 

Insurance | Risk Management | Consulting

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[www.ajg.com](2021%20Austin%20RFP%20Questionnaire.docx)

**20RFP010 Medical and Pharmacy Health Benefit Products**

**Attachment A - RFP Questionaire**

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 Natalie Haskett at Gallagher Benefit Services, Inc.,

210-348-4110, Natalie\_Haskett@ajg.com.

**About Austin ISD**

The Austin Independent School District is the heart of public education in Austin, Texas—a city of ideas and innovation that tops the nation's rankings of the best communities in which to work and live. Austin ISD educates approximately 81,000 students and embraces 130 diverse school communities in one of the fastest-growing, ever-changing metroplexes in the country. In partnership with parents and our community, AISD's mission is to provide a comprehensive educational experience that is high quality, challenging, and inspires all students to make a positive contribution to society. We partner with world-class universities, innovative businesses and nonprofit organizations and engaged community leaders to prepare our students for college, career and life.

**Additional Information about This RFP**

Austin ISD is requesting bids for their benefit programs for an effective date of January 1, 2021. Coverages being bid are medical, pharmacy and H.S.A administration. The medical and pharmacy are on a self-funded basis. Stop Loss RFP will be released at a later date.  
  
The contract for this bid is for 3 years beginning 2021.

**Requested Proposal Specifications**

**MEDICAL/RX/ADMINISTRATION**

1. Please include net of any commission in your proposal
2. Please detail the ASO fee for 2021, 2022, and 2023 in your proposal
3. Current Medical administrator is Aetna with ESI as the pharmacy vendor
4. Approx12,000 eligible employees with15,000 total lives
5. Please complete each section in the workbook. If it does not apply, please indicate “N/A”
6. AISD does not provide coverage for retirees, please assume active coverage only
7. Please use the following 3 digit zip code and parameters for the Geo Access and Provider/Hospital comparisons:
   1. 787
   2. Hospitals 1 within 15 miles
   3. PCP’s 2 within 10 miles
   4. Spec 2 within 10 miles
   5. OBGYN 2 within 10 miles
8. Plan design: See benefit guide.   
   a. Match current coverage, but also include options for consideration that would highlight innovations/cost containment strategies. NOTE: All options must have adequate provider solutions   
   b. Sliced business (i.e. 2 different carriers, but not limited to Multiplan ACO’s) – would you support this benefit structure? If so, please outline specifics, caveats, and pricing. Your minimum participation requirements should be no more than 25%.  
   c. Wrap Network/Out of Area Plan - If true Narrow Network/ACO model is elected, could this be a buy-up option for employees or only an option for out of state dependents? Please provide specifics and pricing.   
   d. Any other cost effective arrangements (i.e. HMO’s, tiered networks, ACO, etc.)  
   e. Do not include reference based pricing models
9. Please include a minimum of $500k annual allowance each year for the duration of the contract. This money is to be used anytime at the District’s discretion and any unused funds can roll over into subsequent years.
10. State your main provider (i.e. facility, major physician groups, ACO’s and labs) expiration dates from now through 2024? For any contracts you know are renewing, please provide an estimate of the following year cost changes.
11. List any provider groups not in your networks today that will be joining a network between now and 2021.
12. Must have Single Sign On integration with proprietary mobile application.
13. RediMd will be administering telehealth for AISD. Please confirm that you are able to coordinate and processes these claims as in-network with the current copay structure.
14. Must provide single customizable member ID cards, not limited to number of plans or color.
15. Please quote medical administration fees in these two scenarios:
    1. assume the use of your PBM, and
    2. Assume the use of an outside PBM. If additional fees will be charge for sharing and/or integrating data with an outside PBM, please include those fees in your quote.
16. If carve out PBM is selected, must provide file feed integration/reporting, not limited to accumulator data only.
17. Must maintain a vendor relationship with Navigate (formerly Live Healthy)
18. Your administration fee should include the cost of detailed claim reports requested by GBS throughout the plan year, plus 100 hours of ad hoc reporting for AISD – Monthly Management, Financial, Utilization & Performance Reports.
19. Carrier Reporting Requirements: (Note - All of these reports must be available upon request)
    1. Monthly Claims by plan and total (on a paid and incurred basis)
    2. Monthly Enrollment broken down by plan
    3. Paid & Pended claims broken down by inpatient/outpatient/Rx
    4. Discount Analysis
    5. Monthly LCR > $75,000
    6. Network Analysis (In vs. Out)
    7. Quarterly medical utilization report for inpatient, outpatient, lab, miscellaneous
    8. Rx Utilization (patient ID, date filled, NDC-11, quantity, days’ supply, AWP, ingredient cost, dispensing fee, tax, allowed cost, plain paid amount, 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#)
20. In addition to the above reporting requirements, your cost must include a full data dump requested by GBS throughout the year.
21. There will be a separate RFP on Stop Loss released later in the year. Your quote will need to include any additional costs for an outside stop loss vendor
22. The out of network reimbursement level should be 110% of Medicare. Please note if your reimbursement level differs, either positively or negatively.
23. Please provide Geo Access reports with your proposal to include the client’s county and surrounding counties.
24. Include HSA administration, if applicable
25. Your quote must include the cost of being claim fiduciary.
26. Respondents will be required to specifically show any capitated arrangements and any risk share arrangements within their program. They cannot state costs are included in claims and must delineate those costs. Include any costs or calculations for these arrangements.
27. No shared savings programs as part of claims will be considered. Please include any shared savings costs as a per employee per month (PEPM).
28. Your quote must include an onsite customer service representative. This person will assist AISD in any member / client needs relating to claims, researching eligibility and other miscellaneous functions. This person must also provide clinical support for various initiatives including, customized disease management programs. Additionally, this person will be required to periodically visit campuses.
29. LCSW dedicated to AISD that can travel by appointment must be available upon client’s request.
30. Your standard Wellness Program must include:
    1. Health Assessment
    2. Online Wellness Program
    3. Personal Healthcare Record
    4. Preventive Care
    5. Disease Management (with reporting capability)
    6. Health Maternity Program
31. 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.
32. Must provide concierge Customer Service with a dedicated 800 number that is customizable.
33. Please provide both a traditional contract and 100% pass through pharmacy arrangement. For the pass through, please clearly delineate the hold back percentage, if applicable.
34. AISD expects to receive the greater of the pharmacy rebate guarantee or 100% of actual rebates.
35. Please explain your rebate payout schedule.
36. Please quote a both a broad and narrow formulary with correlating savings.
37. Please provide any additional guarantees outside of the standard claims and customer service guarantees. These could include, but not limited to, claim targets, discount guarantees, in network utilization, clinical guarantees, etc.
38. Please disclose any pending changes as a result of approved mergers/acquisitions or discussions around potential future plans.
39. Please describe your Transition of Care policy.
40. Please confirm that all SBC’s and other compliance documents will automatically be delivered within 90 days of plan effective date regardless of changes or requests

