-Spouse 03-Dependent 05-Grandchild 17-Stepchild 24-Dep Child of a Dep Child
	Patient First Name		15	101-115	
	Term/Stop Date		8	116-123	CCYYMMDD
	Term/Stop Flag		1	124-124	T-Term, H-Stop

APPENDIX A-10 BANCORP ELIGIBILITY FILE LAYOUT					
No	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	UNIQUE MEMBER ID	A/N	16	001-016	Unique Member ID
2	EMPLOYEE SSN	N	9	017-025	Employee Social Security Number
3	FIRST_NAME	A/N	25	026-050	Member First Name
4	MIDDLE NAME	A/N	15	051-065	Member Middle Name
5	LAST NAME	A/N	30	066-095	Member Last Name
6.	DATE OF BIRTH	D	10	096-105	Birth Date Format = MM/DD/CCYY
7	ADDRESS1	A/N	50	106-155	Member Address 1
8	ADDRESS2	A/N	50	156-205	Member Address 2
9	CITY	A/N	30	206-235	Member City
10	STATE	A/N	2	236-237	Member State
11	ZIP	A/N	10	238-247	Member Zip Code
12	COUNTRY	A/N	30	248-277	Member Country
13	HOME PHONE	A/N	25	278-302	Member Home Phone
14	BUSINESS PHONE	A/N	25	303-327	Member Business Phone
15	CELL PHONE	A/N	25	328-352	Member Cell Number

APPENDIX A-10 BANCORP ELIGIBILITY FILE LAYOUT					
No	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
16	FAX NUMBER	A/N	25	353-377	Member Fax Number
17	EMAIL ADDRESS	A/N	70	378-447	Member Email Address
18	MOTHERS MAIDEN NAME	A/N	30	448-477	Mother's Maiden Name
19	EMPLOYER	A/N	50	478-527	Employer
20	JOINT ACCOUNT	A/N	1	528-528	Joint? Y/N
21	FILLER 1	A/N	417	529-945	Filler
22	HSA EFFECTIVE DT	A/N	10	946-955	HSA Effective Date Format = MM/DD/CCYY
23	HSA DEDUCT AMT	A/N	10	956-965	HSA Deductible Amount
24	HSA TERM DATE	A/N	10	966-975	HSA Term Date Format = MM/DD/CCYY
25	HSA PLAN NUMBER	A/N	10	976-985	HSA Plan Number
26	HSA CONTRIBUTION	A/N	15	986-1000	HSA Contribution
27	GROUP ID*	A/N	50	1001-1050	Bancorp Group ID
28	USER DEFINED 1	A/N	50	1051-1100	User Defined 1
29	USER DEFINED 2	A/N	50	1101-1150	User Defined 2

APPENDIX A-11 BANCORP ELIGIBILITY TERMS FILE					
No	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	UNIQUE ID	A/N	16	001-016	Unique ID
2	SOCIAL SECURITY*	A/N	9	017-025	Social Security Number
3	FIRST NAME*	A/N	25	026-050	Member First Name
4	MIDDLE NAME	A/N	15	051-065	Member Middle Name
5	LAST NAME*	A/N	30	066-095	Member Last Name
6	TERM DATE	A/N	10	096-105	HSA Term Date (process date) Format = MM/DD/CCYY

APPENDIX A-12 BANCORP ENROLLMENT HSA ACCOUNT FILE HEADER RECORD					
No	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD IDENTIFIER	A/N	3	001-003	HDR = Header Record
2	FILE DATE	D	8	004-011	File Create Date Format = MMDDCCYY
3	NUMBER OF TRANSACTIONS	N	6	012-017	Number of Transactions if file

APPENDIX A-12 BANCORP ENROLLMENT HSA ACCOUNT FILE DETAIL RECORD					
No	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	UNIQUE IDENTIFIER	A/N	16	001-016	Unique ID
2	SOCIAL SECURITY*	A/N	9	017-025	Social Security Number
3	FIRST NAME	A/N	25	026-050	Member First Name
4	MIDDLE NAME	A/N	15	051-065	Member Middle Name
5	LAST NAME*	A/N	30	066-095	Member Last Name
6	DATE OF BIRTH*	D	8	096-103	Member Birth Date Format = MMDDCCYY
7	ADDRESS 1	A/N	50	104-153	Address 1

APPENDIX A-12 BANCORP ENROLLMENT HSA ACCOUNT FILE DETAIL RECORD					
No	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
8	ADDRESS 2	A/N	50	154-203	Address 2
9	CITY/PROVINCE	A/N	30	204-233	City or Province
10	STATE	A/N	2	234-235	State
11	ZIP CODE	A/N	10	236-245	Zip Code
12	HOME PHONE	A/N	25	246-270	Home Phone Number
13	EMAIL ADDRESS	A/N	70	271-340	Email Address
14	BRANCH	A/N	3	341-343	Branch
15	ACCOUNT NUMBER*	A/N	11	344-354	Account Number

APPENDIX A-12 BANCORP ENROLLMENT HSA ACCOUNT FILE TRAILER RECORD					
No	**FIELD NAME**	**TYPE**	**LEN**	**LOC**	**DESCRIPTION**
1	RECORD IDENTIFIER	A/N	3	001-003	FTR= Footer Record
2	FILE DATE	D	8	004-011	File Create Date Format = MMDDCCYY
3	NUMBER OF TRANSACTIONS	N	6	012-017	Number of Transactions if file