



Cattaraugus County

Medical Benefits, Medical Management Administrative Services and
Group Insured Medicare Advantage Programs

Request for Proposal #CCHR2024-1

Proposed Effective Date: January 1, 2025

Presented by:



AssuredPartners
90 A John Muir Drive
Amherst, NY 14228

This Request for Proposal (RFP) and all information contained herein, any attachments or exhibits hereto, and all communications in whatever media form, in support of this document are proprietary to Cattaraugus County (“the Client”). Your firm acknowledges the proprietary nature of the aforementioned described information. Your use of such information for purposes other than a vendor relationship or the disclosure of such proprietary information to third parties (other than for the purpose of advancing the intent of the services contemplated by this document) will cause irreparable injury to Cattaraugus County. A breach of this covenant pertaining to the proprietary information will entitle Cattaraugus County to an automatic injunctive relief in addition to any and all other remedies available at law.

Acknowledgment

Name

Company

Table of Contents:

I. Introduction.....	4
II. Background.....	7
III. Overview and Summary of Current Plans.....	13
IV. Specifications.....	15
V. Information Sheets.....	17
VI. Medical Benefits Administration Agreements and Questionnaire.....	19
VII. Medical Management Administration Agreements and Questionnaire.....	32
VIII. Group Insured Medicare Advantage Agreements and Questionnaire.....	37

Attachments:

- EXHIBIT A – MEDICAL PERFORMANCE GUARANTEES
- EXHIBIT B - MEDICAL BENEFIT SUMMARIES
- EXHIBIT C - MEDICAL CENSUS INFORMATION
- EXHIBIT D - MEDICAL DATA & ELIGIBILITY INTEGRATION FIELD SPECIFICATIONS
- EXHIBIT E – MEDICAL ADMINISTRATIVE QUOTE
- EXHIBIT F – MEDICAL PROVIDER DISRUPTION
- EXHIBIT G – MEDICAL PRICING ATTESTATION
- EXHIBIT H – MEDICARE ADVANTAGE ADMINISTRATIVE QUOTE
- EXHIBIT I – POST-65 RETIREE ELIGIBILITY, MEDICAL AND PRESCRIPTION DRUG CLAIMS YEAR TO DATE
- EXHIBIT J – PRESCRIPTION DRUG BENEFIT COPAY SUMMARY
- EXHIBIT K – POST-65 RETIREES PRESCRIPTION DRUG DATA FILE

NOTE: There are three proposals within this request – Medical Administration, Medical Management and a Group Insured Medicare Advantage Program. *Vendors may respond to any or all of these proposals.*

- Completion of Exhibit A as well as Exhibits D-G in this request are mandatory for consideration of your Medical Administration proposal.

- No exhibits are required for your response to the Medical Management Administration proposal (however, you must submit your own pricing proposal with this).

- Exhibit H in this request is mandatory for consideration of your Group Medicare Advantage Program proposal.

Failure to complete these listed Exhibits may result in the elimination of your proposal.

I. Introduction: Request for Proposal (RFP)

You are invited to submit your firm's proposal to provide medical benefits administration services and/or medical management administration (as detailed in this RFP) for Cattaraugus County.

AssuredPartners Associates (“the Consultant”) is requesting a self-funded proposal for the administration of medical benefits and medical management (utilization management and cost management as well as any other offerings) to Cattaraugus County (“the Client”). The response to this RFP will determine the vendor or combination of vendors best suited to assist Cattaraugus County (“the Client”).

Vendors may respond to any or all of the three proposals within this RFP.

If replying to any of the three proposals, you are to follow the RFP instructions and specifications as described (Pages 5-9 and 13-16). You will submit the Confidentiality Agreement (Page 2), respond to all bid specifications (Page 9-11), review the Consultant Rights and Completeness of a proposal submission (Pages 11-12) and respond to all applicable background information (Pages 17-18). For submission of the Medical Administration proposal, you must include all answers to the Medical Administration Questionnaire (Pages 19-31) as well as submit Exhibit A and Exhibits D-G. For submission of the Medical Management proposal, you must include all answers to the Medical Management Questionnaire (Pages 32-36). There will be no required Exhibits to submit for the Medical Management piece, but you are required to submit client-specific pricing details in your own format. For submission of the Group Insured Medicare Advantage proposal, you must include all answers to the Medicare Advantage Questionnaire (Pages 37-48) as well as submit Exhibit H.

The proposed effective date for this account is January 1st, 2025.

Submission of Proposals:

Please provide one (1) electronic copy (via email) of your proposal response and completed Exhibits to:

AssuredPartners
Attention: Nicole Hoffstetter & Sharon Nixon
90 A John Muir Drive
Amherst, NY 14228
Nicole.Hoffstetter@assuredpartners.com
Sharon.Nixon@assuredpartners.com

The deadline for submitting proposals and all proposal attachments is 3:00 PM EST on Wednesday, May 29, 2024.

If you have any questions, please contact Nicole Hoffstetter at (716) 559-7079, Nicole.Hoffstetter@assuredpartners.com or Sharon Nixon at 716-810-8747, Sharon.Nixon@assuredpartners.com

If you will not be responding to this request, please notify Nicole Hoffstetter at (716) 559-7079, Nicole.Hoffstetter@assuredpartners.com or Sharon Nixon at 716-810-8747, Sharon.Nixon@assuredpartners.com

Timeline

Deliverable dates and proposed effective dates are as follows:

Target Date	Event	Party Responsible
05/08/2024	Bidders deadline to present questions. Firm.	Vendors
05/29/2024 by 3:00 PM EST	Full and complete proposal submitted by vendors to AssuredPartners.	Vendors
May/June 2024	Vendor proposal analysis presented to the Client.	AssuredPartners
May/June 2024	Finalist Presentations (finalists selected by the Client).	AssuredPartners / Vendor / The Client
May/June 2024	Announcement of Selected Vendor.	The Client
10/01/2024	Proposed Implementation.	AssuredPartners / Vendor / The Client
01/01/2025	New vendor(s) effective.	AssuredPartners / Vendor / The Client

II. Background

Incumbents

Medical Administration – Independent Health Association (IHA)

Medical Management Administration – Corporate Care Management (CCM)

Over Age 65 Retiree Medical and Prescription Drug Coverage – currently included in the self-funded health plan with IHA for medical administration and ProAct as the Pharmacy Benefit Manager; no current Group Insured Medicare Advantage plans in place

Objectives and Strategy

For medical benefits administration, the selected vendor must demonstrate a comprehensive provider network. By submitting a response to this proposal, it will be your firm's responsibility to provide timely data, claim and eligibility file feeds to a third-party data warehousing vendor, and reports, both standard and ad-hoc, upon request. Your firm must be able to interface with a third-party enrollment vendor. Additionally, plan management/medical management components such as wellness, disease management, wrap around network repricing, claim negotiation, subrogation and large case management may be carved out of your firm's administration.

For purposes of disease management, case management, stop loss and cost management, your firm will need to demonstrate its ability to integrate medical and pharmacy claims regardless of whether you are selected to administer one or all of these programs.

Cattaraugus County currently provides medical and prescription drug coverage to both under and over age 65 retirees. According to the terms of the collective bargaining agreements all retirees, regardless of age have the same medical and prescription drug benefit plan as the active employees. See *Exhibit B, Exhibit J and Exhibit I* for the medical and prescription drug benefits currently in place. Assume all Medicare eligible retirees are enrolled in Medicare Parts A and B.

The Client is seeking fully insured Group Medicare Advantage Plans that provides the same or greater benefits than what is currently being offered through the self-funded medical and prescription drug plans. The plan must provide access to providers both locally and nationally. The plan is looking for a two (2) year pricing commitment.

Please provide insured Group Medicare Advantage quotes for Medical only and a combined Medical/Prescription Drug plan. All plans must provide the same or greater benefits than what is currently in place, with a National PPO provider network.

The Client's goal is in developing a long-term strategy that incorporates plan management opportunities with access to the most appropriate and cost-effective provider networks.

