
REQUEST FOR PROPOSALS

August 14, 2008

RFP #2009-1365-2205

**City of Newport News
OFFICE OF THE PURCHASING DIRECTOR
2400 Washington Avenue
Newport News, VA 23607**



Phone: (757) 926-8721/ Fax: (757) 926-8038

Medical Plan Coverage

ADDENDUM 2

PROPOSAL DUE: August 29, 2008 at Close of Business (COB)

Contract Officer:

Bill Lindsey, CPPO, C.P.M., Purchasing Administrator

This Addendum duplicates and provides Section V (Questionnaire) in an electronic Word format.

Note: No changes have been made to the official document contained within the RFP. This addendum is provided as a courtesy in response to requests that the document be provided in an electronic format.

Company Name: _____

Address: _____

City/State/Zip: _____

Telephone: _____ Fax No.: _____ E-Mail: _____

Fed. Tax ID (or Social Security #): _____

Print Name: _____ Title: _____

Signature: _____ Date: _____

This form must be signed. All signatures must be original and not photocopies

V. Questionnaire

Please provide brief answers to all questions. Where confirmation is requested you should simply respond Yes or No – additional information should only be included if you are not able to fully comply or if an additional charge is required.

A. GENERAL AND ADMINISTRATIVE

1. The proposed effective date for the program is January 1, 2009. Please confirm that all rates and fees quoted herein are valid for this effective date.
2. Confirm that the contract situs is Virginia.
3. Confirm that you are fully compliant with the HIPAA Privacy regulations and EDI rules.
4. Confirm your ability to accept enrollment and eligibility data in an electronic format at no additional cost.
5. Does your organization provide online enrollment capabilities for employees? If yes, please describe and identify additional costs. Can your system be integrated to populate the City's HRIS systems?
6. Can your organization systematically administer transition of care at no charge?
7. Please provide an organizational chart of the management and dedicated service team that you propose to handle this account. This chart should include each team member's name, title, location, job responsibility and years of experience.
8. Please provide certification of your errors and omissions / liability insurance coverage.
9. Confirm any actively-at-work provisions (similar for dependents) and any pre-existing condition limitations will be waived for all eligible participants.
10. Confirm that you will cover all eligible plan participants as of the effective date and that no participants will lose coverage strictly as a result of changing carriers.

B. FINANCIAL

1. Confirm that quoted rates/fees exclude commissions.
2. Confirm that quoted rates/fees are final regardless of actual plan enrollment for the current enrollees
3. Indicate the multi-year rate guarantee or renewal cap(s) that your organization will provide.
4. Confirm that your fees are guaranteed for at least two years. Guarantees extending beyond two years of service are strongly encouraged.
5. Confirm that all renewal information will be communicated at least 150 days prior to the renewal date.

VI. Healthcare

Please provide brief answers to all questions. Where confirmation is requested you should simply respond Yes or No – additional information should only be included if you are not able to fully comply or if additional charge is required.

A. GENERAL AND ADMINISTRATIVE

1. Confirm that employees will receive ID cards prior to the effective date.
2. Confirm that your claims appeals processes are fully compliant with the 2007 Department of Labor regulations.
3. Confirm that the City retains the right to independently audit any or all claim transactions involving the enrolled population.
4. Confirm your ability to forward enrollment and eligibility data in an electronic format to outside vendors (i.e., PBM, disease management) at no additional cost.
5. Will you act as claims fiduciary on behalf of the City? If yes, please detail the fiduciary services you provide and indicate any additional cost(s).
6. As outlined above, the City is considering carving out some services with specialty vendors. Please confirm that you will allow a carve-out on the following services. Please note any limitations or additional charges.

	Yes/No
Disease Management	
Pharmacy Benefit Manager	
Health Improvement	
Reinsurance	

7. Please describe the controls and processes you have in place to prevent fraud.
8. Please describe your subrogation process.

