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Request for Proposal

"RFP 2018-005 Fully Insured Medical and Dental Services"

Client Name: **City of Donna**

Address: 307 S. 12th St., Donna, TX 78537

Effective Date: 10/01/2018

Proposal Due Date: 07/16/2018 at 5:00 P.M.

Questions Due Date: 07/13/2018 at 4:00 P.M.

Much effort has been made to provide all necessary and accurate information. It is the sole responsibility of the proposers to ensure that they have all information necessary to complete submission of their proposals. If more information is needed, please contact Kim Castellanos at R.J. Garza, 956-854-4139, kcastellanos@rjgarza.com or Reagan Latimer at Gallagher Benefit Services, Inc., 210-348-4135, Reagan_Latimer@ajg.com.

About The City of Donna

The City of Donna is located in Hidalgo County with an approximate population of 16,518 residents. The citizens of Donna first started using the motto "The City with a Heart in the Heart of the Rio Grande Valley" to promote the city in the 1940s. By 1945 the town had a population of 4,712 and seventy-eight businesses and continued to be a citrus and vegetable growing center. In 1967 Donna reported 110 businesses (including eight manufacturers), ten churches, a bank, a library, and a newspaper. Donna is named for Donna Hooks, daughter of T. J. Hooks who, beginning in 1900, did quite a bit of land development work in the then frontier world of the Rio Grande Valley.

Requested Proposal Specifications

MEDICAL/RX/ADMINISTRATION

1. Please include 5% commission in your proposal to cover both lines of coverage.

2. Plan design: Match current plan design.

3. Please include a $15,000 allowance for open enrollment/implementation in your proposal.

4. Employer pays 100% of Employee Only premium. Monthly premium costs for dependents are below.

    a. Employee + Spouse: $632.23
    b. Employee + Child(ren): $311.12
    c. Employee + Family: $948.64

5. Please quote administration fees in these two scenarios:
    a. assume the use of your PBM

6. Your administration fee should include the cost of detailed claim reports requested by GBS throughout the plan year – Monthly Management, Financial, Utilization & Performance Reports.

7. Carrier Reporting Requirements: (Note - All of these reports must be available upon request)
    a. Monthly Premium vs. Claims (on a paid and incurred basis)
    b. Monthly Enrollment broken down by plan
    c. Paid & Pended claims broken down by inpatient/outpatient/Rx
    d. Discount Analysis
    e. Monthly LCR > $50,000
    f. Network Analysis (In vs. Out)
    g. Rx Utilization (patient ID, date filled, NDC-11, quantity, days' supply, AWP, ingredient cost, dispensing fee, tax, allowed cost, plain paid amt, member copay, member deductible, admin fee, submitted U&C, cost basis (MAC, AWP, U&C, etc.), brand/generic, mail/retail, formulary tier, maintenance indicator, specialty indicator, submitted compound indicator, submitted DAW indicator, prior authorization indicator, NCPDP#/NABP#)

8. In addition to the above reporting requirements, your cost must include a full data dump requested by GBS throughout the year.

9. Please provide Geo Access reports with your proposal to include the client's county and surrounding counties.

10. Include HSA administration, if applicable

11. Your standard Wellness Program must include:
    a. Health Assessment
    b. Online Wellness Program
    c. Personal Healthcare Record
    d. Preventive Care
    e. Disease Management (with reporting capability)
    f. Health Maternity Program

12. The selected administrator must agree to add their proposal response as an Addendum to the Administrative Service Agreement between the selected administrator and the client and agree to be bound contractually to all the requirements outlined in the Request for Proposal.

13. You must agree to release the renewal proposal within 120 days of expiration

I acknowledge I have read the statements above ☐

DENTAL

1. Please include 5% commission in your proposal to cover both lines of coverage.

2. Plan design: Match current plan design.

3. Employer pays 100% of Employee Only premium. Monthly premium costs for dependents are below.

    a. Employee + Spouse: $27.94
    b. Employee + Child(ren): $26.59
    c. Employee + Family: $56.55

4. Please quote OON providers at 90th Percentile

5. You must agree to release the renewal proposal within 120 days of expiration

I acknowledge I have read the statements above ☐

Medical Administrative Questionnaire

1. From what city will claims be administered?
   Click here to enter text.
2. Do you provide in-state and/or national 800 telephone service? What, if any, are the additional charges for this service? What hours is the service available? Can you offer a dedicated 800 number for the client?
   Click here to enter text.
3. Describe your company's performance standards with respect to:
   a. Employee inquiries (both written and telephonic);
      Click here to enter text.
   b. Claims turnaround;
      Click here to enter text.
   c. Claims accuracy - both financial and procedural
      Click here to enter text.
   d. Claims process with time frames for review
      Click here to enter text.
4. Is your firm willing to incorporate guaranteed turnaround time, COB recovery and quality performance standards in its contract with the client?
   Click here to enter text.
5. Describe your company's quality assurance and/or internal audit procedures and programs. Are you willing to provide the client with quarterly audit reports on its claims? You will be required to allow an annual audit done by an external auditor; do you have any provisions surrounding audits that would in any way limit the client's ability to fully audit their claims?
   Click here to enter text.
6. Describe in detail your claims hardware and software systems, and in particular, your claims editing capabilities (code review). Specifically, address how it checks for procedural discrepancies based on diagnosis, diagnostic "creep", and procedural unbundling. What percent of claims are detected by these edits? What percent of dollars claimed? How do you treat claims detected as a result of these edits? Do you charge extra for this?
   Click here to enter text.
7. What percentage of claims are currently auto-adjudicated by your system? Do you expect this percentage to increase or decrease over time?
   Click here to enter text.
8. What are normal business hours for participant questions or precertification?
   Click here to enter text.
9. Please describe the nature of the contract you would propose, indicating:
   a. The length of time of the contract;
      Click here to enter text.
   b. The length of time your fees are guaranteed beyond the required three years
      Click here to enter text.
   c. Termination notices required
      Click here to enter text.