**I acknowledge I have read the statements above**

**Medical Administrative Questionnaire**

1. From what city will claims be administered?

Click here to enter text.

1. 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.

1. Describe your company's performance standards with respect to:
   1. Employee inquiries (both written and telephonic);

Click here to enter text.

* 1. Claims turnaround;

Click here to enter text.

* 1. Claims accuracy - both financial and procedural

Click here to enter text.

* 1. Claims process with time frames for review

Click here to enter text.

1. 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.

1. 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.

1. 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.

1. 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.

1. What are normal business hours for participant questions or precertification?

Click here to enter text.

1. Please describe the nature of the contract you would propose, indicating:
   1. The length of time of the contract;

Click here to enter text.

* 1. The length of time your fees are guaranteed beyond the required three years

Click here to enter text.

* 1. Termination notices required

Click here to enter text.

1. Please describe the implementation process in detail. Provide a sample timeline assuming award is made next month.

Click here to enter text.

1. How do you propose to collect claims data from the prior carrier to accommodate a smooth transition?

Click here to enter text.

1. How would you determine “Days per 1000” by plan? Please explain in detail.

Click here to enter text.

1. 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.

1. 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.

1. Does your system incorporate scanning capability and if so, is it incorporated into claims adjudication automatically?

Click here to enter text.

1. 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.

1. 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.

1. 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.

1. 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.

1. 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.

1. 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.

1. 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.

1. 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.