B. FINANCIAL

1. Confirm that your proposal includes the following services:

	Self-insured quote (Y/N)
Preparation of Plan Documents	
Preparation of SPDs	
Printing of SPDs	
Mailing of SPDs	
Electronic SPDs (to post on Intranet)	
Enrollment	
ID card production	
Underwriting services	
Claim processing, audit and reporting	
Case management services	

2. Confirm that you will provide HIPAA certificates of creditable coverage at termination of employment and after expiration of COBRA.
3. Confirm that the quoted ASO fees are mature, and that you will administer run out claims for a minimum period of 12 months at plan termination.
4. Do you agree to provide large claims reports, as well as other information necessary to adjudicate stop loss claims and price stop loss renewals, to the City's stop loss carrier at no additional cost to the City? If no, please explain.
5. Are you willing to work with an outside stop loss carrier? Please specify any additional charges.
6. Do you withdraw funds from customer accounts when checks are issued or paid?
7. Do you require a reserve (held by your organization) for incurred but not reported (IBNR) claims?
8. Please indicate if you require a working deposit. If yes, please provide specific requirements.

C. NETWORK DESCRIPTION

1. Confirm that you have fully completed the attached Network Analysis for your PPO network, including Geo Access results, contracted charges by 3-digit-zip, and other network statistics.
2. Confirm that you have fully completed the Provider Disruption Analysis for your PPO network.

3. Please briefly discuss your approach to provider reimbursement.

What percentage of providers are capitated?	
What percentage of providers are discounted fee for service (FFS)?	
What is your average with-hold?	
Do you have an incentive program related to utilization/cost control? Adherence to quality measures? Briefly describe these programs.	

4. Please briefly describe your approach to hospital reimbursement.

What percentages of hospitals are reimbursed on a per case basis?	
What percentages of hospitals are reimbursed on a per diem basis?	
What percentages of hospitals are reimbursed by discounted fee for service (FFS)?	
What percentages of hospitals are reimbursed by other means?	

5. Omitted.

6. Describe any special arrangements that your organization may have with recognized centers for specialty care. Do these arrangements vary by product (HMO, POS, PPO)?
7. What is your source for establishing “usual and customary” fees for non-network services? How often is it updated?

D. MEMBER SERVICES AND SATISFACTION

What is the location of customer service and hours of operation? Discuss any innovative resources for members to access customer service information (e.g., Web-based provider directories, on-line claim inquiries, etc.).

Please confirm the online/Internet-based access you provide to clients and members:

	Yes / No
PRIMARY CARE PHYSICIAN (PCP) changes	
Provider search	
Claim forms	
Check/verify eligibility	
Claims status/Explanation of Benefits	
Request new ID cards	
Obtain health/wellness information	
Contact member services	
Contact 24-hour nurseline	
Quality/outcomes/member satisfaction for network providers	
Other	

E. REPORTING

1. Confirm that you agree to provide the City with a detailed reporting package at no additional cost, including:

	Yes/No
Monthly paid claims	
Monthly Rx claims	
Monthly enrollment by tier	
Monthly large claim report	
Monthly Accounting Statement by the 9 th of the month following	
Quarterly detailed utilization report	
Retiree claims and enrollment to support the GASB 45 valuation analysis	
De-identified detailed medical and pharmacy claim file annually to be used for Zywave Decision Master Warehouse report	
Reporting to show ROI for Wellness programs	

All reports need to be able to be broken out by Actives, Pre 65 Retirees, and Post 65 Retirees.

F. CLINICAL QUALITY INDICATORS

1. Confirm that the following utilization review services are included in your fee quotations.

	Yes/No
Pre-admission certification	
Focused second surgical opinion	
Concurrent/continued stay review	
Discharge planning	
Large/catastrophic case management	
Outpatient surgical review	

2. Are any of your utilization management services provided through an outside vendor? If yes, please state services and vendor names.
3. Provide detail on your use of Predictive Modeling software and its initial returns on investment, including the methodology used to calculate the ROI.
4. Provide detail on how your organization identifies and manages high dollar claims.