10. Please describe the implementation process in detail. Provide a sample timeline assuming award is made next month.
    Click here to enter text.
11. How do you propose to collect claims data from the prior carrier to accommodate a smooth transition?
    Click here to enter text.
12. How would you determine “Days per 1000” by plan? Please explain in detail.
    Click here to enter text.
13. Are you able to administer on-line, electronic transfer, and tape-to-tape eligibility transfers? How does this impact your cost proposal?
    Click here to enter text.
14. Do you have the capability for the client to have access to your claims and eligibility system through an on-line system? Any cost for such a system should be included in your PEPM costs.
    Click here to enter text.
15. Does your system incorporate scanning capability and if so, is it incorporated into claims adjudication automatically?
    Click here to enter text.
16. Do you have physician and patient profiling/reporting capabilities? If so, please describe the standard reports available and ad hoc capability. Provide sample reports.
    Click here to enter text.
17. How would your organization determine usual, reasonable and customary charges for medical, surgical and anesthesia procedures? Answer this question in specific detail for both PPO and indemnity claims including what data source you utilize (e.g. HIAA, etc.) and how often it is updated.
    Click here to enter text.
18. If claims exceed the individual attachment point, how often are updated claim reports sent to the stop-loss carrier? Do you provide both clinical evaluations as well as claim costs with your standard updates to carriers for stop-loss claims? What carriers do you currently work with? Are there any carriers or MGU’s that you have difficulty working with?
    Click here to enter text.
19. Please submit a sample of your proposed claim and Explanation of Benefits forms. Would you be willing to customize the information contained in these forms? Would there be an additional cost?
    Click here to enter text.
20. Please provide a list of all data elements which will be captured off of the claim forms and stored in your claims adjudication system. Do you capture DRG classifications? What information is coded off of a hospital U.B. 92? All revenue codes? How many levels of diagnosis codes are captured?
    Click here to enter text.
21. Please state what records (including the participant and data processing documents) would; in fact, belong to the client upon contract termination.
    Click here to enter text.

22. In the event of contract termination, when would records which are property of the client be released to the party or organization designated by the client? Describe your termination notice requirement.
    Click here to enter text.
23. It is required that all reporting requirements be included in your per capita administrative fee. Do you agree with this provision? Please provide copies of your standard reports for review by the client.
    Click here to enter text.
24. Are you willing to guarantee ASO fees beyond the initial term? If so, what are your proposed service renewal guarantees or terms?
    Click here to enter text.
25. Does your system, or can you, administer a program that identifies and coordinates deductibles/claims on a family basis for dual working spouses?
    Click here to enter text.
26. Please describe any insurance you carry for Fiduciary Liability and Errors and Omissions Insurance. Amount? Carrier?
    Click here to enter text.
27. Do you pay the printing of checks; EOI's, and claim forms? Do you process checks and/or EOB's in house or is this function outsourced?
    Click here to enter text.
28. Can you handle electronic transfer of prescription drug claims?
    Click here to enter text.
29. Please attach samples of standard reports or any special cost containment reports available. If there is a charge, please state.
    Click here to enter text.
30. What process do you have to ensure that claims are not paid after a termination of coverage, or if paid, recovery of payments?
    Click here to enter text.
31. Does the Administrator employ a full-time M.D. as a medical advisor? If not on a full-time basis, when are the advisors available?
    Click here to enter text.
32. Will you work with the client to design a tailor made claim form?
    Click here to enter text.
33. Is your system capable of tracking Unique Provider Identification Number (UPIN)?
    Click here to enter text.
34. Can your system track referrals made by the primary care physician? Is this information date sensitive to the change?
    Click here to enter text.
35. Can your system track and provide information by physician (PCP) as to all patients treated, any/all hospital admissions, any emergency treatment, laboratory and any/all physicians referred by PCP?
    Click here to enter text.
36. Can you guarantee the client that you will enter all ICD-10 and CPT codes to the agreed upon number of digits? The client will insist upon complete and accurate coding entry.

Click here to enter text.

37. Can your system track and process itemized hospital charges by code?
    Click here to enter text.
38. Will there be a guaranteed dedicated contact to assist with the client's Health Benefits? Refusal to adhere to this provision may directly result in your company not being awarded this contract.
    Click here to enter text.
39. Please identify any fees or penalties that will be assessed should the client choose to terminate any or all products provided by the vendor within the first 12 months of the agreement, or prior to the agreement end date. Your response should include all related penalties or fees regardless of whether or not they have been previously stated in this RFP response.
    Click here to enter text.
40. Does your claims system have the following capabilities?