1. 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.

1. 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.

1. Please describe any insurance you carry for Fiduciary Liability and Errors and Omissions Insurance. Amount? Carrier?

Click here to enter text.

1. 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.

1. Can you handle electronic transfer of prescription drug claims?

Click here to enter text.

1. 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.

1. 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.

1. 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.

1. Will you work with the client to design a tailor made claim form?

Click here to enter text.

1. Is your system capable of tracking Unique Provider Identification Number (UPIN)?

Click here to enter text.

1. Can your system track referrals made by the primary care physician? Is this information date sensitive to the change?

Click here to enter text.

1. 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.

1. 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.

1. Can your system track and process itemized hospital charges by code?

Click here to enter text.

1. 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.

1. 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.

1. Does your claims system have the following capabilities?
   1. Able to process in-network, out-of-network, and out-of-area claims

Yes  No

* 1. Is there a fee to reprice out-of-network provider claims?

Yes  No

* 1. Integrated access to provider-specific data including contractual and financial arrangements

Yes  No

* 1. Able to maintain historical eligibility information

Yes  No

* 1. Able to separate eligibility dates for employees and each covered dependent

Yes  No

* 1. 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

* 1. Able to process hospital and all other medical plan related claims including prescription drugs and capture hospital revenue codes

Yes  No

* 1. Ability to Identify authorized referrals and admissions by network status.

Yes  No

* 1. Able to apply stringent utilization and price controls for out-of-network usage

Yes  No

* 1. Able to automatically match claims with utilization management information both in-network and out-of-network

Yes  No

* 1. Common database for edits, pricing, production of EOI's and reporting

Yes  No

* 1. Able to customize EOI messages

Yes  No

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

Yes  No

* 1. Able to show the actual and negotiated charge on the EOI

Yes  No

* 1. Able to show the applicable procedure code

Yes  No

* 1. Able to show the percentage of payment

Yes  No

* 1. Able to show the amount of deductible satisfied

Yes  No

* 1. Automatic rollover of FSA claims

Yes  No

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

Yes  No

* 1. Able to integrate telemedicine encounter claims

Yes  No

1. 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

* 1. Claim Processing Accuracy (95%)
  2. Claim Turnaround (90% - 10 days)
  3. Financial Payment Accuracy (99.5%)
  4. Financial Coding Accuracy (97%)
  5. Implementation score greater than 90%
  6. Employee Satisfaction score greater than 90%

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

Yes  No

1. 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

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

Yes  No

**Retail/Mail Order Prescription Drug Questionnaire**

1. Who owns your organization? If applicable, please describe the organizational relationship between your organization and its parent company.

Click here to enter text.

1. When did your organization begin administering the following? POS retail programs, mail service programs, and integrated POS retail/mail service pharmacy programs.

Click here to enter text.

1. Is the Quantity Level limits plans flexible or does the client have to abide by proposers set programs?

Click here to enter text.

1. Please provide a location for each of the following as they relate to the client’s account: Home Office, Regional Office, Claims Processing, Mail Order Services, and Customer Service.

Click here to enter text.

1. Please list all employees that will be assigned to the client’s account including their titles, roles and responsibilities and information regarding advanced customer service systems and programs, personal ownership and commitment by customer service staff to provide prompt and accurate information to members.

Click here to enter text.

1. Is your organization authorized to do business in the state of Texas? What other states are you authorized to do business in?

Click here to enter text.

1. Do the fees provided include any level of commissions, overrides or bonuses?

Click here to enter text.

1. Does your organization agree that all records, member files, and miscellaneous data used in administration of this plan shall remain the property of the client?

Click here to enter text.

1. For those third party administrators with integrated pharmacy services, who is your pharmacy benefit manager?

Click here to enter text.

1. Please describe methodology for ingredient costing and whether zero balance costing is applied.

Click here to enter text.

1. Please describe your mail-order system.

Click here to enter text.

1. Please describe available programs/options to control high costs associated with compound drugs and specialty drugs.

Click here to enter text.

1. Please describe your patient compliance program. What interventions do you perform? What evidence do you have of the program's success?

Click here to enter text.

1. Please provide your ability to interface with other carriers for the delivery of claims data that supports plan design (deductibles, maximum out of pocket).