Primary requirements to meet this goal:

- ◆ Provide a strategy incorporating network reimbursement/managed care capabilities into new or existing programs.
- ◆ If the client retains third-party vendors for any line of business (such as pharmacy, medical management, etc.), the chosen vendor must be able to integrate and share data with these third-party vendors.
- ◆ Deliver accurate, responsive and timely claims payment.
- ◆ Provide effective and accurate member services.
- ◆ Provide timely, standard reporting and data file feeds to Premier and/or subcontracted vendors to assist the client in managing its plan.

The Client is looking to select and implement a claims administrator with plan management capabilities for self-insured medical programs. It is not the Client's intent to implement more restrictive plan design features within their medical plans but to enhance the management of these programs through access to strong, quality-based networks. Therefore, this RFP will allow the Client to:

- ◆ Select an administrator with a well-developed provider network to ensure employee access to high quality care through network physicians, hospitals and providers.
- ◆ Maintain effective pre-admission certification, concurrent review and case management programs for all employees regardless of in or out-of-network access.
- ◆ Maintain freedom of choice for the employees to those providers best able to offer both the quality care and utilization controls necessary to meet benefits cost objectives.
- ◆ Maintain effective utilization management in all areas.

Selection Criteria

The vendor selected to provide the benefits specified will be required to provide competitive pricing. Key criteria in the vendor selection process are (*some of these criteria applies to the medical benefits administration piece only*):

1. Ability and willingness to deliver a pure pass-through arrangement with full and complete transparency where your revenue is exclusively in the form of an explicit administrative fee for both medical claims payment and administration. Where outside vendors are subcontracted for any services, please provide the fee based on hourly, percentage of savings or case rate. Please indicate administrator cost add-ons and explain how these additional costs are critical to plan administration.
2. Competitive and guaranteed financial terms including network access fees, discounts, pass-through revenue, etc.
3. Your delivery of the Client's binding contract that supports your proposal with no contradictions or omissions.
4. Your ability to integrate prescription drug data with medical claims data and/or other third-party data feeds to set the Client up for success using data-driven medical management, predictive modeling, plan design decision making, etc. This will include your ability to send

claims and eligibility files to the Consultant's data warehouse vendor on a weekly basis (if Client utilizes the Consultant's data warehouse).

5. If the client retains third-party vendors for any line of business (such as pharmacy, medical management, etc.), the chosen vendor must be able to integrate and share data with these third-party vendors. Any applicable fees should be noted in the Medical Administrative Quote (*Exhibit E*).
6. Ability to offer a large and comprehensive, seamless, national network of providers with competitive discounts.
7. Ability to demonstrate cost savings through claim management, network discounts, management of fees, efficacy of cost containment programs, etc.
8. Willingness to work with the Client's plan and eligibility auditors based on criteria established by the Client.
9. A complete response to this RFP in the requested format and with all requested attachments/exhibits.
10. Demonstrated performance of high-quality claim administration and customer service.
11. Willingness and ability to prospectively collaborate with the Client regarding development and implementation of new benefit plans.
12. Fully integrated platforms and systems. Ability to respond rapidly to information technology (IT) and system requests.
13. Complete Medical Performance Guarantees (*Exhibit A*).

Bid Specifications

1. In responding to each specification, indicate "Confirmed" or "Bid specification not met." If you indicate "Confirmed," you will be deemed to comply 100% with all aspects of the specification. If your proposal deviates in any way from the specifications, you must indicate "Bid specification not met" and provide full and complete details (see #2 below).
2. Failure to meet any bid specifications must be detailed in your response. After an analysis of proposals submitted in response to this RFP, the Client reserves the right to modify the requirements and terms of this RFP and request resubmission of some, or all, items from any initial bidders.
3. Your proposal shall remain valid through January 1st, 2025.
4. All aspects of the client's business to which you may have access as a result of this RFP are considered strictly confidential.

5. Nothing contained in this RFP creates, nor shall be construed to create, any contractual relationship between the Client and any vendor. The Client makes no commitment in or by virtue of this RFP to purchase any services or items from any vendor, nor does receipt of your proposal place the Client under obligation to enter into an agreement to purchase services from your organization.
6. Your proposal shall become the sole and exclusive property of the Client. The Client reserves the right to modify, reject, or use without limitation any or all of the ideas from the proposals. The Client will not disclose the pricing contained in any proposal to any party other than its attorneys, representatives, or the Consultant except as may be necessary to complete a blind analysis of responses provided to this RFP.
7. Vendors from whom proposals are solicited may not discuss this RFP with anyone outside their own organization other than the Consultant or the Client's authorized personnel. If your organization is awarded the account, you may not advertise or publish the fact that the Client has selected your company as their partner without written permission from the Client. You are not allowed to use the Client's name, trademark or any of its subsidiaries in any advertising or publication or other communication, other than in your proposal, without the prior written consent of an officer of the Client.
8. Expenses incurred in preparing and presenting a proposal to the Client is the sole responsibility of the vendor and may not be charged to the Client in any way. You must specifically agree that the Client shall have no responsibility or liability, whether in contract, tort or otherwise, for any loss, damage or liability for its actions in releasing this RFP, or rejecting, considering and choosing among the proposals.
9. Include with your response proposed contract, specific to the Client, which reflects your proposed pricing and terms.
10. You must agree to make available internal legal counsel with the authority to negotiate contract terms (on an unlimited basis) as needed to address any concerns or issues the Client may have with your proposed contract.
11. All claims and related data acquired as a result of any relationship with the Client will be deemed the property of the Client. You must agree to provide an electronic transfer of the Client data within 14 calendar days of any request by the Client. In the event of termination, the selected vendor will agree to provide all data and pertinent records required for program administration to the Client within thirty (30) days upon notification of termination. Data requested may include current eligibility information, full claim records detailing all claims transactions, prior authorization file for the previous twelve (12) months and case management notes and reporting at no additional cost to the Client.
12. Separate attachments which directly affect the quoted terms of your proposal are NOT permitted. A response to any specification, pricing assumption, underwriting caveat, or limitation on terms or quoted rates must be included where appropriate in your bid specification response.

Consultant Rights

The Consultant reserves the right to:

- ◆ Reject any proposal(s) received;
- ◆ Communicate or negotiate exclusively with one or more of the organizations invited to submit proposals;
- ◆ Request one or more of the quoting organizations to clarify its proposal, supply additional information, or expand upon its original submission;
- ◆ Enter into agreements or arrangements not specified herein;
- ◆ Base selection of the finalist(s) on factors such as adequacy of service personnel, claim adjudication services, cost management options, utilization review services, case management, reporting, IT capabilities and willingness to enter into a long-term relationship.

Completeness

Your proposal must be complete and comply with all specifications.

The following important factors should be emphasized in your proposal:

- ◆ Administration, claim processing and service;
- ◆ Managed care capabilities, including scope and quality of existing provider networks;
- ◆ Medical management programs and services (Utilization Management, Case Management, Disease Management);
- ◆ Administrative charges and retention;
- ◆ Availability of reporting capabilities;
- ◆ Compliance with specifications as presented;
- ◆ Ability to provide data file feeds/ downloads to subcontracted vendors on a weekly basis;
- ◆ On-line capabilities, including web tools, employer portal with reporting and an online benefit eligibility management and employee portal;
- ◆ Ability to accept a direct feed from enrollment vendor;
- ◆ Performance Guarantees.

III. Overview and Summary of Current Plans

Benefit Summaries

See *Exhibit B*.

Key Plan Requirements

- ◆ Fully review all plans presented;
- ◆ Identify all features of a plan that would require manual intervention or revision to be adjudicated by your claims system.