    a. Able to process in-network, out-of-network, and out-of-area claims
       Yes ☐ No ☐
    b. Is there a fee to reprice out-of-network provider claims
       Yes ☐ No ☐
    c. Integrated access to provider-specific data including contractual and financial arrangements
       Yes ☐ No ☐
    d. Able to maintain historical eligibility information
       Yes ☐ No ☐
    e. Able to separate eligibility dates for employees and each covered dependent
       Yes ☐ No ☐
    f. Flexibility to process benefits at difference coinsurance and out-of-pocket levels for in-network, out-of-network, and out-of-area plans
       Yes ☐ No ☐
    g. Able to process hospital and all other medical plan related claims including prescription drugs and capture hospital revenue codes
       Yes ☐ No ☐
    h. Ability to Identify authorized referrals and admissions by network status.
       Yes ☐ No ☐
    i. Able to apply stringent utilization and price controls for out-of-network usage
       Yes ☐ No ☐
    j. Able to automatically match claims with utilization management information both in-network and out-of-network
       Yes ☐ No ☐
    k. Common database for edits, pricing, production of EOI's and reporting
       Yes ☐ No ☐
    l. Able to customize EOI messages
       Yes ☐ No ☐

m. Able to report account specific per capita utilization and savings statistics by network site

Yes ☐ No ☐

n. Able to show the actual and negotiated charge on the EOI

Yes ☐ No ☐

o. Able to show the applicable procedure code

Yes ☐ No ☐

p. Able to show the percentage of payment

Yes ☐ No ☐

q. Able to show the amount of deductible satisfied

Yes ☐ No ☐

r. Automatic rollover of FSA claims

Yes ☐ No ☐

s. Able to accept or reject rollover FSA claims on an individual employee basis

Yes ☐ No ☐

t. Able to integrate telemedicine encounter claims

Yes ☐ No ☐

41. Is your organization also willing to agree to the following performance standards? The percentage at risk will be negotiated at a later date.

	Yes	No
a. Claim Processing Accuracy (95%)	☐	☐
b. Claim Turnaround (90% - 10 days)	☐	☐
c. Financial Payment Accuracy (99.5%)	☐	☐
d. Financial Coding Accuracy (97%)	☐	☐
e. Implementation score greater than 90%	☐	☐
f. Employee Satisfaction score greater than 90%	☐	☐

42. Do you share OON provider negotiated discounts with the Plan?

Yes ☐ No ☐

43. Is there a fee for accommodating the transfer of carrier data feeds for eligibility, deductible and out-of-pocket accumulator data, or any other data exchanges that may be necessary, between your system and those of the employers other benefit vendors?

Yes ☐ No ☐

44. Is there a charge to participants who work or reside outside of Texas who access a network provider outside of Texas? -

Yes ☐ No ☐

Patient Advocacy Questionnaire

1. Please provide a brief overview of your company. Include information on the length of time your company has been in business, number of clients, facilities and ownership.
   Click here to enter text.
2. What is the average daily call volume your company handles?
   Click here to enter text.
3. What are your standard service metrics for wait time, abandoned calls, service levels and blockage?
   Click here to enter text.
4. How many facilities do you have and where are they located? How many workstations does each facility have?
   Click here to enter text.
5. Please describe your ACD and telecommunications structure including number of T1 circuits.
   Click here to enter text.
6. Please describe your minimum computer hardware and software for each agent workstation. What is the typical start-up time for a new program?
   Click here to enter text.
7. What hours is your computer center staffed? How many people do you have in your IT department?
   Click here to enter text.
8. What security measures do you have in place to protect client data?
   Click here to enter text.
9. What are your ACD reporting capabilities? What report delivery options do you offer?
   Click here to enter text.
10. Can you provide customized reports? Is there a customer portal?
    Click here to enter text.
11. Describe the type and frequency of reporting that you will provide,
    Click here to enter text.
12. Please provide samples of your standard reports.
    Click here to enter text.
13. What is the start-up process for a new account? Please describe your forecasting process. Which staffing and/or scheduling tools do you use? Please provide information on your key management. How are account managers selected for each program?
    Click here to enter text.
14. How many client programs does each account manager oversee?
    Click here to enter text.
15. What is your hiring criteria and process for new agents? How do you train your agents, initially and on-going? What type of agent motivation and retention programs are currently in place?
    Click here to enter text.
16. What is your overall annual agent turnover rate?

Click here to enter text.

17. What quality assurance programs do you have in place? Describe your monitoring capabilities. Do you provide remote monitoring capabilities to your clients? What is your quality assurance staff to agent ratio?
    Click here to enter text.
18. How often are your agents monitored? Please provide a copy of your standard monitoring form.
    Click here to enter text.
19. How does your company illustrate a return on the client's investment?
    Click here to enter text.
20. Describe how your program assists members in addressing provider balance billing for ineligible items such as excesses of reasonable and customary.
    Click here to enter text.
21. Please provide a list of the scope of services that your company provides.
    Click here to enter text.
22. What tools & resources to you provide or are available the client to distribute to the employees?
    Click here to enter text.
23. Please provide all costs associated with your services. Include price per minute. Please denote initial charges and on-going costs.
    Click here to enter text.
24. What start-up fees do you charge?
    Click here to enter text.

Audit Language Questionnaire

Please answer **"Agree"** or **"Disagree"** only:

1. Client retains access to 100% of all claims data including all data fields necessary to perform a 100% analysis of claims paid by the plan for the applicable period, including but not limited to all claims payment fields, provider name, provider billing address, and all provider contact information including phone number.
   Click here to enter text.
2. The client may audit the two prior plan years
   Click here to enter text.
3. The Administrative Service Agreement will include the following language, "Incurred Claims for the prior two plan years, and all claims paid through the current plan year".
   Click here to enter text.
4. Remove any restrictions that could limit client's access to service including:
   a. Selection of 3rd party vendors to perform review or recovery
   Click here to enter text.
   b. Limitations on 3rd party contract terms (i.e. "no contingency arrangements")
   Click here to enter text.
5. Any improper payments by the plan as determined by the client or administrator may be recovered by the administrator, the client or a third party chosen by the client at the client's sole discretion. NOTE TO THE INCUMBENT: This should be effective retroactively to include the most-recent contract and plan year(s).
   Click here to enter text.

