Questionnaire

Please respond to all questions. If a firm is partnering with other firms in order to provide a complete response to this RFP, please coordinate all partner responses and incorporate them (and identify the partner entity/ies) into one comprehensive response to this RFP questionnaire. It will be assumed that your responses apply uniformly to all products and sites that you are quoting unless you clearly indicate otherwise.

General Information

1. List any and all partner firms included in your response including pertinent background information on each firm. Also, please identify the primary firm.

2. Furnish the name, office location and professional biography for each individual listed below. If selected, replacement of any key personnel must be approved by the District.

   - Lead Executive (Senior leader with ultimate decision-making authority)
   - Account Manager (the person with overall responsibility for the client relationship)
   - Account Service Representative (the daily liaison for administrative issues)
   - Primary Claims Representative
   - Claims Unit Manager
   - Implementation Manager
   - Underwriting Manager
   - Member (Customer) Service Manger
   - Eligibility Manager

3. Provide two current public entity customers for reference checks (preferably school districts). These customers should be of comparable size, the contact should be the benefits decision-maker and the customers should have their claims paid in the same claims office proposed to handle the District. Also include two references that have recently cancelled your organization's services for a reason other than bankruptcy or merger/acquisition.

4. Describe how your organization handles an account such as the District. Describe how the renewal process is handled. Would the individuals listed above be responsible for handling this account after the initial implementation? The initial renewal?

5. List the address(es) for the following offices that will be servicing the District:

Facility	**Address(es)**
Corporate Office	
Account Management Office	
Claims Service Office(s)	
Customer Service Office (Call Center)	

Network and Medical Management Office	
Underwriting Office	

6. Indicate the methods by which you can accept eligibility from the District:

7. Medical coverage is effective on the 91st day eligibility. Indicate the frequency you would like to receive eligibility updates.

8. Indicate the self-service functions available to members through your website.

9. Provide NCQA or other accreditation status as applicable.

Claims Administration/Customer Service

1. Provide the following information specific to the claims unit that will service the District. (If separate claims units will handle the District, provide the following information separately for each unit.)

    ____ Number of customers handled by the unit
    ____ Number of customers with 1,000+ lives
    ____ Number of processors in the unit
    ____ Average length of service for processors
    ____ Average turnover rate for processors over past two years

2. Briefly describe how clients are assigned to your claims unit(s): Client-dedicated unit? Teams with lead and back-up staff? Pooled staffing?

3. Will you provide a dedicated phone number just for the District?

4. Briefly describe your claims system(s):

    a. Fraud protection.
    b. Real-time online updating of system.
    c. COB savings percentages for the past two years (excluding Medicare).
    d. Processes for third-party liability or subrogation
    e. Ability to generate warning notices to employees when dependents approach limiting age.

5. Provide a sample Explanation of Benefits.

6. Provide the following information regarding performance for (i) 2017 and (ii) 2018 YTD:

    a. Number of customers
    b. Number of major customers (1,000 + employees)
    c. Claim volume
    d. Dollar volume
    e. Turnaround time (percentage settled within 10 business days, 20 business days, and 30 business days)
    f. Dollar payment accuracy percentage (dollars paid accurately divided by total dollars paid)
    g. Statistical coding accuracy percentage (claims coded accurately divided by total claims coded)
    h. Client survey results (percentage of responses as “satisfied” or “very satisfied”)
    i. Telephone service: average speed of answer in seconds and average hold times
    j. Telephone service abandonment percentage (calls abandoned divided by total calls).
    k. ID card issue time (percentage of cards issued within 10 calendar days).

7. Provide the following information regarding your claims office/customer service telephone service:

    a. Hours of operation including time zone applicable.
    b. Does claim/customer service system feature automated call tracking systems so that the content of prior calls made by the customer is available to the responding representative?
    c. What provisions are made to handle patient grievances?
    d. Describe (include flowchart) of your dispute resolution process.

8. When was your last audit? Please provide a copy. If you cannot, please explain.

9. What Usual and Customary (U&C) methodology do you use for each line of coverage? How often do you update? What is the source of the U&C data?

10. How do you address provider bill upcoding and unbundling for fee-for-service reimbursements?

<u>Pharmacy Program</u>

1. Provide name of Pharmacy Benefit Manager (PBM) or Pharmacy Benefit Administrator (PBA if applicable). Is this an owned solution or sub-contracted?

2. Please find the attached Rx utilization file (Exhibit 8) and provide a detailed disruption report for your proposed formulary.