G. HEALTHCARE TECHNOLOGY

1. Do you have a FAQ's section on your Web site?
2. Please describe the breadth, depth and content of clinical information available on your site.
 - a. Who provides and updates the clinical content?
 - b. How frequently is this updated?
 - c. How can participants access the clinical library of information?
3. Do you have an e-based hospital and physician cost/quality/outcomes comparison tool? If yes, please describe. Who provides the content for the hospital cost/quality comparison tool?
4. Can participants view a summary of their benefit plan on your Web site?
5. Can incentives to participate in wellness activities be included in the health program? If yes, please describe.

H. PLAN COMMUNICATION AND OPEN ENROLLMENT

1. What services will you provide to ensure a smooth open enrollment? Would you be willing to conduct employee educational meetings?
2. Will you attend onsite informational and enrollment meetings free of charge at the all the City of Newport News facilities? What restrictions, if any, would apply?
3. By what date would you need to receive open enrollment data in order to process the data and distribute member ID cards prior to January 1, 2009.
4. Confirm that you will provide all initial and ongoing administrative and communication materials at no charge (directories, claim forms, enrollment and change forms).
5. Do you have an online tool / cost calculator to assist participants in determining which plan to elect? If yes, please describe.

I. PERFORMANCE GUARANTEES

1. Are you willing to offer the following performance guarantees with fees/premiums at risk for each?

Category	Measurement Criteria	Yes/No
Average speed of answer	30 seconds or less	
Call abandonment	5% or less	
ID card production and accuracy	Within 10 days of receiving eligibility	
Claim turnaround time	90% of clean claims within 14 calendar days	
Claim financial accuracy	99% or more	
Claim payment accuracy	98% or more	
Account management satisfaction	As determined by client	
Problem resolution	90% within 2 business days	
Smooth implementation	As determined by client	

2. Detail other specific performance guarantees that you are willing to offer that go beyond traditional measures for claims processing accuracy and timeliness and customer services that address claims management and clinical quality concerns.

J. BEHAVIORAL HEALTH

1. Can your systems integrate network and non-network claims to administer combined maximums and limits for specific services (e.g., overall plan maximum or number of outpatient MHSA visits)?
2. Please provide the number of behavioral health providers in your network as utilized for purposes of the network match.
3. What initiatives have you undertaken to address the growing problem of psychiatrist availability?
4. Can members look up participating behavioral health providers on your Web site?

VII. Disease Management

Please provide brief answers to all questions.

A. GENERAL

1. How long has your organization been performing disease management services?
2. What is your organization's current ownership status?
3. Describe any recent or planned organizational changes.
4. Do you outsource any of your disease management programs to an outside entity? If yes, please identify and describe the coordination between you and the outside entity.
5. Describe how your organization will interface with the City's communication resources to communicate the program to employees and physicians.
6. Can communication materials be customized? If yes, identify what can be customized and if there would be any additional fees for customization.
7. Confirm that you have provided copies of all communication materials (employer, employee and physician) as reference documents.
8. Provide the following information for three current employer references the City may contact. Please include organizations similar to the City.

	Contact Name	Phone Number	Number of Eligible Employees	Programs Being Delivered	Length of Relationship

B. PROGRAM ADMINISTRATION

1. What disease management programs are currently in place? Please indicate the length of time each has been offered.

	Available Yes/No	Length of Time Offered	Number of Participants
Heart Disease			
Asthma			
Diabetes			
Lower Back Pain			
Mental Illness/Depression			
End Stage Renal Disease			
High Risk Pregnancy			
Other, please specify			

2. How does your organization specifically manage and decrease health and healthcare disparities based upon ethnic, racial and socioeconomic factors?

3. What criteria do you use to identify participants?

	Criteria
Case Management	
Medical Claims	
Prescription Drug Claims	
Lab Claims	
Health Risk Assessments	
Other (please list)	

4. If a participant initially declines enrollment, what process is in place to re-contact the individual to invite again and what is the frequency?

