Specification No.: CBO-2019-01

Advertisement Date: August 7, 2019

Request for Proposal for

Healthcare PPO/HMO, Medical Review Services, Vision, Dental PPO/HMO

For the City of Chicago (the "City" or the "Lead Agency")
And
Active Employees—Cook County, Illinois ("Cook County"), Chicago Park District, City Colleges of Chicago, and the Officers' Annuity and Benefit Fund of Cook County and Forest Preserve District Employees' Annuity and Benefit Fund of Cook County (the "Cook County Pension Fund"),
(which are sometimes referred to individually as an Agency or a Municipal Agency, and collectively as the Agencies or Municipal Agencies)

Issued By Lead Agency:

- Chicago Benefits Office of the City of Chicago's Department of Finance.

Commencement Date:

- Generally January 1, 2021, but varies by Agency; see General Invitation section.

Contract Period:

- Generally three years from Commencement Date with two options to renew the Contract, each option for a period of one year, but varies but varies by Agency; see General Invitation section.

Website, Designated Email Address:

- All communications shall be through the designated email address: 2019BenefitsRFP@cityofchicago.org and/or via the website: www.CityofChicago.org/benefits .

Deadlines:

- Presubmittal conference, optional: Wednesday August 14, 2019. See General Invitation for location and time.
- Questions may be submitted to the designated email box by Thursday August 15, 2019, 9:30 a.m. Central Time.
- Proposals are to be submitted prior to, but no later than the deadline of Tuesday October 1, 2019, 10:30 a.m. Central Time.
- Late proposals will not be accepted.

Submit:

- Submit 12 Physical Proposals: Submit 12 physical proposals in 3-ring binders, signed and sworn to before a notary public.
- Submit 30 Electronic Copies: Thirty copies of the proposal are to be submitted on USB drives, not encrypted.
- Optional: You may also submit redacted copies for FOIA purposes, in both the 3-ring binder and the USB drives.
- Delivery: All proposals shall be addressed and delivered to:
  Daniel J. Ashley, Assistant Benefits Manager
  Chicago Benefits Office, City of Chicago
  333 S. State Street, Room 400
  Chicago, IL 60604

  Note: The Chicago Benefits Office accepts deliveries 8:30 a.m. – 4:30 p.m. Monday – Friday except holidays
- Additional Requirements: See further instructions in the Submittal Requirements section.

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GENERAL INVITATION

Brief Overview

The Agencies are a consortium of several local government and/or municipal entities with varying benefits for their Subscribers and their dependents (collectively "members" or "participants"). The tables below provide a brief overview of the Agencies for 2018, a snapshot of the current vendors, and anticipated contract commencement date:

Proposals Requested, by Agency

	City of Chicago	**Cook County**	**Cook County Pension**	**Chicago Park District**	**City Colleges**
Medical PPO	Yes	Yes	Yes	Yes	Yes
Medical HMO	Yes	Yes	Yes	Yes	Yes
Dental PPO	Yes	Yes	No	Yes	Yes
Dental HMO	Yes	Yes	No	Yes	Yes
Vision	Yes	No	Yes. Seeking vision proposals both as stand alone and included within Medical	Yes	Yes
Medical Review Services	Yes	No	Yes	No	No
EAP	No	Yes	No	No	No
Medical Medicare Supp	Yes	No	Yes	Yes	Yes

Existing Relationships, Demographics & Financial Data, By Agency

(FI = Fully Insured, SI = Self Insured, Cost+ = Partly FI & Partly SI, MM=Million)

City of Chicago

		Employees		Retirees		Grand totals for both employee and retiree plans.	
Name of Vendor	**Plan Name/Type**	**Number of Covered Employees**	**Number of Covered Lives (Including Employees)**	**Number of Retirees**	**Number of Retired Lives (Including Retirees)**	**2018 Number of Claims Processed**	**Total Dollars Paid for service**
BCBS Employee Medical	Blue Advantage HMO (Cost Plus)	8,353	23,865	0*	0*	n/a	$96.57 MM
BCBS Employee Medical	PPO (SI)	25,551	60,915	0*	0*	799,099	$278.14 MM
BCBS Retiree Medical	PPO (SI)	n/a	n/a	70	88	2085	See below
BCBS Retiree Medicare Supp	PPO (SI)	n/a	n/a	2,408	2,703	93,331	$7.73 MM ***
BCBS Dental	PPO (SI)	26,334	64,388	0	0	94,369	$11.79 MM
BCBS Dental	HMO (FI)	5,998	17,864	0	0	n/a	$2.26 MM
Davis Vision	Vision (FI)	33,904	84,780	0	0	n/a	$3.07 MM
Telligen **	Medical Review Services	25,621	61,003	**	**	n/a	$5.58 MM

*City collective bargaining agreements allow certain public safety employees to retire early and remain enrolled in the employee PPO and HMO plans until the 1st of the month of 65th birthday. Because they are receiving active plan benefits and are under 65, they are not shown as retirees.