It is a requirement of this proposal to outline your firm's:

- ◆ Criteria used for claims denial;
- ◆ Appeal process; the selected vendor should be able to provide fiduciary responsibility for level two claims appeals;
- ◆ Services for outsourced claims appeals;
- ◆ Provide a sample Explanation Of Benefits (EOB), as well as sample messaging, such as participant advice, vendor directed inquiries, etc.;
- ◆ Dedicated service representative should be assigned to the Client for employer and member customer service and claims adjudication;
- ◆ Affordable Care Act (ACA)/Health Care Reform and other State or Federal compliance assistance;
- ◆ HIPAA compliance;
- ◆ Provide a sample member identification card;
- ◆ Bidding companies will be required to provide performance guarantees to the plan for specific member service, administration, claims adjudication services and accurate data file feeds performed on the Plan's behalf. See Medical Performance Guarantees, *Exhibit A*.
- ◆ Bidding companies are expected to provide toll-free access to claims and customer service personnel as follows:
 - 8:00 AM – 8:00 PM (Eastern Standard Time) Monday through Friday, and;
 - 24-hour provider access through voice response or member service is expected. Your proposal must address the provider service inquiry process you can provide on the plan's behalf.
- ◆ Provide employee communication materials for implementation of new administrator process and open enrollment meetings. Support client with employee communication materials for new plans or programs.
- ◆ Summary Benefit Comparisons (SBCs) must be created and provided for Open Enrollment.

Bidding company must outline:

- ◆ Vendor's contractual position on "simple negligence" vs. "gross negligence";
- ◆ Vendor's contractual position on indemnification.

Managed Care Requirements

All programs should keep the following requirement in mind:

- ◆ Provide a detailed and complete description of the provider networks in existence at all employee locations.
- ◆ Provide specific information regarding the number and types of specialists available in your networks. Mental Health and Chemical Dependency providers must be included in the network offer to employees. This is an important consideration, so please include an analysis of the availability and accessibility of network physicians. A record of current member population by zip code is shown in *Exhibit C*.
- ◆ The Client may request that your company recruit ADDITIONAL physicians in certain specialties at major locations in response to employee request. The network must allow for this;
 - Your proposal must explain how your network(s) will accommodate these requests. Include an explanation of your process and criteria for action and decision;
- ◆ Your firm must be able to provide an annual analysis of each network's performance. Please include an explanation of your ability to add or change provider networks at the Client's request.
- ◆ Provide pre-certification reporting and case management reporting on a monthly basis and upon request as needed by the stop-loss carrier, if applicable.

IV. Specifications

Contract Anniversary Date

The contract anniversary date is January 1st, 2025.

Guaranteed Rate/Fee/Conditions

Guarantee all rates/fees for one (1) year from the plan's effective date. You can also provide rate/fee guarantees with two (2) and three (3) year options.

Notice

We request a minimum of one hundred twenty (120) day notice for any rate/fee change for renewal.

Cancellation Provisions

After the first year's contract period, the Client reserves the right to terminate its contract without cause, provided such notification is given at least sixty (60) days in advance.

Rights and Access to Records

All claim records, eligibility data and associated files used by the carrier in its role, as claim administrator shall remain the property of the Client as Plan Sponsor and Plan Administrator.

Transfer of Records at Future Cancellation

The claims administrator must agree to transfer to the client, within thirty (30) days of notice of termination, all required data and records necessary to administer the plans. The transfer may be made electronically, based on the mutual agreement between the Client and the administrator.

Audit and Access Rights

It will be the right of the Client or its representative(s) to review and audit claims and administrative charges under the contract if awarded.

Designated Account Manager

Please provide information about the team that will provide service to the Client.

Printing

When printing is required (example: SPD, ID Cards, etc.), you must present a complete draft and subsequent proof to the Client for sign-off. The Client will not pay for any printed materials not specifically approved in writing.

V. Information Sheets

Instructions

The following section will detail basic information regarding your organization.

Please answer each question clearly and completely. Responses should be concise and to the point. When responding, please state the question asked and then respond directly.

Please do not refer us to other source documentation. You are welcome to provide marketing materials; however, these materials should be used as support for a question and not as the response itself.

If you are unable to answer a part of this information request, please indicate why you cannot. If you are unwilling to disclose particular information requested please indicate your reasons.

If there is additional relevant information or documentation which you feel would aid the Client in the selection process, please provide that information separately and note specific page number references where appropriate.

Background

1. Please provide a brief description of your organization.
2. Please provide an address for the locations below:
 - Corporate headquarters;
 - Ownership (Provide current description of any significant merger/acquisition activity and the impact there might be on service provided to the Client);
 - Local service office;
 - Claims office;
 - Customer service office.
3. Provide a list of services and products offered by your organization. For purposes of this proposal, provide:
 - Full name of primary contact;
 - Work address of primary contact;
 - Primary contact phone number;
 - Primary contact fax number;
 - Primary contact email address.
4. Have there been or are there pending legal actions against your firm in the past three (3) year period which may have a negative impact on the structure or financial stability of your organization? If yes, state the action and the possible impact to your operation and to this employer if a client.

5. How long has your present claims adjudication system been in place? What was the last date of major change or enhancement to the system? What advantages does your claims system provide to a self-funded or a high-deductible health plan?

Financial Protection

Indicate Coverage Carried		
Malpractice Liability*	\$	
Professional Liability*	\$	
Errors & Omissions*	\$	
Umbrella Coverage*	\$	

**List covered parties for each and applicable coverage per entity (physicians, specialists, review organizations, employers, etc.)*

References

For Medical Benefits Administration/Medical Management Administration - Please provide the client name, address, telephone number, email address and contact name for five (5) clients for whom you have administered self-funded medical programs. Of the (5) clients, please provide at least three (3) references from self-insured clients within the past twenty-four (24) months.

For Group Fully Insured Medicare Advantage Programs – Please provide the client name, address, telephone number, email address and contact name for (3) clients for whom you have successfully transitioned over age 65, Medicare eligible retirees to a fully insured group Medicare Advantage Plan(s) that provides national coverage.

For Medical Management Administration - Please provide the client name, address, telephone number, email address and contact name for three (3) clients for whom you have administered medical management programs. Of the (3) clients, please provide at least two (2) that fall within the past twenty-four (24) months.

VI. Medical Benefits Administration Agreements and Questionnaire
(not applicable if only submitting insured Group Medicare Advantage Administration and/or Medical Management Administration piece(s))

As the vendor for the Client's program, you will be required to provide at least the following services under your full-service administration quotation. Your proposal should include these services, and appropriate pricing should be assumed in your response. In the event that you are unable to comply with one of the services requested, please specifically note that fact in your response.

The Claims Administrator agrees to provide an accurate claims data feed to a third-party claims and eligibility warehouse. If data is incorrect or missing, the Claims Administrator will be required to provide, correct, or replace the data within two (2) weeks of notification by the Plan or its designee. See *Exhibit D* for claims data field requirements.

Complete *Exhibit E*, Medical Administrative Quote, acknowledging any additional charges and the charge amounts. Note: *The County may consider removing the over age 65 retiree population from the self-funded health plan and implementing an insured Medicare Advantage PPO. It is important that you provide pricing based on the current enrollment for the self-funded plan that includes all actives and retirees as well as for plan with the over age 65 retiree population removed from the self-funded health plan.*

Summary of Vendor Services

General account management services including the following:

- ◆ On-line enrollment capability (with an independent vendor);
- ◆ Direct claim verification of eligibility;
- ◆ Direct claims submission;
- ◆ Claim adjudication;
- ◆ HCRA Filing
- ◆ Customer Services (employer, provider or participant inquiries);
- ◆ Medical Management services and reports;
- ◆ Annual financial accounting reports;
- ◆ Banking transfer, reporting and reconciliation services;
- ◆ Implementation;
- ◆ Communication services;
- ◆ Underwriting and actuarial services, including the following:
 - Development of Costs/Benefits Analysis for existing as well as alternative Plan Designs (Example: Point of Service (POS) Program);
- ◆ Renewal services;
- ◆ Regulatory compliance services;
- ◆ Managed Network Services (to include adjudication of non-network claims);
- ◆ Utilization Review Services/Large Case Management
- ◆ Disease Management/Wellness Plans and reporting;
- ◆ Fiduciary responsibility for second level appeals;
- ◆ Network access; primary and wrap-around;

- ◆ Subrogation;
- ◆ Vision;
- ◆ SPD and SBC production, printing, distribution and updates;
- ◆ COBRA/HIPAA Administration;
- ◆ Stop loss reporting;
- ◆ Ad-hoc reporting;
- ◆ Download of data files to external vendors.