Claim Processing Capabilities

Please answer **"Automated"** or **"Manual"** only

Processes:

1. Claims inventory - Click here to enter text.
2. Eligibility of employees - Click here to enter text.
3. Eligibility of dependent - Click here to enter text.
4. Track dual addresses (i.e. QMCSO) - Click here to enter text.
5. Usual, customary, reasonable - Click here to enter text.
6. Benefit plan excluded charges - Click here to enter text.
7. Pre-existing conditions - Click here to enter text.
8. Adjudication - Click here to enter text.
9. Coordination of benefits - Click here to enter text.
10. Check issuance - Click here to enter text.
11. Subrogation - Click here to enter text.
12. Explanation of benefits issuance - Click here to enter text.
13. UR authorized in-patient days - Click here to enter text.
14. Medical necessity - Click here to enter text.
15. Deductible - Click here to enter text.
16. Out-of-pocket benefit maximums - Click here to enter text.
17. Co-insurance - Click here to enter text.
18. Duplicate charges - Click here to enter text.
19. Second opinion program - Click here to enter text.
20. Co-pays - Click here to enter text.
21. Preferred provider/Nonpar - Click here to enter text.
22. Unbundling of charges - Click here to enter text.
23. Physician referrals - Click here to enter text.

Disease Management Questionnaire

GENERAL QUESTIONS

1. Please provide a brief description of your organization, including history, business philosophy, and target market.
   Click here to enter text.
2. Describe any unique qualifications that distinguish your company within the disease management industry.
   Click here to enter text.
3. How do you protect individual participant data? How are you addressing HIPAA-specific data privacy requirements? Are you up to date with HIPAA compliance with EDI and privacy requirements? Date first operational:
   Click here to enter text.
4. Describe your service area.
   Click here to enter text.

ACCOUNT MANAGEMENT/IMPLEMENTATION

1. Who are the individuals that would provide account management services to the client? What are their qualifications?
   Click here to enter text.
2. Provide a detailed description of the implementation process, including how you will work with the client, its plans and other programs.
   Click here to enter text.
3. How often will you meet in person with the client during implementation, including promotion and education of client beneficiaries regarding the availability of your program?
   Click here to enter text.
4. Once the program is implemented, how often will you meet with the CLIENT to provide feedback, updates and reports?
   Click here to enter text.
5. Describe your process to communicate the disease management program to employees.
   Click here to enter text.
6. Can communications materials be customized? If yes, identify what can be customized and if there would be any additional fees for customization.
   Click here to enter text.
7. Are multi-lingual materials available?
   Click here to enter text.
8. Please provide copies of all implementation AND communication materials.
   Click here to enter text.
9. List the diseases covered in your disease management programs and specify whether they are currently available or in development.
   Click here to enter text.
10. Do you use clinical practice guidelines? If yes, specify which guidelines are used and how they are applied.
    Click here to enter text.
11. Describe the types of interventions and methods of delivery used for the disease management programs you offer.
    Click here to enter text.
12. Explain how Disease Management interventions are targeted to individual participants' needs and motivation to change.
    Click here to enter text.

13. Do you use a readiness to change behavioral model in the delivery of your services? If so, describe.
    Click here to enter text.
14. How do you track and monitor patients over time?
    Click here to enter text.
15. Describe how you handle co-morbid conditions and provide a list of the co-morbid conditions you address.
    Click here to enter text.
16. Do you have an educational component to your program and educational materials?
    Click here to enter text.
17. What is the literacy level of your written materials?
    Click here to enter text.
18. What methods do you use to identify candidates for the disease management programs and the frequency of each method?
    Click here to enter text.
19. Describe your information technology infrastructure.
    Click here to enter text.
20. Describe the desktop system that is used in your Disease Management operations?
    Click here to enter text.
21. Do you use any data mining software in your Disease Management?
    Click here to enter text.
22. Describe system security and back-up procedures.
    Click here to enter text.
23. Describe the process of Claims Data and Eligibility transfer from the Medical plan TPA.
    Click here to enter text.
24. How much data do you need initially?
    Click here to enter text.
25. What is the frequency of subsequent feeds?
    Click here to enter text.
26. Please provide the file feed format and any necessary specifications.
    Click here to enter text.

ENROLLMENT

1. How does your organization encourage participation in Disease Management programs?
   Click here to enter text.
2. What is your program enrollment rate?
   Click here to enter text.
3. Do participants graduate from the program? If so, what is the graduation criteria?
   Click here to enter text.
4. How often are outbound calls made to participants?
   Click here to enter text.
5. Describe the makeup, qualifications, and experience of the Disease Management staff?
   Click here to enter text.
6. List the components that make up your staff training and indicate whether each component occurs during orientation or is ongoing.
   Click here to enter text.
7. Provide the hours of operation.
   Click here to enter text.
8. Do you offer a 24-hour nurse line service?
   Click here to enter text.