Click here to enter text.

1. Please describe your formulary process -- how drugs are selected, by whom, how often it is updated, etc.

Click here to enter text.

1. Please describe your ability to manage a customized formulary (one of our design).

Click here to enter text.

1. Please describe how you communicate the formulary and any midyear changes to the formulary to physicians, pharmacists and our employees.

Click here to enter text.

1. Please describe your rebate process -- how do you track utilization, how and when you submit utilization to manufacturers, how and when you distribute rebate monies.

Click here to enter text.

1. What pharmacy rebate guarantees are you providing?

Click here to enter text.

1. All retail and Retail-90 claims must be priced using “lowest of logic," which means that claims will price at the lowest of the discounted ingredient price plus dispensing fee, the MAC plus dispensing fee, or the pharmacy’s U&C amount (including the pharmacy's sale price, if any). Pharmacies/Offerors will not be allowed to use “zero balance logic” or charge a "minimum copayment amount." Please explain if the above does not meet your criteria.

Click here to enter text.

1. When a formulary change occurs, will respondent send a target communication to affected individuals 60 days prior to the change taking effect? If so, please provide a copy of the communication.

Click here to enter text.

1. Please confirm a pre-implementation audit would include pharmacy as well as medical.

Click here to enter text.

1. Please list all national and local retail pharmacies available to members.

Click here to enter text.

1. Please provide statistics on employee resolutions as well as statistics for each service line when an employee calls into the help line.

Click here to enter text.

1. What is the staffing model for serving the Plan Sponsor?

Click here to enter text.

1. Will staff be dedicated to the Plan Sponsor for no additional cost?

Click here to enter text.

1. Please provide claim adjudication statistics for the proposed claim office. Your Standard and 2016 Results for the following:
   1. Financial accuracy (percent of dollars paid correctly)

Click here to enter text.

* 1. Overall accuracy (average payment incidence accuracy)

Click here to enter text.

* 1. Percentage of clean claims completed in 15 calendar days

Click here to enter text.

* 1. Percentage of clean claims completed in 30 calendar days

Click here to enter text.

1. Please provide sample of performance guarantees and administrative fee adjustments for failure to meet implementation and ongoing service requirements.

Click here to enter text.

1. Please provide vendor fiduciary levels and any fees associated with each level.

Click here to enter text.

1. Please indicate the amount of Implementation Credit you will provide, which will be funds that the client may use to offset "Implementation expenses." At no point will the client be required to pay for used or unused portions of the credit offered by your organization.

Click here to enter text.

1. What is respondent’s preferred billing method? Are there any alternatives?

Click here to enter text.

1. Will respondent mail out SBCs to employees for no additional cost to the client?

Click here to enter text.

1. Please describe technologies which assure claims payment accuracy and timely turnaround; electronic eligibility interface; flexible technology to respond promptly and efficiently to rapid plan design changes, interactive voice response for members when accessing services, and/or web applications.

Click here to enter text.

1. Please provide a description of your fraud control programs. Specifically describe your internal fraud control procedures for prevention of the following:
   1. Processor or other internal fraud

Click here to enter text.

* 1. Provider fraud

Click here to enter text.

* 1. Enrollee fraud

Click here to enter text.

* 1. Method of reporting fraud control activities and results back to clients

Click here to enter text.

e. Where are offices located that will handle fraud; provide staffing for these offices and an organization chart.

Click here to enter text.

1. Describe your standard appeals procedures for disputed claims.

Click here to enter text.

1. Do you provide services for Independent Review for external review claims?

Click here to enter text.

1. Describe your standard subrogation process.

Click here to enter text.

1. Please provide sample reporting to include but not limited to:
   1. Census by demographic profiles

Click here to enter text.

* 1. Recoveries for coordination of benefits, subrogation, claims processing errors, etc.

Click here to enter text.

* 1. Large case claimants by plan

Click here to enter text.

* 1. Report of participant activity by plan for preventive screenings, physical exams, ect.

Click here to enter text.

1. Ability for the client to access "drill-down" reporting on specified utilization concerns of the client

Click here to enter text.

1. Ability to report on appeals status and turn-around performance, etc.

Click here to enter text.