5. Do participants graduate from the program?

6. Indicate which of the program components are included in your disease management programs.

	Yes/No
Participant:	
Assessment	
Participant newsletter	
Disease – specific information	
Dedicated health coach/nurse	
Skill development	
Treatment plan adherence	
Drug compliance	
Lifestyle management	
Psychosocial support	
Biometric monitoring	
Physician	
Program information packet	
Newsletter	
Regular patient updates	
Patient alerts	
Provider – specific reports	
Dedicated phone support	
Local provider liaison	
Other, please explain	

7. Confirm that you have included samples of participant materials for the proposed diseases (heart, diabetes, asthma, high risk pregnancy) as reference documents.
8. Do you have a dedicated Web site for disease management participants? If yes, please provide the address.
9. Are you willing to provide your services exclusive of predictive modeling by allowing the health plan to identify participants? If yes, please include fees for this option.
10. If not 24/7, describe your after-hours support.
11. How does your organization work with participants who are hearing impaired?
12. Do you have translators available for non-English speaking participants?
13. Do you track and report member satisfaction/feedback in your disease management programs for each participant?
14. For your employer-based clients, indicate the data sources used to identify potential program participants.

	Yes (percent of participants identified)	No
Medical claims		
Pharmacy claims		
Lab values		
Short Term Disability		
Worker's compensation		
Behavior health		
Health risk assessment		
Physician referral		
Self-referral		
Employer's internal health professionals		
Other employer-based program/vendors		

15. Provide a brief summary of how you interface with participants, primary care physicians and your employer client. Include examples of what tools/information your organization provides the participant in preparation for a provider visit.

C. REPORTING

1. Do you provide reports to clients regarding client specific patient involvement in your Disease Management programs?
2. Indicate which reporting elements are included in your standard client reports.

	Yes/No
Number of identified candidates	
Number of enrolled participants by condition	
Number of enrolled participants by condition and risk level	
Number of participants who have voluntarily dropped out	
Number of participants who have completed program	
Clinical outcomes (e.g. HbA1c, lipids, etc)	
Health and functional status	
Risk reduction	
Utilization of care	
Cost savings	
ROI	
Participant satisfaction	

3. Indicate whether the elements included in your standard client reports are client specific, book of business or not available.

	Client Specific	Book of Business	Not Available
Number of identified candidates			
Number of enrolled participants by condition			
Number of enrolled participants by condition and risk level			
Number of participants who have voluntarily dropped out			
Number of participants who have completed program			
Clinical outcomes (e.g. HbA1c, lipids, etc)			
Health and functional status			
Risk reduction			
Utilization of care			
Cost savings			
ROI			
Participant satisfaction			

4. Indicate the frequency of your standard reporting.

	Frequency of Reporting
Number of identified candidates	
Number of enrolled participants by condition	
Number of enrolled participants by condition and risk level	
Number of participants who have voluntarily dropped out	
Number of participants who have completed program	
Clinical outcomes (e.g. HbA1c, lipids, etc)	
Health and functional status	
Risk reduction	
Utilization of care	
Cost savings	
ROI	
Participant satisfaction	

5. How do you measure participant satisfaction?

6. Will the participation satisfaction results be specific to the City’s population?

7. Describe how you measure program outcomes and cost savings.

8. Describe in detail your organization’s methodology to determine ROI for your programs including assumptions.

D. INCENTIVE ARRANGEMENTS

1. Do you have experience working with incentive arrangements for other clients? If yes, please describe.

2. Do you favor an approach that emphasizes rewarding desired behaviors (i.e., a diabetic receiving annual eye and foot check-ups), or clinical results (i.e., HBA1c). Why?

3. What additional cost, if any, does this program add to your basic disease management fees?

VIII. Pharmacy Benefit Management

A. GENERAL AND ADMINISTRATIVE

1. Provide your organization's current annual trend rates (not including the leveraged impact of fixed copays).

	Annual Trend
Retail	
Mail Order	
Administrative Fees	

B. RETAIL NETWORK

2. Provide your pharmacy terms in the attached chart.

	Contract Terms
Retail Generic discount	
Retail Brand discount	
Retail Dispensing Fees	
Mail Order Generic discount	
Mail Order Brand discount	
Administrative Fees	
Pharmacy Rebates	
Guarantees	

- 3. Please confirm that you have completed the Pharmacy Tier Comparison chart.
- 4. Do you own your own retail pharmacy network or is it subcontracted to an independent PBM?
- 5. Please indicate the number of pharmacies in your broad network vs. your narrow network.