Claim Adjudication

The Client will update eligible employees and dependents on a monthly basis. You will certify eligibility, with benefit payments being sent directly to the provider and/or employee, as appropriate. Your claim administration services must include:

- ◆ A dedicated claims supervisor (team leader) that will be assigned to the Client's account;
- ◆ Receipt and maintenance of historical claim data and eligibility rosters (paper, electronic or tape) from the current vendor. Liaison with the current vendor as needed. Eligibility will be updated as required;
- ◆ All necessary forms, claim forms, EOBs and checks, etc., claim forms and ID cards *may* need to be printed with the company logo;
- ◆ ID cards (when applicable) to include pharmacy vendor information, even though pharmacy administration may not be provided by your company;
- ◆ Appropriate EOB, paid or denied. If a network discount is applied, the EOB must reference the patient is not responsible for the amount of the negotiated contract discount;
- ◆ Printed instructions for completing any necessary forms as well as a description of whatever documentation must accompany the claim for processing. Initially, claim kits may be provided;
- ◆ Review, adjudication, processing and payment of all claims including folding, stuffing, addressing (including postage) of all drafts, EOBs, and forms;
- ◆ "Clean claims" must be processed within ten (10) business days of receipt;
- ◆ A toll-free arrangement for employee and provider use in obtaining the following service:
 - Proper administration of all Coordination of Benefits (COB), non-duplication, no fault and other subrogation provisions;
 - Contact and communication with claimants and providers as required resolving problems or responding to questions. Provider "flagging" should be initiated when required due to ongoing submission of questionable claims.
- ◆ Claim investigation and analysis prior to payment. Outline your process and suspense procedure with regard to questionable claims, incomplete claims, or in an instance where a fee or charge is in excess of your reasonable and customary profile;
- ◆ Auditing, upon request, of medical claims in excess of \$25,000;
- ◆ Performance of this important portion of your services will be subject to guarantees based upon the employees' satisfaction and adherence to plan guidelines.

Customer Service

Timely and accurate claim service and responsiveness to employee inquiries are important factors. Customer service capacities and guarantees will play an important role in the Client's decision. Customer service expectations include:

- ◆ Dedicated customer service supervisor will be assigned to the Client;
- ◆ Dedicated customer service personnel will have easy access to claims processing personnel for information;
- ◆ Indicate how services will be subject to guarantees based upon timeliness, employee satisfaction and accuracy performance.

Management Reports

To provide a proper accounting for the ongoing and/or monthly management of the Plan, you must be able to provide the reports listed. Detailed quantitative analysis of a paid claims history package must include a claim breakdown of hospital utilization and major diagnostic category data. It is required that monthly or quarterly reports be available within thirty one (31) days following the end of that period. The reports generated must be able to reflect experience by line of coverage, split between the Plan, its operating units, employees, dependents and COBRA participants plus a total for all activity.

Describe and include samples of all management reports included within the quoted administrative expense. Include examples of the reporting package. Required management reports within your quoted administration fee include:

- ◆ Full population report (quarterly);
- ◆ Claims transaction report (weekly with a monthly summary);
- ◆ Detailed analysis of paid claim history by month (report package must include a claim breakdown by plan; location/branch and employee/dependent categories);
- ◆ General claim utilization report identifying claims submitted, claims eligible, deductible, coinsurance assessments, R&C cutbacks, COB applications, network/non-network expenses and savings by type of service and major procedure category every six (6) months;
- ◆ Monthly claim summary for active/COBRA population broken out by employee and dependent categories;
- ◆ Monthly network/non-network expense and savings report in addition to the six (6) month report;
- ◆ Claims turnaround/audit performance report;
- ◆ Customer service performance report;
- ◆ Claims denial/suspended report with explanation;
- ◆ Claims lag report for medical (monthly);
- ◆ Annual Incurred but Not Reported (IBNR) calculation/report to be provided prior to January 1st of each plan year;
- ◆ Utilization reports depicting activity (quarterly). Also quarterly Utilization Review (UR) reports must be available showing age, sex and case mix adjustments;

- ◆ Identify your firm’s capacity to produce reports to measure the experience in the following categories:
 - Plan experience against similar plan designs on a national, regional or local level;
 - Average length of stay;
 - Average cost per hospital stay;
 - Number of claims paid and number of transactions;
 - Information by diagnostic related group;
 - Information by specific physician provider and hospital provider;
 - Information by line of coverage.
- ◆ Effectiveness of your managed care program including:
 - Savings from utilization management;
 - Savings from individual case management.
- ◆ Describe and provide samples of utilization and savings reports you are able to provide. With what frequency are these reports provided? What ad-hoc reporting capabilities are available for medical management?
- ◆ Ad-hoc reports for all claims and eligibility data (outline the process, time and cost associated with the development of ad-hoc reports.) Provide samples of capacities.
- ◆ Benchmarking report providing the Client’s data compared to regional or national benchmarks.

File Download to External Vendors

Describe capabilities to provide file feeds for eligibility and claims data as required to facilitate externally administered plan management services, including data warehousing of claims, integration with a third-party enrollment system as well as integration with a third-party case management and case utilization vendor, pharmacy and/or wellness. Specify in pricing proposal if there are any additional charges, including but not limited to, integration, data transfers and sharing clinical information.

Annual Financial Accounting Reports

It is required that you provide a year-end financial accounting for the Client’s program within three (3) months of the end of the plan year. This report must also provide a full disclosure of administrative costs, NYS Public Goods Pool Report, any ACA fees and other annual financial supportive data.

Implementation

If you are awarded this program, it will be your responsibility to:

- ◆ Produce a detailed implementation calendar identifying dates, types of information required and responsibilities. Assume that you will be notified of vendor/administrator selection prior to May 29th, 2024 for a plan effective date of January 1st, 2025. Detail both pre-implementation and post-implementation strategies;

- ◆ Receive initial eligibility data and updates. The bidding company is required to audit the weekly in force census and reconcile discrepancies in the claim system eligibility record. Termination notices will be provided by the Client.
- ◆ Describe approach to administrating prior administrator's run-out claims;
- ◆ Prepare, submit for approval, and print employee identification cards, which will be distributed to covered employees and their eligible dependents;
- ◆ Print claim forms that will be used by plan participants for the submission of claims for out-of-network plans;
- ◆ Review all plans, draft plan abstracts, and confirm plan provisions;
- ◆ Demonstrate tested benefit file for all plan designs;
- ◆ Provide all reasonable assistance as may be requested during the transition period, including participation at employee meetings.

Note: You will be responsible for drafting, printing and distributing required enrollment cards and related forms, ID cards, claim forms, claim instructive materials, claim envelopes and claim kits, SPDs and SBCs.

Legal Services

The carrier must administer applicable legal services, including:

- ◆ Preparing and filing all legal documents necessary to implement and maintain the plan, including policies, amendments, contracts and required state filings including HCRA filings;
- ◆ Necessary legal defense in the event of litigation, involving a managed care network and its providers and/or utilization review services;
- ◆ Monitoring federal and state legislation affecting the plans; and
- ◆ Preparing annual Schedule C forms as well as 5500 information, if applicable.

Managed Care Network and Utilization Review

The carrier is expected to maintain required managed care network and utilization review services for the Plan. Utilization review services including hospital pre-certification, concurrent review, discharge planning, second surgical opinions and individual case management should be quoted as a monthly rate per employee to be included in the rate exhibit (carefully review the sections of this RFP which address Preferred Provider, Utilization Review/Claim Management and Managed Prescription Drug services).