1. Sample explanation of benefits forms, coordination of benefits requests, requests for third party accident forms, and other notices that would be provided to members. Can the above reports be pulled off the respondent’s portal? If so, how often?

Click here to enter text.

1. Will respondent provide a monthly large case review with the clinical consultant for no additional cost?

Click here to enter text.

1. Please provide a formulary disruption report.

Click here to enter text.

1. Will respondent provide and mail creditable coverage notices for no additional cost to the client?

Click here to enter text.

1. Please provide a list and summary of additional value added services not mentioned above with a price schedule.

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.

1. The client may audit the two prior plan years

Click here to enter text.

1. 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.

1. Remove any restrictions that could limit client’s access to service including:
   1. Selection of 3rd party vendors to perform review or recovery

Click here to enter text.

* 1. Limitations on 3rd party contract terms (i.e. “no contingency arrangements”)

Click here to enter text.

1. 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.

1. Describe any unique qualifications that distinguish your company within the disease management industry.

Click here to enter text.

1. 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.

1. Describe your service area.

Click here to enter text.

**ACCOUNT MANAGEMENT/IMPLEMENTATION**

1. Describe your process to communicate the disease management program to employees.

Click here to enter text.

1. 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.

1. Are multi-lingual materials available?

Click here to enter text.

1. Please provide copies of all implementation AND communication materials.

Click here to enter text.

1. List the diseases covered in your disease management programs and specify whether they are currently available or in development.

Click here to enter text.

1. Do you use clinical practice guidelines? If yes, specify which guidelines are used and how they are applied.

Click here to enter text.

1. Describe the types of interventions and methods of delivery used for the disease management programs you offer.

Click here to enter text.

1. Explain how Disease Management interventions are targeted to individual participants’ needs and motivation to change.

Click here to enter text.

1. Do you use a readiness to change behavioral model in the delivery of your services? If so, describe.

Click here to enter text.

1. How do you track and monitor patients over time?

Click here to enter text.

1. Describe how you handle co-morbid conditions and provide a list of the co-morbid conditions you address.

Click here to enter text.

1. Do you have an educational component to your program and educational materials?

Click here to enter text.

1. What is the literacy level of your written materials?

Click here to enter text.

1. What methods do you use to identify candidates for the disease management programs and the frequency of each method?

Click here to enter text.

1. Describe your information technology infrastructure.

Click here to enter text.

1. Describe the desktop system that is used in your Disease Management operations?

Click here to enter text.

1. Do you use any data mining software in your Disease Management?

Click here to enter text.

1. Describe system security and back-up procedures.

Click here to enter text.

1. Describe the process of Claims Data and Eligibility transfer from the Medical plan TPA.

Click here to enter text.

1. How much data do you need initially?

Click here to enter text.

1. What is the frequency of subsequent feeds?

Click here to enter text.

1. 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.

1. What is your program enrollment rate?

Click here to enter text.

1. Do participants graduate from the program? If so, what is the graduation criteria?

Click here to enter text.

1. How often are outbound calls made to participants?

Click here to enter text.

1. Describe the makeup, qualifications, and experience of the Disease Management staff?

Click here to enter text.

1. 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.

1. Do you offer a 24-hour nurse line service?

Click here to enter text.

1. 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.

1. 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.

1. How do you identify the participants’ physician and how are they incorporated within the care of participant?

Click here to enter text.

1. How do you handle physicians that are non-compliant with the necessary protocol for the patient’s disease state?

Click here to enter text.

1. 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.

1. Describe how your organization retrieves & reviews paid claim data when analyzing a prospective client’s needs.

Click here to enter text.

1. Are reporting tools available to clients electronically?

Click here to enter text.

1. Do you utilize any statistical methodology for early disease detection (e.g. predictive modeling)?

Click here to enter text.

1. Indicate which measures you use to determine program impact and cost savings.

Click here to enter text.

1. Please provide a sample of standard client reports.

Click here to enter text.

1. 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.

1. Describe the types of client reports available. How often are reports provided?

Click here to enter text.

1. Will you provide comparative data from your book of business?

Click here to enter text.

1. Please provide copies of standard client reports.

Click here to enter text.

1. Are you capable and will you provide customized client reports?

Click here to enter text.