9. Describe in detail how your organization will implement the current plan and what services your organization can provide to assist the client in managing the Diabetic Plan.
   Click here to enter text.
10. Describe how your organization collaborates with an employer's other health care initiatives to deliver integrated disease/condition management services.
    Click here to enter text.
11. How do you identify the participants' physician and how are they incorporated within the care of participant?
    Click here to enter text.
12. How do you handle physicians that are non-compliant with the necessary protocol for the patient's disease state?
    Click here to enter text.
13. Describe all care management services available through your organization to large employers. Which services, if any are outsourced to third parties?
    Click here to enter text.
14. Describe how your organization retrieves & reviews paid claim data when analyzing a prospective client's needs.
    Click here to enter text.
15. Are reporting tools available to clients electronically?
    Click here to enter text.
16. Do you utilize any statistical methodology for early disease detection (e.g. predictive modeling)?
    Click here to enter text.
17. Indicate which measures you use to determine program impact and cost savings.
    Click here to enter text.
18. Please provide a sample of standard client reports.
    Click here to enter text.
19. What data elements are captured and tracked in your Disease Management programs and which ones can you report back to the client?
    Click here to enter text.
20. Describe the types of client reports available. How often are reports provided?
    Click here to enter text.
21. Will you provide comparative data from your book of business?
    Click here to enter text.
22. Please provide copies of standard client reports.
    Click here to enter text.
23. Are you capable and will you provide customized client reports?
    Click here to enter text.
24. What services are included in your fees? Describe all potential extra fees in providing services.
    Click here to enter text.
25. List all Disease Management programs and services you propose to provide to the client and indicate your proposed fees.
    Click here to enter text.

Utilization Management Questionnaire

1. Name of Firm, Headquarters Address and Phone Number:
   Click here to enter text.
2. Executive contact, name and title:
   Click here to enter text.
3. How many locations does your firm have working within its Utilization Review Program?
   Click here to enter text.
4. Include primary contact, number of professionals by category (M.D., R.N., etc.) number of para-professionals and size of support staff. Identify the location which would provide review services.
   Click here to enter text.
5. How long has your firm been providing Utilization Review services?
   Click here to enter text.
6. What is the present number of employees working in Utilization Review?
   Click here to enter text.
7. Approximately how many groups and covered persons does your firm presently serve?
   Click here to enter text.
8. What were these totals 12 months ago?
   Click here to enter text.
9. Can the above services be purchased separately?
   Click here to enter text.
10. Does your firm provide consulting advice or other services in regard to Wellness Programs?
    Click here to enter text.
11. Does your firm have any geographic restrictions regarding where it may provide services?
    Click here to enter text.
12. Please provide the most recent annual report for your firm. (Submit with your proposal.)
    Click here to enter text.
13. Are your UR services provided by your company, a subsidiary or a vendor?
    Click here to enter text.
14. Are all hospitalizations, regardless of diagnosis, included in Utilization Review?
    Click here to enter text.
15. How is each party kept informed? (Patient, Physician, Employer)
    Click here to enter text.
16. How are certifications obtained by phone and by mail?
    Click here to enter text.
17. What specific information is submitted in the initial request for certification? (Include sample form)
    Click here to enter text.
18. Are length of stay guidelines provided with initial admission approval?
    Click here to enter text.
19. To what extent are nurses and/or physicians involved, step-by-step in the certification procedures? At what point is a physician called to review the nurse in the evaluation?
    Click here to enter text.
20. Are concurrent review and discharge planning normally included with your firm's pre-admission certification review?
    Click here to enter text.
21. Are length of stay extensions typically administered within this part of the program?
    Click here to enter text.

22. What procedures does your firm believe belong with concurrent review and discharge planning?
    Click here to enter text.
23. Is this procedure handled by your firm or delegated?
    Click here to enter text.
24. If delegated, do you contract with various Peer Review Organizations?
    Click here to enter text.
25. How are contracts made by your administrators with attending physicians to be certain estimated discharge dates are met?
    Click here to enter text.
26. Does your firm regard Retrospective Review and Hospital Bill Audit as one or separate services?
    Click here to enter text.
27. What is your procedure regarding retrospective review?
    Click here to enter text.
28. What is your procedure regarding hospital audits?
    Click here to enter text.
29. Does your firm provide a medical case management program?
    Click here to enter text.
30. Indicate how your program states its objectives in view of typical goals of:
    a. Identifying alternate care
       Click here to enter text.
    b. Recommending accelerated care
       Click here to enter text.
    c. Reduction of medical complications
       Click here to enter text.
31. Has your firm identified a list of illnesses and injuries it considers best for MCM? If so, please list:
    Click here to enter text.
32. If your firm were selected to administer the Utilization Review Program, do you believe your firm would be in a position to also administer the MCM program more efficiently than the primary claim administrator? Explain.
    Click here to enter text.
33. Indicate what levels of Disease Management your firm currently provides by disease state.
    Click here to enter text.
34. Number of local full-time equivalent Medical Directors on staff?
    Click here to enter text.
35. Number of local full-time equivalent Nurses on staff?
    Click here to enter text.
36. Average number of year's clinical experience and utilization review experience.
    Click here to enter text.
37. Do you have on-line access to claim payment function?
    Click here to enter text.
38. Do you handle both in-network and out-of-network claims?
    Click here to enter text.
39. How are cases identified for potential case management? Describe specialized handling of catastrophic illnesses.
    Click here to enter text.

40. What guidelines do you use for in-patient pre-admission certification and concurrent review? To what extent is concurrent review performed on-site at the hospital?
    Click here to enter text.
41. How do you measure patient satisfaction?
    Click here to enter text.
42. Are you accredited by NCQA or any other accrediting organization? Please provide name of organizations and accreditation dates.
    Click here to enter text.
43. Based upon your firm's experience, what do you believe is typically a satisfactory lead time (stated in days) to implement a Utilization Review Program?
    Click here to enter text.
44. Will your firm be willing to provide a representative to attend meetings to explain your Utilization Review Program?
    Click here to enter text.
45. Please provide us with examples of your recent communication work
    Click here to enter text.
46. Does your firm issue ID cards or stickers to be used on existing ID cards?
    Click here to enter text.
47. Does your firm supply postage-paid envelopes for mail-in requests?
    Click here to enter text.
48. How many hours per day and days per week are your firm's phone lines open?
    Click here to enter text.
49. Do you provide a toll-free number for use by covered members, providers, and the client?
    Click here to enter text.