	# of Pharmacies
Broad Network	
Narrow Network	

6. Please provide a geo access report for pharmacies in Virginia

C. MAIL ORDER SERVICE

- 1. Do you own your own mail order facility, or is it subcontracted to an independent PBM? If it is subcontracted, please indicate the name of the subcontractor.
- 2. Where is your mail order facility located?
- 3. What are the hours of operation for Customer Service?
- 4. Do you have the capabilities to allow members to order prescriptions via:

	Yes / No
Telephone	
Fax	
Internet	
Mail	

5. What methods of shipping do you use to ship prescription orders to members?

6. Do you monitor patient over compliance and under compliance?
7. Do you provide retrospective drug utilization review? If yes, please explain. Please indicate if there is an additional cost.
8. Please identify specific drugs or drug classes for which you recommend special limits or controls.
9. Do you offer a prior authorization program? Are these programs mandatory or voluntary? Who performs prior authorization?
10. What specific drugs or drug classes do you recommend be placed under prior authorization?
11. If a fraud or abuse problem is identified, how would your participating pharmacies intervene?
12. How often is your formulary updated?
13. How are formulary changes communicated to each of the following: (Select all that apply.)

	Internet	Letter	Newsletter	Formulary Reprint	Other
All Members					
Affected Members					
Physicians					
Pharmacists					

14. How often does your organization communicate formulary changes to members?
15. What is the process for selecting drugs to be included on the formulary?

Access to formulary	
Access to clinical protocols	
Other, please specify	

D. PHARMACY MANAGEMENT / OTHER

1. Can you administer a mandatory generic program, in which the patient pays the brand copay PLUS the difference between brand and generic costs if a brand drug is dispensed when a generic is available?
2. Under a mandatory generic program, how long after the brand patent expiration do you permit members to purchase the brand drug without incurring a penalty?
3. Can you administer coinsurance on retail prescriptions? Mail order prescriptions?

4. Can you administer an upfront deductible on your copay plans for retail prescriptions? Mail order prescriptions?
5. Does your program exclude drug classes if an over-the-counter equivalent exists? Yes/No/Optional
6. Do you have a specialty injectible drug program? If yes, please explain (including how it is administered).
7. Can you provide member statements/EOBs with year-to-date drug spend, including the amount paid by the member vs. the plan? If yes, please explain including frequency, method of delivery and cost.
8. Can members look up participating pharmacies on your Web site?
9. What services/information can members access on-line?

IX. Health Improvement

Please provide brief answers to all questions. Where confirmation is requested you should simply respond Yes or No – additional information should only be included if you are not able to fully comply or if additional charge is required.

A. GENERAL

1. How long has your organization been performing wellness services?
2. What is your organization's current ownership status?
3. Indicate by population size, the number and percentage of employer clients your organization contracts directly with for health improvement/wellness services.

	Number of Employees	Percent of Employer Base
Less than 1,000 employees		
1,000 to 4,999		
5,000 to 10,000		
More than 10,000		
Total		

B. HEALTH RISK APPRAISAL (HRA)

1. Do you have a health risk assessment tool (survey) on your Web site for members to complete? Do you also have the ability to administer paper HRAs?
2. Was the HRA tool developed by your organization or do you utilize another vendor's tool? Please provide the vendor name if tool is outsourced.
3. How can you confirm that your HRA tool is valid and reliable?
4. What information does your HRA request/require from participants? Please provide a sample HRA. Please confirm that the City of Newport News can customize the HRA by deleting certain questions and/or by adding questions specific to their population.
5. The City may want to offer basic screenings (cholesterol, blood pressure, blood sugar, weight) as part of the HRA process. The City may offer on-site screenings for employees. Please describe how you will facilitate this process, including, scheduling, staffing, etc.
6. How will you report aggregate results to the City? Please provide a sample report.
7. How will you report specific feedback to participants? Please provide delivery options and a sample report of results. What is your commitment for turnaround times?
8. Confirm that HRA results can be reported to a Primary Care Physician (PCP)/Family Doctor with member authorization.