1. What services are included in your fees? Describe all potential extra fees in providing services.

Click here to enter text.

1. 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. Are your UR services provided by your company, a subsidiary or a vendor?

Click here to enter text.

1. Are all hospitalizations, regardless of diagnosis, included in Utilization Review?

Click here to enter text.

1. How is each party kept informed? (Patient, Physician, Employer)

Click here to enter text.

1. How are certifications obtained by phone and by mail?

Click here to enter text.

1. What specific information is submitted in the initial request for certification? (Include sample form)

Click here to enter text.

1. Are length of stay guidelines provided with initial admission approval?

Click here to enter text.

1. 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.

1. Are concurrent review and discharge planning normally included with your firm’s pre-admission certification review?

Click here to enter text.

1. Are length of stay extensions typically administered within this part of the program?

Click here to enter text.

1. What procedures does your firm believe belong with concurrent review and discharge planning?

Click here to enter text.

1. Is this procedure handled by your firm or delegated?

Click here to enter text.

1. If delegated, do you contract with various Peer Review Organizations?

Click here to enter text.

1. How are contracts made by your administrators with attending physicians to be certain estimated discharge dates are met?

Click here to enter text.

1. Does your firm regard Retrospective Review and Hospital Bill Audit as one or separate services?

Click here to enter text.

1. What is your procedure regarding retrospective review?

Click here to enter text.

1. What is your procedure regarding hospital audits?

Click here to enter text.

1. Does your firm provide a medical case management program?

Click here to enter text.

1. Indicate how your program states its objectives in view of typical goals of:
   1. Identifying alternate care

Click here to enter text.

* 1. Recommending accelerated care

Click here to enter text.

* 1. Reduction of medical complications

Click here to enter text.

1. Has your firm identified a list of illnesses and injuries it considers best for MCM? If so, please list:

Click here to enter text.

1. Indicate what levels of Disease Management your firm currently provides by disease state.

Click here to enter text.

1. Number of local full-time equivalent Medical Directors on staff?

Click here to enter text.

1. Number of local full-time equivalent Nurses on staff?

Click here to enter text.

1. How are cases identified for potential case management? Describe specialized handling of catastrophic illnesses.

Click here to enter text.

1. 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.

1. How do you measure patient satisfaction?

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)?
   1. Premature infants:

Click here to enter text.

* 1. Cardiovascular care:

Click here to enter text.

* 1. Burns:

Click here to enter text.

* 1. Organ transplants:

Click here to enter text.

* 1. Severe trauma:

Click here to enter text.

* 1. Other tertiary:

Click here to enter text.

1. Are hospital reimbursements at the lesser of billed charges or contracted price?

Click here to enter text.

1. How many Primary Care Physicians and Specialist Physicians are participating in your Network in the counties surrounding the client?

Click here to enter text.

1. 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.

1. Are there any fees associated with the repricing of claims for out-of-network providers? If so, please explain.

Click here to enter text.

1. Are participating primary care physicians required to accept new patients?

Click here to enter text.

1. Do physicians have risk-sharing arrangements (e.g., risk pools, withholds)? If yes, please describe.

Click here to enter text.

1. 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.

1. 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.

1. 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.

1. 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.

1. Describe your quality assurance program and provide a copy of any guidelines utilized.

Click here to enter text.

1. 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.

1. Does network perform clinical outcome studies? If so, describe:

Click here to enter text.

1. Is a portion of physician compensation directly based on individual quality results?

Click here to enter text.

1. What percentage of your statewide network is owned by you and what percentage is leased?

Click here to enter text.

1. What frequency of service data is maintained and how often are reports run and reviewed?

Click here to enter text.

1. What charge data is captured and how often are reports run summarizing the results?

Click here to enter text.

1. What provider data is captured and how often are reports run summarizing the results?

Click here to enter text.

1. How is hospital reimbursement calculated and who does it? Is payment accuracy verified? If so, how? What is your hospital stop loss levels and how does the reimbursement change if the level is hit?

Click here to enter text.

1. 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.

1. Does network credential all participating providers and facilities? If not, which are?

Click here to enter text.

1. What hospital credentialing and re-credentialing criteria are required?

Click here to enter text.

1. How often are facilities re-credentialed?

Click here to enter text.