Ongoing Services

- ◆ Describe your approach to account management, including scheduled meetings;
- ◆ Describe the renewal process, including establishing new premium rates, claim projections and estimation of an appropriate level for IBNR claim reserves.

Customer Service, Claims Administration and Enrollment

1. Please provide the number of clients to which you provide claims processing and customer service.

2. What services or features pertinent to medical claims administration make your company unique from other administrators?
3. Describe the flexibility of your claims system to deliver non-standard benefits designs and high deductible health-plans.
4. How will your customer service team be trained to assist members during the transition process?
5. What support do you provide to the client to manage eligibility and other administrative tasks?
6. Do you have any clients that contracted with your company in the last two (2) years that experienced a significant decrease in overall cost/claims payments (exclusive of first year claims lag)? Explain.
7. How do members communicate with customer service?
8. Are there on-site Member Service Representatives available 24/7/365? If not, can a member email member service? What is the response time for emailed questions? Do you provide live on-line help for customer service?
9. What percentage of calls are recorded?
10. Is an automated voice system available for routine questions?
11. Can you provide ID Cards within forty eight (48) hours of request?
12. Can you provide ID card with the Client's logo?
13. If prescription drug services, medical management and/or wellness are administered by another vendor, can one client ID card be generated for both medical and prescription drug?
14. What are your hours of operation for the Client/Employer service?
15. Describe the qualifications and training of your customer service staff:
 - What is the average length of employment for member service representatives?
 - What are your turn-around statistics of other operations staff (for example, claims, enrollment, employer service)?
16. Is your firm willing to provide claims administration services only and appropriate download of files for outsourcing other services? This would include outsourced plan management (including utilization management), second level appeals, claims cost negotiation, wrap network for out-of-

network claims and subrogation. Please quote a cost for this type of administration.

17. Describe the qualifications and training of your claims processors, member services and enrollment staff?
18. What tools are available to ensure that your Customer Service Representatives are providing accurate information, specifically, for self-funded plans, such as the different responses required for an ERISA plan vs. a non-ERISA plan?
19. What member education materials do you provide either through mail or on-line? Please provide samples.
20. How many customer service representatives are employed by your company who are dedicated to self-funding?
21. How many claims processors are employed by your company who are dedicated to self-funding?
22. Does your member services department have access to claims, medical management, network or enrollment representatives as necessary to clarify benefits or to answer group/member specific questions?
23. What quality and performance criteria are used to audit operations staff (claims, service, enrollment)?
24. Can client specific reports with outcomes for claims, service and eligibility specific quality audits be provided?
25. Describe the outcomes of your audit program.
26. What is your claim processing turn-around time?
27. What is the claim processing accuracy?
28. Do you have a Primary Care Physician (PCP) capitation program? If so, please explain how this program works and if it applies to self-insured entities. Please also describe how it is billed.
29. Can you provide a customized client EOB to include Client's plan name, logo, special remarks and notifications?
30. What type of standard monthly reports do you offer? What formats are they in? Please include sample copies. What other type of reports are available at no cost to the Client?
31. What types of ad-hoc or special-request reports have you been requested to provide for other clients? Are reports available on-line? Is there a cost?

32. Confirm your acceptance of a minimum of four (4) annual meetings between the account executive or the designated service representative and the Client.
33. Do you provide COBRA/HIPAA administration services?
34. Describe your audit program specific to COBRA/HIPAA administration. What are the outcomes of this program?
35. Will you provide client access to your eligibility system for the purposes of changing, deleting or adding a member? What training is provided to the client to access this service? Is there an extra fee for this?
36. Describe your HIPAA privacy/security policies and procedures regarding claims, service and enrollment.
37. Describe the interface between representatives from member and employer services.
38. How do you confirm that all benefit plans and group information loaded in your system is correct, and how is this demonstrated or presented to the Client? Please describe the audit process for the plan specific benefits and information implemented on the plan's original effective date, and how this is incorporated into your implementation plan and demonstrated to the client.
39. Please provide a sample implementation plan that incorporates timelines and details specific to all operational and service areas.

Network Services

1. Name of all proposed networks for Cattaraugus County.
2. Address of proposed networks for Cattaraugus County.
3. Date (month/year) of proposed networks operation in each state (use all states as listed on the census provided that a member resides in, *Exhibit C*) applicable to this proposal.
4. Do you own any of networks proposed? If not, please state which networks are partially owned or rented. Provide the percentage of ownership represented for each.
5. Have there been or are there pending legal actions against any of the networks and/or your firm's owned network in the past three (3) year period which may have a negative impact on the structure or financial stability of the network? If yes, state the action and the possible impact to your operation and to this network.

6. Describe your process for calculating Reasonable and Customary (“R&C”) charges and what database is being utilized. Describe how frequently your schedules are updated and how rates vary geographically. What percentile is used for R&C?
7. What software do you use to price DRGs? What version is your software?
8. What version of the DRG Grouper do you use to determine a DRG calculation? Please provide a link to the DRG Grouper source that is used.
9. Complete the Medical Provider Disruption (*Exhibit F*). Entire completion of the spreadsheet is required to be considered.
10. For out-of-network claims, are reimbursements calculated using a percent of savings or do you have other contractual arrangements that are used?
11. Indicate fees for both local and national PPO access.
12. Describe your process for terminating a physician from your network and for adding physicians to your network.
13. Describe your communication process to members when a doctor is terminated/resigns.
14. Geo-Access Report. Please prepare a “Geo-Access” report using the enclosed (*Exhibit C*) census data. The report should show provider availability for participating physicians and specialists (for specialists, at *minimum* use PCP’s, OB/GYN’s, Pediatricians and Hospitals) within a 15-mile radius. Please also provide information on those zip codes where the access standard is not met.
15. Please answer the following:
 - Number participating in-network;
 - Number of practicing participating physicians in the market (based on the census provided, *Exhibit C*);
 - Number of participating physicians accepting new patients (based on the census provided, *Exhibit C*);
 - Participating physicians’ average percent discount (while states and categories can each be different we are looking for you to add them all up and divide to provide us an average; if you want to break the averages out per category, that would be acceptable as well);
 - Number of specialists by type in-network (we are looking for as many specialties as you can provide – to include the categories of specialties listed in question #16 above as well as specialties like cardiologists, pulmonologists, etc.; we are looking for these in-network, in area, based on the census provided, *Exhibit C*);

- Type of Reimbursement:
 - What percentage (%) of in-network providers are paid with a fee schedule vs. a percent (%) of charges?
 - What percentage (%) of hospitals are paid with a fee schedule vs. a DRG/Per-Diem?
 - Provide an overall discount percentage for all services by each network;
 - Please attach a copy of your provider directory for each network or a website for provider look up.
16. What national wrap-around/travel network(s) are available to members? Are there additional access fees for these networks? Indicate your ability to implement an alternative national network to those you currently use.
17. Complete *Exhibit E*, Medical Administrative Quote, acknowledging any additional charges not listed and the charge amounts under “Additional Fees”. Please fill out *Exhibit E* as is – using the provided form. If vendor desires to submit proposed pricing in their house format, please submit in addition to a filled out *Exhibit E*.
18. Complete Medical Pricing Attestation (*Exhibit G*).

Data Integration

1. Will you allow an external Medical Management vendor? If so, will this external vendor have access to claims information, and how would they receive this information from you? Any additional costs for integration, data transfers and sharing clinical information must be included in your pricing proposal.
2. What formats do you accept for eligibility updates? How will these updates be confirmed?
3. How frequently is eligibility updated?
4. Are you able to accept and apply daily transmissions of group and member eligibility data from the client at no cost?
5. Is all data transmitted to and from your firm HIPAA compliant for all aspects of privacy and security requirements?
6. How do you identify high-cost claimants? Describe interface among claims, medical management and stop loss for these claimants.
7. How do you identify duplicate claims?
8. Do you track high cost claimants or potential high claimants through integration of medical and prescription claims? Explain this process.