C. WELLNESS PROGRAMS

1. Confirm that you will conduct on-site programs. Please note number of hours per 12 month period. What resources do you provide for on-site programs? Please list additional charges.
2. Please list any specific lifestyle change based modules available.
3. Does your Web site have information on seasonally appropriate issues (i.e., benefits of using sunscreen, how to avoid Lyme Disease, etc.)? If yes, please describe.
4. Do you provide enrollees with literature to enhance health awareness (i.e., quarterly newsletter, magazines, etc.)? Please note frequency and type of communication. Please confirm that there are no additional costs associated with the distribution of these materials.
5. Can wellness communications be customized for the City? If yes, please outline the degree of customization that will be permitted.
6. Please outline the smoking cessation assistance that would be available to the City's members. Your response should include formal classes, Web-based tools, community resources, etc.

7. Please outline the healthy eating/weight loss assistance that would be available to the City of Newport News' members. Your response should include formal classes, Web-based tools, community resources, etc.
8. Please outline the physical exercise assistance that would be available to the employees. Your response should include formal classes, Web-based tools, community resources, etc.
9. Please list any other key programs (in addition to smoking cessation, healthy eating/weight loss and physical exercise) that are available to members.
10. Are you able to offer discounted fitness center memberships? If yes, please list the Virginia facilities in your network and the level of the discount.
11. Please indicate if your plan tracks preventive care compliance. If yes, please outline criteria and tracking method.
12. Please indicate if your plans directly contact patients to improve compliance with treatment protocols:

Population	Test / Treatment	Yes/No
Woman > 50	Mammogram	
Man or Woman > 55	Cholesterol check	
Children	Immunizations	
Elderly	Flu shot	
Elderly	Colon cancer	
Diabetics	Eye exam	

13. How does your organization specifically manage and decrease health and healthcare disparities based upon ethnic, racial and socioeconomic factors?
14. Do you proactively outreach to members? If so, what are your criteria for identifying participants? What methods of outreach do you use and under what circumstances do they vary? How do you measure participation and at what frequency?
15. Please describe how behavior change is encouraged and monitored through your Coaching Program.
16. What is your process for risk stratification of the City's population?
17. Do you offer interactive Web-tools such as online chats with a wellness counselor, nurse, etc.?
18. Can members download educational information from your Web sites? If yes, what topics are included?

X. Reinsurance

Current Coverage:

Current Medical Carrier:	Anthem
Current Medical Network:	Anthem
Current Reinsurance Carrier:	Anthem
Policy Period:	July 1, 2008 through December 31, 2008
Commission:	None
Specific Deductible:	\$200,000
Aggregating Deductible:	None
Lasers:	None
Specific Contract Basis:	Paid
Specific Coverage:	Medical & Pharmacy
Specific Rate Composite PEPM:	\$15.25
Aggregate Coverage:	None

Requested Coverage:

Policy Period:	January 1, 2009 through December 31, 2009
Specific Deductible:	\$200,000, \$300,000
Aggregating Deductible:	None
Commission:	None
Specific Contract Basis:	12/12, 15/12
Specific Coverage:	Medical & Pharmacy
Aggregate Coverage:	None

1. Please confirm that your reinsurance proposal covers both medical and pharmacy claims under the specific stop-loss deductible and the aggregate attachment point.
2. Please provide your definition of a paid claim.
3. Please specify requirements for final underwriting.
4. In the event of a specific claim:
 - a. How is the client notified?
 - b. How long does it take for a claim to be reinsured after it hits/exceeds the threshold?
 - c. How are additional claims handled?