1. What percent of physicians are credentialed? What documentation is kept in network files?

Click here to enter text.

1. Is the credentialing function delegated to a third party (e.g., IPA or hospital)? If so, to whom?

Click here to enter text.

1. Is each physician credentialed before being accepted into network?

Click here to enter text.

1. What percent of your participating physicians are board certified PCP and Specialists?

Click here to enter text.

1. 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.

1. 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.

1. What other services are available, and at what cost?

Click here to enter text.

1. Please include copies of the following:
   1. Financial statement or annual report

Click here to enter text.

* 1. Current organizational chart

Click here to enter text.

* 1. Background and profile of your management personnel

Click here to enter text.

* 1. Sample hospital contract and reimbursement arrangement

Click here to enter text.

* 1. Sample physician contract and reimbursement arrangement

Click here to enter text.

* 1. Copies of standard data report (especially reports that demonstrate medical management capabilities and/or savings achieved)

Click here to enter text.

* 1. 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.

1. 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.

1. 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.

1. 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.

1. 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.

1. In settling the claim, you will be required to perform up to the following minimum standards:
   1. 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.

* 1. 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.

* 1. 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.

* 1. No claim can be over 60 days old for any reason;

Click here to enter text.

* 1. The clerical error ratio on claims must be less than two percent and dollar ratio of one percent;

Click here to enter text.

* 1. Meet all federal guidelines on claims turnaround and processing standards;

Click here to enter text.

* 1. Meet all electronic standards for transmission of electronic claims;

Click here to enter text.

* 1. Be completely compliant with all HIPAA requirements for claims administrators; and

Click here to enter text.

* 1. Medical must meet PPACA standards/requirements

Click here to enter text.

1. TPA will be responsible for re-pricing of all claims for PPO discounts.

Click here to enter text.

1. 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.

1. Administrative service personnel shall be available for on-site consultations with client personnel as necessary.

Click here to enter text.

1. 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.

1. 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.

1. 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.

1. 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:
   1. ad hoc reports requested on as needed basis

Click here to enter text.

* 1. enrollment materials

Click here to enter text.

* 1. claim forms

Click here to enter text.

* 1. identification cards

Click here to enter text.

* 1. plan booklets

Click here to enter text.

* 1. PPO savings reports

Click here to enter text.

* 1. provider reports monthly, quarterly and annual

Click here to enter text.

* 1. reasonable and customary information

Click here to enter text.

* 1. dedicated service professional to assist the client with electronic claims status system

Click or tap here to enter text.

**Health Savings Account (H.S.A) Administration**

1. Do you provide a separate card for health savings accounts?

Click here to enter text.

* 1. Do you accommodate a banking facility for administration of health savings account?

Click here to enter text.

* 1. If provided, are these services sub-contracted? Please identify bank name and location.

Click here to enter text.

* 1. Where would customer service for members and benefits staff be handled?

Click here to enter text.

* 1. Please provide organization chart for account management team for HSA administration.

Click here to enter text.

* 1. Please describe the process for submitting participant funding information to bank.

Click here to enter text.

* 1. Will members be provided web access for account information?

Click here to enter text.

1. How are accounts established and activated?

Click here to enter text.

* 1. How are funds associated with inactive accounts managed?

Click here to enter text.

* 1. Please provide a sample discrepancy report which provides a list of employees whose funds could not be deposited into an active account. How often can this report be provided?

Click here to enter text.

* 1. How does the respondent manage accounts to ensure no account goes above IRS limits?

Click here to enter text.

* 1. Will vendor manage accounts to avoid excess contributions?

Click here to enter text.

1. Please provide sample monthly/quarterly reports to be provided to plan sponsor.

Click here to enter text.

* 1. Are members provided IRS forms for tax purposes? Please provide sample forms.

Click here to enter text.

* 1. Describe process for correction of errors

Click here to enter text.

* 1. Please provide statistics on employee resolutions as well as statistics for each service line when an employee calls into the help line.

Click here to enter text.

* 1. Please note, The Client’s open enrollment period is typically 15 days during the month of October. Please confirm respondent will be able accommodate all necessary activities (e.g. loading files, ID card production, etc.) to meet a 1/1 start date.

Click here to enter text.