Network Evaluation Questionnaire

1. Where do you provide the following tertiary care? What types of contracts do you have with these facilities (none, case to case, or blanket)?
   a. Premature infants:
      Click here to enter text.
   b. Cardiovascular care:
      Click here to enter text.
   c. Burns:
      Click here to enter text.
   d. Organ transplants:
      Click here to enter text.
   e. Severe trauma:
      Click here to enter text.
   f. Other tertiary:
      Click here to enter text.
2. Are hospital reimbursements at the lesser of billed charges or contracted price?
   Click here to enter text.
3. How many Primary Care Physicians and Specialist Physicians are participating in your Network in the 4 counties surrounding the client?
   Click here to enter text.
4. Are you able to track out-of-network charges? If yes, what percentage of the physician charges reimbursed within medical plans you sponsor/administer are paid to participating physicians?
   Click here to enter text.
5. Describe your reimbursement arrangement (e.g., McGraw-Hill M.D.R. - HIAA, R&C, etc.) and provide the CPT code allowable chart.
   Click here to enter text.
6. Are there any fees associated with the repricing of claims for out-of-network providers? If so, please explain.
   Click here to enter text.
7. Are participating primary care physicians required to accept new patients?
   Click here to enter text.
8. Do primary care physicians have “gatekeeper” responsibilities within your system?
   Click here to enter text.
9. If not, how are specialty utilization and out-of-network referral costs controlled?
   Click here to enter text.
10. Are PCP referrals required to access specialist care?
    Click here to enter text.
11. What information/assistance for referrals does the Network provide PCPs?
    Click here to enter text.
12. Do physicians have risk-sharing arrangements (e.g., risk pools, withholds)? If yes, please describe.
    Click here to enter text.
13. Describe your physician selection and termination criteria. Describe your credentialing requirements for physicians. Are these requirements made prior to or after acceptance into the network? Who performs the credentials review and how often are physicians re-credentialed? This may be provided elsewhere on proposal.
    Click here to enter text.

14. How many physicians have been added and dropped out of the network over the last three years? Describe and quantify reasons.
    Click here to enter text.
15. Provide a GeoAccess Map of Network Physicians and Hospitals in the counties immediately surrounding the client for an exact zip code match.
    Click here to enter text.
16. Clearly outline your proposed PPO Discount Performance Guarantee to include any claims which may be excluded and all caveats to above mentioned guarantee.
    Click here to enter text.
17. Describe your quality assurance program and provide a copy of any guidelines utilized.
    Click here to enter text.
18. What data and education do you provide to providers? Do you have a provider "report cards" system (e.g., specialist referral rate, in-patient statistics) member feedback, comparisons to standards and peers? If so, describe.
    Click here to enter text.
19. Does a technology assessment process exist?
    Click here to enter text.
20. How are medical necessity guidelines developed and modified?
    Click here to enter text.
21. How are guidelines communicated to network providers?
    Click here to enter text.
22. Does network perform clinical outcome studies? If so, describe:
    Click here to enter text.
23. Is a portion of physician compensation directly based on individual quality results?
    Click here to enter text.
24. What percentage of your statewide network is owned by you and what percentage is leased?
    Click here to enter text.
25. If you are utilizing a lease network, please list the areas of the state by client that you access via the lease network.
    Click here to enter text.
26. Describe work flow. Does the network re-price claims prior to submission to payer? Is this data captured? (Please provide reports.)
    Click here to enter text.
27. What data is available and in what format?
    Click here to enter text.
28. What census data, membership demographics is available?
    Click here to enter text.
29. What frequency of service data is maintained and how often are reports run and reviewed?
    Click here to enter text.
30. What charge data is captured and how often are reports run summarizing the results?
    Click here to enter text.
31. What provider data is captured and how often are reports run summarizing the results?
    Click here to enter text.
32. How is hospital reimbursement calculated and who does it? The network or a third party? Is payment accuracy verified? If so, how?
    Click here to enter text.
33. How is physician reimbursement calculated and who does it? The network or a third party? Is payment accuracy verified? If so, how?

Click here to enter text.

34. Is payment accuracy verified and if so, how?
    Click here to enter text.
35. Does network credential all participating providers and facilities? If not, which are?
    Click here to enter text.
36. What hospital credentialing and re-credentialing criteria are required?
    Click here to enter text.
37. How often are facilities re-credentialed?
    Click here to enter text.
38. What percent of physicians are credentialed? What documentation is kept in network files?
    Click here to enter text.
39. Is the credentialing function delegated to a third party (e.g., IPA or hospital)? If so, to whom?
    Click here to enter text.
40. Is each physician credentialed before being accepted into network?
    Click here to enter text.
41. What percent of your participating physicians are board certified PCP and Specialists?
    Click here to enter text.
42. Do you contract with any entities such as prescription drug organizations, mental, nervous and chemical dependency companies, etc. which perform their functions at discounted and/or capitated rates?
    Click here to enter text.
43. Please describe these arrangements, the associated reimbursement contract, the utilization reporting capabilities and the generic substitution rate (for prescription drug arrangements).
    Click here to enter text.