3. Would the District have any opportunity to customize formulary offering to minimize disruption?

4. If self-funded, please provide overall cost projection based on provided utilization report.

5. Briefly describe how customer receives benefit from the manufacturer rebates. If insured arrangement? If self-funded arrangement?

6. Please describe any clinical management programs offered through the PBM/PBA.

7. Please describe your mail order program and the servicing location for mail order. Is this an owned solution or sub-contracted? Is the mail order customer service call center the same as the medical customer service call center?

Reporting / Underwriting

1. List and describe the various standard reports (medical and Rx) that are provided and included in your rates. Include samples.

2. What additional reports are available and at what additional cost? Include samples.

3. What is the standard turn-around time for ad-hoc report requests?

4. Describe any on-line claim data retrieval and manipulation services available to the District, including costs. Provide a list of available reports that the employer can access electronically.

5. What trend factors are you using for each line of coverage for 2019 (HMO, PPO, Rx)? Indicate whether the total trend factor is adjusted regionally or applied nationally.

6. Do you pool claims? If so what pooling level is used?

7. Describe your rating methodology for a group the size of the District. How many years' experience is used? Applicable weighing?

Utilization Management

1. Explain your system for managing hospital utilization including use of automated diagnosis protocols?

2. Explain the use of non-medical personnel, nurses and physicians in the utilization review process.

3. Who do you use for independent third-party review?

4. Discuss the criteria upon which "medical necessity" is established.

5. How do you measure under-utilization, readmission rates and post-surgery complications for physicians in your networks?

6. Briefly describe your large case management capabilities, including the criteria for cases to enter case management. How do you handle case management situations when a physician disagrees with your recommendation?

7. Describe any "centers of excellence" type programs you may have for high cost and/or high-risk conditions or procedures.

8. Explain how you manage mental health/chemical dependency benefits?

9. How do you identify, evaluate and limit alternative care settings?

10. How do you handle non-traditional services, such as chiropractic and acupuncture?

11. How are emergency admissions defined? How are they handled?

12. Confirm and describe inclusion of any clinical programs for:

    ____ Diabetes
    ____ Hypertension
    ____ Asthma
    ____ Coronary Artery Disease
    ____ Chronic Obtrusive Pulmonary Disease (COPD)
    ____ Other

Provider Network

1. Briefly describe any Bonus or Withhold Arrangements that you have in place in your provider contracts.

2. Discuss any major network providers in Northern Nevada (hospital chains and/or physician groups) that are up for contract renegotiation in 2019 or 2020.

3. Please provide network disruption report (GeoAccess) or similar report based on attached employee census zip code file (Exhibit 4) and describe any significant provider access considerations.

4. Please provide a provider disruption report based on Exhibit 9 for the top fifty (50) utilized Providers by both dollar amount and encounters.

5. Please provide a complete Excel file of your Northern Nevada contracted providers including Tax Identification Number and identify the Primary Care Physicians accepting new patients.

6. Please describe if your provider network is leased or owned in Northern Nevada, Southern Nevada, Rural Nevada, outside Nevada. If it is leased, please provide details on the network ownership term of lease network arrangement, etc.

7. Please describe how you will assist members' access provider services if the member is having difficulty getting into a provider due to closed panels or other reasons.

8. Briefly describe how you will keep the District advised as to any provider changes in your network.

9. Please describe your process for provider nomination to be added to the network.

Performance Guarantees

It is the District's intention to enter a long-term relationship with the selected partner. Thus, we hope never to invoke performance guarantee penalties. We need, however, to ensure high quality service for the substantial employee population.

Please confirm your commitment to apply performance guarantees based on the following minimum standards and clearly identify any exceptions. If you are willing to commit to a higher standard for any item listed, please note accordingly. Also, please advise of any other service guarantee not listed, for which you are willing to include.

Claim Financial Accuracy. Financial accuracy shall be ninety nine percent (99%) or greater based on the claims dollar amount paid.

Claim Procedural Accuracy. Claim payment accuracy shall be ninety eight percent (98%) or greater based on claim count.

Claim Turn-Around Time. Ninety five percent (95%) or more of all clean claims shall be processed within thirty (30) calendar days of receipt of the clean claim.

Customer Service Stats.

Average Seconds to Answer (ASA) phone calls and Abandonment Rate:

- ASA will be two (2) minutes or less
- Abandonment Rate will be ten percent (10%) or less

All calls will be returned within two (2) business day

Eligibility Maintenance. Within two (2) days of receipt.

ID Card Timely Distribution.

- Prior to plan effective date
- Annual open enrollment (please identify acceptable standard)
- Ongoing basis for adds and changes (please identify acceptable standard)

Implementation commitments. Meeting target dates on a mutually agreed timeline.