9. Please describe your ability to integrate third-party data (pharmacy, medical management and/or wellness) into your medical management member out-of-pocket maximum and deductible accumulators as well as any fees that may apply to the below scenarios:
 - Medical, Pharmacy, Medical Management and/or Wellness with the same carrier
 - Medical and/or Pharmacy, Medical Management and/or Wellness with separate carriers

10. *Exhibit D* shows the current field specifications that are required for medical and eligibility data integration with the Consultant’s third-party vendor. Please confirm, using the empty column, Column C, in *Exhibit D*, which fields can be met (including the optional fields). If a field cannot be met, please explain why.

Privacy and Security

1. Describe your policies regarding HIPAA privacy and security.
2. How do you ensure that subcontractors comply with these policies?
3. Do you use cloud-based applications?
4. Will you provide a copy of your SSAE 16?

Internet Capabilities

1. Do you have a customer service website?
2. Does your website include access to online benefits and SPDs?
3. Does your website provide provider directories online?
4. What is the frequency of online updates?
5. Is Internet access to member services available?
6. Which services are available on the Internet for the employer/members?

Employer/Employee Internet Services	Check all that apply
Check eligibility	
Claim status	
Order ID cards	
Order provider directories	
View provider directories	

Schedule appointments	
Interactive Wellness	
Other	

7. Which services are available on the Internet for the provider?

Provider Internet Services	Check all that apply
Check eligibility	
Claim status	
Schedule referrals	
Other	

8. Upon approval by client, may the consultant have access to the Employee Reporting? How would this be accessed?
9. Do you have on-line enrollment capabilities (i.e. changes, adds, deletes)? Please describe any fees associated for this service, such as for multiple users, eligibility download, multiple offerings (i.e. LTD, Life, etc.). Please provide a demo website to view. Are there capabilities to have on-line access to run reports, etc. for the Client's personnel?
10. If you have employer online enrollment capabilities, can this site be used to provide eligibility to other service vendors (i.e. life, prescription drug, etc.)?
11. Do you have an FTP site to send and receive data?
12. Can your firm provide us with both pre-paid and post-paid claims data?

Stop Loss

1. Explain your internal/cross departmental stop loss communication process.
2. What is your method of communication if a member exceeds their specific deductible?
3. Who do you notify when a member has exceeded their specific deductible?
4. Provide copies of your stop loss reporting package. Include:
 - o Trigger reports
 - o 50% Reports
 - o High Cost Claimant Reports to include prognosis, diagnosis and case notes
5. What is the frequency of your stop loss reporting?

VIII. Medical Management Administration Agreements and Questionnaire
(not applicable if only submitting Medical Administration and/or Medicare Advantage Administration piece(s))

As the vendor for the Client's program, you will be required to provide at least the following services under medical management administration quotation. Your proposal should include these services, and appropriate pricing should be assumed in your response. In the event that you are unable to comply with one of the services requested, please specifically note that fact in your response.

Summary of Vendor Services

General account management services including the following:

- ◆ Customer Services (employer, provider or participant inquiries)
- ◆ Medical Management services and reports
- ◆ Implementation
- ◆ Communication services
- ◆ Renewal services
- ◆ Compliance services (if applicable to Medical Management)
- ◆ Utilization Review Services/Large Case Management
- ◆ Disease Management/Wellness Plans and reporting
- ◆ Appeals

Customer Service

Timely and accurate service and responsiveness to employee inquiries are important factors. Customer service capacities and guarantees will play an important role in the Client's decision. Customer service expectations include:

- ◆ Dedicated customer service supervisor will be assigned to the Client;
- ◆ Indicate how services will be subject to guarantees based upon timeliness, employee satisfaction and accuracy performance.

Implementation

If you are awarded this program, it will be your responsibility to:

- ◆ Produce a detailed implementation calendar identifying dates, types of information required and responsibilities. Assume that you will be notified of vendor/administrator selection prior to October 1, 2024 for a plan effective date of January 1st, 2025. Detail both pre-implementation and post-implementation strategies;
- ◆ Receive initial eligibility data and updates.
- ◆ Prepare, submit for approval, and provide debit cards (if applicable), which will be distributed to covered employees and their eligible dependents;
- ◆ Review all plans and confirm plan provisions;

- ◆ Provide all reasonable assistance as may be requested during the transition period, including participation at employee meetings.

Legal Services

The carrier must administer applicable legal services, including:

- ◆ Preparing and filing all legal documents necessary to implement and maintain the plan, including policies, amendments, contracts and required state filings (if applicable)
- ◆ Necessary legal defense in the event of litigation, involving a managed care network and its providers and/or utilization review services;
- ◆ Monitoring federal and state legislation affecting the plans.

Managed Care Network and Utilization Review

The carrier is expected to maintain required managed care network and utilization review services for the Plan. Utilization review services including hospital pre-certification, concurrent review, discharge planning, second surgical opinions and individual case management should be quoted as a monthly rate per employee to be included in the rate exhibit (carefully review the sections of this RFP which address Preferred Provider, Utilization Review/Claim Management and Managed Prescription Drug services).

Ongoing Services

- ◆ Describe your approach to account management, including scheduled meetings;
- ◆ Describe the renewal process, including establishing new premium rates, claim projections and estimation of an appropriate level for IBNR claim reserves.

Precertification

1. Describe hospital pre-certification procedures and requirements of how emergency admissions after normal business hours are handled.
2. Can Cattaraugus County or its designated representative receive a monthly precertification report?

Concurrent Review

1. How do you determine the appropriateness and level of care for ongoing stays in a hospital or health care facility?

Retrospective Review

1. Describe your process for providing hospital bill audits and retrospective stay reviews.

Disease Management

1. Please indicate the Disease Management Programs you currently have in place, stating the disease and type of program. Are outcome data reports available? If yes, how often and please provide program highlights, sample reporting and any correspondence. How do you educate/notify members about this program?
2. How is an employer's plan performance benchmarked for Disease Management? Do you benchmark against your whole book of business? Against national data? Both?
3. Provide outcome reports of Disease Management once a member has been identified. How is this information managed to ensure the best options are communicated to the patient?

Case Management

1. What are your criteria to identify members who should be in Case Management, focusing on potential stop loss cases and high dollar claims diagnoses?
2. If you are proposing a combined medical and prescription drug program, specifically point out the value of the integrated medical/Rx program and how it impacts programs such as channel management, case management and disease management.
3. If you are not providing medical and prescription drug claims administration, how are you working with the claims administrator(s) to ensure that you receive timely, complete and accurate data?
4. Once a member has been identified as a candidate for Case Management, describe your process.
5. Provide an explanation of your reporting for Case Management. Provide sample reports and frequency of those reports.
6. Provide an explanation of how you integrate Case Management and Disease Management.
7. What is your policy and process for patients who refuse Case Management?
8. Describe your procedure for a member who is a potential transplant candidate.
9. How do you bill for Utilization Management/Case Management services? How do you differentiate between level I and level II case management? Do you bill separately for medical director review? Please clarify all services included in any separate charges.
10. Describe your medical management process, including peer review procedures and the appeals process.

Interface and Coordination with Client and Vendors

1. Describe your procedures for coordinating with Cattaraugus County's consultant, stop loss provider, PBM and other vendors.
2. How is data and reporting facilitated with the stop loss vendor?
3. Are you able to receive and send data to/from the medical and/or PBM and other vendors on a real time or daily basis?

Reporting

1. Identify your firm's capacity to produce reports to measure the experience in the following categories:
 - Average length of stay
 - Average cost per hospital stay
 - Information by diagnostic related group
 - Information by specific physician provider and hospital provider
 - Effectiveness of your managed care program including:
 - Savings from utilization management
 - Savings from individual case management
2. Describe and provide samples of utilization and savings reports you can provide. With what frequency are these reports provided? What ad-hoc reporting capabilities are available for medical management?