44. What is your fee for accessing the network? What services are included in the fee?
    Click here to enter text.
45. Can your ACO and Narrow networks be tiered?
    Click here to enter text.
46. What other services are available, and at what cost?
    Click here to enter text.
47. Please include copies of the following:
    a. Financial statement or annual report
       Click here to enter text.
    b. Current organizational chart
       Click here to enter text.
    c. Background and profile of your management personnel
       Click here to enter text.
    d. Sample hospital contract and reimbursement arrangement
       Click here to enter text.
    e. Sample physician contract and reimbursement arrangement
       Click here to enter text.
    f. Copies of standard data report (especially reports that demonstrate medical management capabilities and/or savings achieved)
       Click here to enter text.
    g. Client area provider directory
       Click here to enter text.

Performance Acknowledgement

Please answer **"Agree"** or **"Disagree"** only. If you disagree, please explain:

CLAIMS SETTLEMENT

1. ASO - A client account will be established and you will be given authority to draw benefit checks from this account. The client would like to operate a zero balance account for this plan. Please indicate if this is a problem for your organization.

Click here to enter text.

2. It will be your responsibility to maintain computer eligibility. The client would like an adequate "direct" claim status system for review of claim processing as well. You will be responsible for training on the claim status system.

Click here to enter text.

3. You will be responsible for the complete calculation of the benefits payable, including investigation, follow-up coordination of benefits, preparation and sending of Form 1099 to providers, and the drawing and mailing of checks. Other than PPO providers, checks are to be mailed directly to the employee unless he/she specifies on the claim form that payment should be sent directly to the medical/dental providers.

Click here to enter text.

4. The TPA will be fully responsible for preparation and dissemination of any information to be sent to the I.R.S. If penalties are assessed because of incorrect or late filings by the TPA, the TPA will be responsible for any such assessments and will hold the client harmless.

Click here to enter text.

5. If the client or an employee of the client has a question concerning the settlement or status of a claim, it is your responsibility to provide a satisfactory and timely answer to the question.

Click here to enter text.

6. In settling the claim, you will be required to perform up to the following minimum standards:
   a. All claims received in your office(s) in proper, complete order will be calculated and paid within 10 working days;
      Click here to enter text.
   b. All benefit checks must reach the employee or provider within 30 days after submission of a claim, unless more information or C.O.B. is involved;
      Click here to enter text.
   c. No claim shall go un-worked for more than 21 days. The status of a pending or C.O.B. claim must be updated on the system within this time;
      Click here to enter text.
   d. No claim can be over 60 days old for any reason;
      Click here to enter text.
   e. The clerical error ratio on claims must be less than two percent and dollar ratio of one percent;
      Click here to enter text.
   f. Meet all federal guidelines on claims turnaround and processing standards;
      Click here to enter text.
   g. Meet all electronic standards for transmission of electronic claims;
      Click here to enter text.
   h. Be completely compliant with all HIPAA requirements for claims administrators; and

Click here to enter text.

i. Medical must meet PPACA standards/requirements
Click here to enter text.

7. TPA will be responsible for re-pricing of all claims for PPO discounts.
Click here to enter text.
8. A 1-800 number shall be provided to the employees for customer service from 6 a.m. to 10 p.m. Central Standard time. Please include a toll free nurse line as well.
Click here to enter text.
9. Administrative service personnel shall be available for on-site consultations with client personnel as necessary.
Click here to enter text.
10. All records, member files and miscellaneous data necessary to administer the plan shall be the property of the client. The selected administrator will be asked to transfer records to the client in an electronic format of their choice.
Click here to enter text.
11. The administrator shall not charge against the plan experience any claim payment not authorized under the health policy (except those specifically authorized in writing by the client). In the event of such an error, the administrator shall be responsible for all collections and/or plan reimbursement expenses.
Click here to enter text.
12. The administrator shall indemnify, hold, and save the client, the consultant and their agents, officers and employees harmless from liability of any nature or kind, including costs, expenses, and attorney's fees, for harm suffered by an entity or person as a result of the negligent, reckless, or willful acts of omissions by the carrier, its officers, agents or employees.
Click here to enter text.
13. The proposals/proposers must quote a price for all services. The client does not wish to pay additional/separate fees under the contract for the following items, whether or not they are customized:
a. ad hoc reports requested on as needed basis
Click here to enter text.
b. enrollment materials
Click here to enter text.
c. claim forms
Click here to enter text.
d. identification cards
Click here to enter text.
e. plan booklets
Click here to enter text.
f. PPO savings reports
Click here to enter text.
g. provider reports monthly, quarterly and annual
Click here to enter text.
h. reasonable and customary information
Click here to enter text.
i. dedicated service professional to assist the client with electronic claims status system
Click here to enter text.

14. The client may conduct an annual written randomly selected employee satisfaction survey. The TPA must meet an employee satisfaction level of 90% as determined by the client.
    Click here to enter text.
15. Annual renewal prices will not exceed the percentage increase specified in the proposal. All proposals/proposers must sign and agree to this stipulation in order to be considered.
    Click here to enter text.
16. All proposals/proposers must sign and agree to the standard contract language regarding indemnification, ownership of records and databases, term of agreement, and no arbitration clause in order to be considered.
    Click here to enter text.
17. Besides on-line claims adjudication services, the Administrator must maintain a detailed eligibility file that includes date of birth, social security number, premium detail and address information for the employee and/or dependent(s). The Administrator should be able to calculate premium listings by line of coverage and disburse reinsurance payments for the clients. Claim checks must be run on a client directed schedule. The Administrator must be able to administer all of the benefits offered by the client accurately and timely. The Administrator must be capable of designing and assisting in booklet preparation, plan documents, custom claim forms, ID Cards, and worksheets. Failure to fulfill these provisions on a consistent basis may result in termination of this contract for default.
    Click here to enter text.
18. All proposals must include a flat administration fee. All proposals must exclude any alternative revenue streams generated via the claims wire. This includes but is not limited to arrangements like shared savings, NAP, or blue card fees.
    Click here to enter text.