Timely Account Communications. Timely notification of any changes in assigned team personnel, office locations or contact information, other critical data – no later than 15 days prior to the change event, or within 48 hours of an unanticipated event.

Customer Satisfaction. Annual member survey. The standard will be a pass/fail measure based on the aggregate responses from members (please identify acceptable standard).

Summary Plan Descriptions / Evidence of Coverage EOC's. Provided to members within ninety (90) days of effective date.

Claims experience reports. Provide claims experience reports on a monthly/quarterly basis that provide claims, utilization, trends, and norms by the 10th of the following month.

Renewal. Renewal rate (fee) proposals provided by June 30th of each year.

Account Management. Criteria subjective based on the District's experiences.

Penalties.

- Indicate the maximum percentage of premiums or fees that you would be willing to put at risk for each criteria and for performance guarantees in aggregate – per quarter? Per annum?
- How would the guarantee penalties be applied if more than one category failed in the same quarter? (e.g., additive penalties?)
- Explain how these performance guarantees will be reported and validated.

Implementation

Implementation activities will start as soon as the vendor is selected. These activities include those associated with employee communications and enrollment and ongoing care transition procedures.

1. Provide a detailed work plan you would use to implement the District medical benefits program effective January 1, 2020. Include all key activities, target completion dates, and indicate the person on your team who would be responsible. Key activities include but are not be limited to:

   - initial planning meeting
   - coordination with District staff
   - periodic update meetings
   - eligibility workflows
   - provider education
   - network development
   - enrollment meeting training
   - member services training
   - provider directory communication
   - enrollment
   - ID card production and distribution

2. Describe both standard and optional communications services your company can provide. Indicate services that would result in any additional costs to the District.

3. Describe your standard system for distributing printed materials to District employees. Is there additional cost to the District?

4. Describe your enrollment process. What materials are distributed at enrollment meetings? Provide enrollment kit samples. How do you distribute ID cards? Who will be present at employee enrollment meetings?

5. How will you inform and educate the member services staff about the District's program?

6. How would you recommend that the District handle enrollment in locations where participants reside out-of-area, for example, Retirees?

7. How would you recommend the District handle the following situations:

   - eligible dependent(s) residing in an area where employee's network is not available
   - dependent child(ren) requiring coverage due to a Qualified Medical Child Support Order (QMCSO)
   - eligible employees/dependents while on vacation

8. What is your process for dealing with appeals from employees who are having problems getting to see a doctor, problems arising out of their first encounter with a doctor or other typical situations that arise at the beginning of a new program?

9. Describe your approach to "transition of care" for employees/dependents who are receiving treatment on the effective date of the program. Outline any differences between your plans (i.e. HMO / PPO).

<u>Dental Plan</u>

Exhibits 1, 2 and 3 provide the current dental plan design for the District's self-funded dental program. Although not required, if you are including a dental plan option(s) with your medical/prescription plan proposal(s), please provide the following information:

1. Proposed plan design option(s) to include benefit structure, coverages and exclusions. Please identify the areas where the plan option(s) do not align with the current dental plan design or benefit levels.

2. Excel file of Dental Network providers including TIN.

3. Provide description of services covered at Basic and Major benefit levels

4. Out of Network Usual and Customary methodology being proposed

5. Information on Carrier/TPA.

6. Dental claims information is included in Exhibit 5.

7. Rates must be proposed on a 5-tier basis guaranteed for the period January 1, 2020 through December 31, 2020.

8. Please indicate any rate maximums/caps for 2021 and 2022.

9. Indicate which performance guarantees as outlined in "Performance Guarantee" section would apply.

Wellness

Wellness programs are not being solicited as part of this RFP process and is not a required element. Wellness program elements may be offered and will be evaluated and considered as part of a proposer's submission.

Wellness program elements must be fully outlined. Additionally:

1. Please describe any wellness program elements being offered.

2. Are any of these program elements sub-contracted? If so, please provide information on the subcontractor.

3. Describe how your company is prepared to support the District's current wellness program.

Litigation & Dispute History

1. List all projects that have had litigation or disputes within the last 5 years.
2. Has there been a termination from a contract before completion? If so, describe when, where, and why.
3. Has the firm been declared to be in default on any contract?
4. Has any type of settlement been paid by the firm or to the firm in excess of $25,000? If so, describe when, where, and why.
5. Has there been a judgment rendered for breach of contract, other than a breach for legitimate cause? If so, describe when, where, and why.
6. If a judgment has been entered and a case has been appealed, provide the general facts of the case and the basis of the appeal.