Other

1. Is your medical Utilization Review Department accredited? If so, with what accrediting agency?
2. Outline staffing and their credentials; include the medical director in your staffing model. For example, number of Registered Nurses, number of Licensed Nurse Practitioners, number of non-professionals.
3. What differentiates your self-funded case management department?
4. Please describe any additional managed care or cost management features you provide.

Pricing

1. Include with your response a client-specific contract which reflects your proposed pricing and terms.

VII. Group Insured Medicare Advantage Agreements and Questionnaire
(not applicable if only submitting Medical Administration and/or Medical Management Administration piece(s))

The client is seeking proposals for a Group Insured Medicare Advantage proposal for both Medical only coverage as well as combined Medical/Prescription Drug coverage. Please provide a two-year pricing commitment.

The carrier must have in-depth knowledge and expertise in providing fully insured medical, prescription drug, mental health and disease/case management for Cattaraugus County eligible retired members, age 65 and older, currently covered by the self-funded health plan. The fully insured Group Medicare Advantage Plan must be able to provide participating network providers on a national basis and duplicate or enhance the current benefit design.

Complete *Exhibit H*, Group Medicare Advantage Administrative Quote, acknowledging any additional charges and the charge amounts.

General Information

1. What is your organization's legal name and current ownership status?
2. In what state are you incorporated or registered?
3. Have there been (in the past 24 months) any substantial changes (platform changes, merger/acquisition, divestiture, reorganization) in your organization? If yes, please explain.
4. What accreditations are held by your organization or are you pursuing (NCQA, URAC etc.)?
5. If your company proposes to use subcontractors in the delivery of services to the client please list each and describe the services provided.

Industry Experience

1. Describe your organization's experience offering Medicare products. Include a brief history of key developments in your Medicare plan offerings.
2. Please outline the key differentiators your organization has over competitors for providing group Medicare Advantage products to employers.
3. How long has your organization offered Medicare Advantage plans? How many group contracts do you have nationally?
4. What was your organization's average annual Medicare Advantage membership in the last 3 years?
 - 1) Group and Individual MA Products
 - 2) Group MA Products only

5. Have you lost any significant group Medicare Advantage clients in the last two years? If so, what was the business reason?
6. What percentage of your total group Medicare Advantage membership has renewed for the next plan year?

Organizational Background

1. Please provide a statement and/or business plan discussing your organization’s commitment to Medicare Advantage Products.
2. How does your organization view the future stability of premiums for the Medicare Advantage products?
3. In the past three years, has your company filed any form of bankruptcy proceeding? If so, please describe?
4. Has your company undergone any major organizational changes over the past 5 years? If so, please describe?

Member Service

1. Describe how you provide member services for group MA plans. How does your group MA member services function differ from your individual MA member services function?
2. Describe how your organization’s customer service staff are trained to meet the needs of the Medicare population and how your technology, policies, and procedures are specifically designed to meet those needs?
3. For the office that will handle client’s account, please provide the following service statistics:

	Standard	2023 Actual
■ Telephone average speed of answer		
■ Percentage of calls abandoned		
■ Average waiting time		
■ Average call time		
■ Average time for problem resolution from initial notification		
■ Percentage of problems resolved during first call/contact (member does not need to call back)		

4. For the customer service center that will support the client's Medicare Advantage members?
 - a) What are the days and hours of operation?
 - b) How are after-hours calls handled?
 - c) What specialized services are available to retirees who are hearing impaired?
 - d) Are Spanish-speaking representative available?
5. Will the client receive a dedicated or designated customer service team to the retiree experience?
6. What resources do you provide to members to guide them through aging into Medicare?
7. How will your team handle the initial high call/activity volume expected, specifically:
 - a) At vendor announcement leading up to annual enrollment
 - b) During annual enrollment
8. Describe the customer service escalation process, including the process for manager call-backs to members.
9. Are any customer service functions performed offshore?
10. What percent of calls to member services are recorded? How long are the recordings retained?
11. How would you monitor the quality of customer service provided to the client's retirees?
12. How frequently are customer service audits conducted?
13. Can customer service representatives accept and make warm transfers to a third-party vendor, such as the client's PBM, plan and eligibility administrator?
14. Describe how your customer service representatives help the retiree navigate the Medicare Advantage plan (e.g. choose in-network providers, avoid balance billing, etc.)
15. How will you assist the client retirees transferring to a Medicare Advantage plan determine whether their physician is in the National Medicare Advantage PPO network and accepts Medicare assignment?
16. Confirm that you will call providers on behalf of participants to resolve issues such as coding and billing errors.
17. Can your organization offer member advocacy services to the client's retirees?
18. How does employee feedback influence process improvement at your organization?

19. How do you measure members' satisfaction? How often is data collected? How is this information shared with providers, employers, and/or members as appropriate?

Member Tools

1. Please describe any online tools available to retirees.
2. Provide a sample login to view your online provider directory and member portal.
3. What changes do you expect to make to your website in the next 12-36 months? How will they affect the client members?
4. What is your website maintenance schedule and how does it affect members' access to the site?
5. What mobile apps are available to your Group Medicare Advantage members?
6. What privacy controls are in place to ensure the confidentiality of on-line claims information?
7. How long is an individual claimant's payment history maintained on-line?
8. Confirm that members will have electronic EOB 'print on demand' capability from your website.

Claims Processing/Administration

1. Where will claim processing be handled?
2. Please provide claim adjudication statistics for the proposed claim office in the table below.

	Standard	2024 Actual
■ Financial accuracy (percent of claims paid correctly)		
■ Overall accuracy		
■ Turnaround time in 14 calendar days (% of all claims processed within 14 days)		
■ Turnaround time in 28 calendar days (% of all claims processed within 28 days)		

3. What percent of overall claims are auto adjudicated?
4. When was the last major upgrade of your claim processing system?

5. Are there any upgrades to your claim processing system planned for the next 24 months? If so, please explain.

6. Briefly describe your company's approach to providing comprehensive claim management services to provide the expeditious delivery of benefits.

Health Management

1. Do your Medicare Advantage plan offerings include any additional benefits outside of the medical plan such as gym memberships, fitness programs, routine hearing, vision, dental, other discounts, etc.? Please provide a list and description of additional benefits included.

2. What tools are provided to participants to encourage interaction with their physician?

3. Please describe the top three initiatives your company has implemented in the past 2 years to improve quality and outcomes of patient care.

4. Please provide your protocol and criteria for identifying members who should be included in your care management program.

5. Please provide examples of your efforts to educate members and providers on your care management programs.

6. Please provide any outcomes tracked from care management services, including member satisfaction.

7. Please describe your plan's efforts to support providers with tools and information needed to better manage their patient's health, including your efforts to measure providers' satisfaction with your health plans' efforts.

8. Please describe your plan's telemedicine philosophy. Do you offer Virtual Visits? How do you educate members about these plan benefits?

Cost Management and clinical initiatives

1. What clinical management programs would be included in the client's Medicare Advantage Plan? Provide a brief description of each program.

- a) Inpatient utilization management
- b) Care and management
- c) Complex/end-of-life case management
- d) Disease/chronic condition management
- e) Wellness/health coaching
- f) Behavioral health
- g) Other

2. Confirm that all the above clinical programs are included in the quote you are providing with this RFP.
3. Provide your proposed behavioral health (BH) services and available BH programs, indicating whether the service and/or program is included in the base fee or what the additional cost would be.
4. Would the client have the ability to modify the intensity/breadth of clinical programs you implement for its membership?
5. In what ways (if any) do your clinical programs for Group Medicare Advantage plans differ from the programs you administer for your commercial book of business?
6. What tactics do your clinicians use to ensure retirees have a safe and healthy home environment?
7. Will you provide a dedicated or designated clinical management team for the client's retirees?
8. Does your organization have a clinical team that is clinical team that will be dedicated (or designated) to the client Medicare Advantage participants? If so, please describe the team below.
9. Do all members of your clinical management team use the same technology platform? If not, how do your different clinical groups share information? How do they create a seamless experience for the member?
10. What chronic conditions trigger intervention from a disease management nurse?
11. What criteria determine whether a member with diabetes is recruited into your disease management program?
12. What percentage of your organization's diabetic group MA population is engaged with a disease management program?
13. How do you define "engaged"?
14. What recent trends in clinical care have been identified and what are the associated programs implemented to address them?
15. What initiatives is your company planning to help further reduce your costs relative to Medicare?
16. How does your organization identify gaps in care and what tactics do you use to close the gaps?
17. Provide case studies that illustrate the benefit of coordinating with providers to improve quality, cost, and member experience for Group Medicare Advantage

members. Based on the client census included (*Exhibit C*), what is the percentage of retirees who could benefit from such provider relationships?