STATISTICS

1. The client has not designed nor developed an informational system. Therefore, the major portion of your statistical responsibilities will be to provide the client with monthly appropriate claims information they deem necessary for their operations.
   Click here to enter text.
2. The other type of statistical reporting you must provide for the medical benefits is a monthly total of the paid claims by plan. This monthly total must be provided by the 15th of the following month.
   Click here to enter text.
3. Daily, weekly and monthly check registers must be available.
   Click here to enter text.

Dental Administrative Questionnaire

1. Where will claims be administered?
   Click here to enter text.
2. Do you provide in-state and/or national 800 telephone service?
   Click here to enter text.
   a. What, if any, are the additional charges for this service?
      Click here to enter text.
   b. What hours is the service available?
      Click here to enter text.
3. Describe your company's performance standards with respect to:
   a. employee inquiries (both written and telephonic);
      Click here to enter text.
   b. claims turnaround;
      Click here to enter text.
   c. claims accuracy (statistical, payment, financial, technical);
      Click here to enter text.
   d. number of claims received monthly by plan type;
      Click here to enter text.
   e. number of claims processed monthly by plan type, and;
      Click here to enter text.
   f. current average processing time and current backlog in days.
      Click here to enter text.
   g. Please indicate the actual performance of the office indicated in item 1 above during the prior two calendar years in attaining these standards.
      Click here to enter text.
4. Describe your company's quality assurance and/or internal audit procedures and programs.
   Click here to enter text.
   a. To whom does your in-house audit/quality assurance person(s) report?
      Click here to enter text.
   b. What percentage of all claims processed are audited?
      Click here to enter text.
   c. Describe methodology used in computing processing time.
      Click here to enter text.
   d. Is the claim "receive date" the same for the claim and subsequent adjustments?
      Click here to enter text.
   e. Are you willing to provide the client with quarterly audit reports on its claims?
      Click here to enter text.
   f. Are you willing to allow an annual audit done by an external auditor?
      Click here to enter text.
5. Please list a contact and telephone number for your services.
   Click here to enter text.
6. What are normal business hours for participant questions or pre-determination?
   Click here to enter text.

7. Please describe the nature of the contract you would propose, indicating:
   a. the length of time of the contract;
      Click here to enter text.
   b. the length of time your fees are guaranteed beyond the required three years; and
      Click here to enter text.
   c. termination notice requirements.
      Click here to enter text.

   Note: The client requires a minimum three year contract.
8. If your company is selected, describe in detail the steps and schedule that would need to occur to assume the claims payment functions on the effective date.
   Click here to enter text.
9. Are you able to administer on-line, electronic transfer, and tape-to-tape eligibility transfers?
   Click here to enter text.
   a. How, if at all, does this impact your cost proposal?
      Click here to enter text.
10. Do you have the capability for the client to have access to your claims and eligibility system through an on-line system?
    Click here to enter text.
    a. Is there an additional cost for this access? If so, please provide the cost information.
       Click here to enter text.
11. Please submit a sample of your proposed claim and Explanation of Benefits forms.
    a. Would you be willing to customize the information contained in these forms?
       Click here to enter text.
    b. Would there be an additional cost?
       Click here to enter text.
12. Please state what records (including the participant and data processing documents) would, in fact, belong to the client upon contract termination. Describe how and where claim records will be stored. Specify whether storage media is electronic or hard copy, on-site or off-site.
    Click here to enter text.
13. In the event of contract termination, when would records, which are property of the client, be released to the party or organization designated by the client?
    Click here to enter text.
    a. Describe your termination notice requirement.
       Click here to enter text.
    b. Are records stored in an easily retrievable manner?
       Click here to enter text.
14. Are you willing to guarantee cost beyond the initial three-year term?
    Click here to enter text.
15. Does your system, or can you, administer a program that identifies and coordinates deductibles/claims on a family basis for dual working spouses?
    Click here to enter text.
16. Please describe any insurance you carry for Fiduciary Liability and Errors and Omissions Insurance.
    Click here to enter text.
    a. Please provide liability limit and carrier.
       Click here to enter text.

17. Do you pay the printing of checks; E.O.B.'s, and claim forms?
    Click here to enter text.
18. What process do you have to ensure that claims are not paid after a termination of coverage, or if paid, recovery of payments?
    Click here to enter text.
19. Does the Administrator employ a full-time DDS as a dental advisor?
    Click here to enter text.
    a. If not on a full-time basis, when is the advisor available?
       Click here to enter text.
20. Are plan changes, discounts, fee schedules to be loaded into the computer system by Administrator employees or an outside support group?
    Click here to enter text.
    a. Are changes verified back to the client as to accuracy and implementation date?
       Click here to enter text.
21. Please explain in detail your refund process.
    Click here to enter text.
    a. How do you identify refunds?
       Click here to enter text.
    b. Are letters are sent out? If so, how many?
       Click here to enter text.
    c. Is this a manual or automated process?
       Click here to enter text.
    d. Is the provider ever contacted by any other means than by a letter?
       Click here to enter text.
22. Do you have an on-line enrollment system? If so, please explain in detail how it functions (i.e. ability to transmit data back to the client in an electronic format).
    Click here to enter text.
23. Please explain in detail how you will assist the client during open enrollment.
    Click here to enter text.