Pharmacy

(You will find the Prescription Drug Data File provided for this section in *Exhibit K*)

1. Provide information regarding the therapeutic management programs currently in place.
2. Provide details on your mail-order functionality/process.
3. How will transition of care issues be handled?
4. Please provide a description of your grievance, coverage determination and appeals process.
5. Describe the member engagement strategies your organization employs to encourage members to utilize medications in the lowest possible cost sharing tier, to manage their drug utilization and costs and improve their health.
6. Describe your Drug Utilization Review program including retrospective, concurrent and prospective. Include in your description the program enables the pharmacist to work with other health professionals and members work together to achieve the members' targeted outcomes and the goal of safe and effective use of medications.
7. Provide a copy of the proposed formulary. How does it differ from a commercial formulary?
8. The County is requesting that the plan quoted is the same or greater than the prescription plan currently in place. See *Exhibit K* Pharmacy Claims Data for your use in providing a prescription drug report detailing if there are prescriptions currently covered that will be excluded from the Group Medicare Advantage PPO plan.

Overall Plan Operations

1. Please describe the group enrollment process. Specifically address signature requirements and data requirements.
2. If a participant receives services from a provider that agrees to accept your organization's reimbursement, is this provider allowed to balance-bill the member?
3. Does your organization have the capabilities to offer direct billing services to retirees? If so, can you administer multiple subsidy levels (ie: monthly premium less monthly client subsidy)?
4. Do you provide pre-enrollment support via the Web or toll-free number to answer potential members' questions?
5. What benefits are available to retirees traveling or temporarily residing out of the plan's service area?

6. Describe how split families will be handled (e.g., retiree over age 65 with spouse under age 65).
7. Describe your ability to customize benefits.

Network

1. Confirm that you offer an employer-sponsored Medicare Advantage solution across the entire United States (National Medicare Advantage PPO). Otherwise, disclose any counties/metropolitan areas in which you are not currently sponsoring a Medicare Advantage product. If possible, include a medical provider disruption report. It is important for the client to know in advance if there are any medical providers currently being utilized that are not covered by the Insured Group Medicare Advantage Plan. Exhibits F contains Medical claims data that can be used for this purpose.
2. Does your organization provide education and direct outreach regarding Medicare Advantage plans to providers who may not participate in your network?
3. Are any of your major hospital contracts or provider groups up for renewal within the next 36 months? If so, list the hospital/groups by name and location.
4. Has your Medicare Advantage service area changed in the past 12 months? If so, how and why?
5. Provide data for your Medicare Advantage network's physician and hospital turnover rate over the last three years.
6. How do you identify providers for recruitment into your National Medicare Advantage PPO network?
7. Would you approach a provider for recruitment upon member request? If so, what is the process?
8. How would you transition care for a member currently engaged in a course of treatment?
9. Describe the impact on members using providers who do not accept your MA program. Confirm if members using these providers are required to pay out of pocket, then submit a claim for reimbursement after the service is rendered. Describe steps you are taking to work with non-accepting providers to gain agreement to accept your MA program.
10. How do you incent providers outside your National Medicare Advantage PPO network to submit claims electronically?
11. Do you utilize any leased networks from other organizations? If so, disclose which networks are leased and its impact on the participant experience.
12. How much advanced notice are network providers required to give you prior to deciding not to renew their contract?

13. For what categories of service do you currently have a Centers of Excellence (COE) program for your Group Medicare Advantage plans?

- a) Where are the COEs located?
- b) Do you have any plans to expand your COE program?

Communications

1. Describe the level of communications support you will be able to provide client in implementing a Medicare Advantage plan. Your response should also indicate if there are any costs associated with communication or implementation support.
2. What ongoing communication support do you provide?
3. Please provide samples of any communication campaigns or monthly/quarterly newsletters sent to Medicare plan participants.
4. What are your capabilities to produce retiree-friendly communication materials?
5. What resources does your organization offer to educate members on how to maximize their benefits and save money?
6. Describe your member communication initiatives and any targeted outreach programs for specific populations that might be applicable to the client.
7. Given the unique nature of Medicare retirees, what delivery channels do you use to maximize effectiveness?

Stars

1. What is the Star Rating of the contract you are proposing for our client? What is the star rating of this contract over the past three years? How much of the membership on this contract is group plan membership versus individual plan membership?
2. What steps are you taking to ensure that you offer a 4 star or greater plan? Describe your commitment to the Star Rating program.
3. What was the average star rating across all your Medicare Advantage plans in the last three years? (Average rating should be based on CMS membership enrollment used for the star ratings release for the respective years)
4. What portion of your Medicare Advantage plans currently has a 4.0 star rating or higher?
5. Describe your firm's commitment to the Stars quality rating program.
 - a) Describe your short-term initiatives to improve your Star ratings.
 - b) Describe your long-term initiatives to improve your Star ratings.

6. Provide a brief description of your CMS Star quality rating enhancement strategy and timeline including:

- a) Any quality improvement initiatives in place
- b) How it fits with your overall Group Medicare Advantage strategy

7. Provide any relevant case studies that demonstrate how your Stars enhancement initiatives are impacting your firm's Star quality scores.

8. How have you aligned your medical management, Star ratings, and HCC risk-adjustment activities to improve your Group Medicare Advantage plans' efficiency and effectiveness?

9. If your organization's National Medicare Advantage PPO membership achieved a 2021 star rating of 4.0 or higher:

- a) How will your organization maintain and improve this rating?
- b) What are your expectations for the impact a 4.0 or higher Star Rating will have on the client's future premiums assuming reasonable/expected rate actions from CMS?

10. If your organization's National Medicare Advantage PPO network did not achieve a 2021 star rating of 4.0 or higher:

- a) What hurdles caused you to miss the CMS bonus payments?
- b) Describe your organization's strategy to achieve a 4.0+ Stars rating for 2021 and beyond (for the National Medicare Advantage PPO Plan)

Account Management

1. Please supply the following for the primary relationship contact in the categories below: name, contact information, years with company, years of experience in the field (may include time at other organizations), years in present position, number of accounts serviced, percent of time committed to the client during implementation, percent of time committed to the client ongoing (post-implementation).

- a) Implementation Team
- b) Account Management Team

2. Describe your company's philosophy and approach to supporting group Medicare Advantage customers.

3. Confirm that the client's account manager will be a part of the implementation team.

4. Provide a brief biography, including name, function and responsibilities, location, years of industry service, and years with the company for any staff who will routinely be assigned to the client.

5. Describe proposed key personnel's experience with retiree group medical plans.
6. Describe when and how the implementation manager will transition responsibility for the client account to the ongoing account management team.
7. Confirm that the client will be notified 30 days in advance of any planned change in account management and that the departing account manager will remain staffed on the account until the transition is fully complete.
8. How does your company help clients measure employee satisfaction? How often is this done?
9. Please include a copy of your most recent employee/member satisfaction results.

Implementation

1. Describe your implementation process and include a detailed timeline of action items for the employer as well as the carrier.
2. What pre-enrollment support will be provided for retirees? Does that include support through a live customer representative?
3. Please outline the team that will be involved in the implementation including bio's with background and experience.
4. How does your company propose communicating a transition plan to the client's participants?