**Telligen services relate primarily to Employee Medical PPO; limited services for Employee Medical HMO & Retiree Medical PPO Rx

***$75.52 combines the small number of non-Medicare retirees above with the Medicare supplement retirees

Cook County

		Employees		Retirees		Grand totals for both employee and retiree plans.	
Name of Vendor	**Plan Name/Type**	**Number of Covered Employees**	**Number of Covered Lives**	**Number of Retirees**	**Number of Retired Lives**	**2018 Number of Claims Processed**	**Total Dollars Paid for service**
BCBS Medical	HMO	12,771	31,940	0	0	74,000	$147 MM
BCBS Medical	PPO	7,434	18,500	0	0	347,213	$121 MM
Guardian	DMO (Dental HMO)	7901	10,855	0	0	n/a	$2.3 MM
Guardian	Dental PPO	11,461	18,200	0	0	133,298	$6.3 MM
	EAP						

Cook County Pension Fund

Name of Vendor	Plan Name/Type	Number of Covered Employees	Number of Covered Lives	Number of Retirees/ (# of contracts)	Number of Retired Lives	2018 Number of Claims Processed	2018 Claims Paid*
UHC	Choice (EPO) Non Medicare	N/A	N/A	2,039	2,793	73,697	$31,928,725
UHC	Choice (EPO) Medicare	N/A	N/A	3,816	5,126	157,376	$11,253,031
UHC	Choice Plus (PPO) Non Medicare	N/A	N/A	304	420	14,370	$7,134,071
UHC	Choice Plus (PPO) Medicare	N/A	N/A	3,376	4,345	164,941	$8,185,000

Note: Cook County Pension Fund is not seeking a vision program as vision is included with the Medical plans; all plans have a vision benefit component NOT reflected in the claim totals above. Total 2018 vision claims were $219,628. CCPF prefers this approach to having a stand-alone vision contract and accordingly its Agency Exhibit shows the vision benefits that are included. However, the CCPF does seek proposals on a self-insured vision RFP, so that there will be an alternative in the case that one or more medical proposers can't match the current plan design structure. CCPF does not sponsor a Medicare Supplement program, but the plan design coordinates the same HMO/PPO design for under 65 participants with Medicare as those over 65 Medicare. Coordination is on an "exclusion basis". The plan design subtracts Medicare's payment from contractually allowed amount and then applies deductible/copay/coinsurance to the remainder. There is no separate Medicare Supplement plan. All plans are self-insured.

City Colleges of Chicago

		Employees		Retirees		Grand totals for both employee and retiree plans.	
Name of Vendor	**Plan Name/Type**	**Number of Covered Employees**	**Number of Covered Lives**	**Number of Retirees**	**Number of Retired Lives**	**2018 Number of Claims Processed**	**Total Dollars Paid for service**
BCBS Medical	HMO Illinois* (FI)	145	297	26	44	4,934	$0.91 MM
BCBS Medical	HMO Blue Advantage* (FI)	660	1,480	233	325	28,201	$5.94 MM
BCBS Medical?	PPO (SI)	867	1,750	549	759	60,306	$15 MM
BCBS	Dental PPO (SI)	1,789	3831	444	683	8,786	$1.67 MM
VSP	Vision (SI)	1,710	3,638	436	653	1,857	$0.33 MM

*Note re: HMO(s): Prior to 7/1/2019, City colleges offered HMO Illinois and Blue Advantage HMO. Effective 7/1/19 only Blue Advantage HMO is offered.

Park District

		Employees		Retirees		Grand totals for both employee and retiree plans.	
Name of Vendor	**Plan Name/Type**	**Number of Covered Employees**	**Number of Covered Lives**	**Number of Retirees**	**Number of Retired Lives**	**2018 Number of Claims Processed**	**Total Dollars Paid for service**
BCBS Medical	BCO	711	1568	26	38	__	$9.64 MM
BCBS Medical	HMO Blue advantage	1129	2162	125	169	__	$11.32 MM
Humana	PPO dental	760		187		__	$0.57 MM
	HMO dental	745		214		__	$0.25 MM
VSP	Vision*(FI)	886	n/a	0	0	See below	$ 93 k

*Vision at the Park district is voluntary, employee-pay-all. Claims: 522 exams, 266 glasses, 158 contacts.

General Invitation - Continued

The Agencies request responses to provide the services specified in the Scope. The Agencies are jointly requesting one proposal for all Agencies. Proposals shall not, however, include cross-subsidization of any Agency by higher rates or less favorable terms for another Agency. There is no guarantee that all Municipal Agencies will select the same Proposer. Further, the Agencies reserve the right to (i) select one or more Proposers to provide the services; (ii) reject any and all proposals; (iii) identify any areas where a conflict of interest may require limitations on a Proposer.

The selected Proposer shall perform the services directly. Proposals submitted by brokers and by others not capable of directly performing the services specified herein will not be accepted.

A potential Proposer must download the RFP, and must register by identifying the Proposer in an email to the designated email address. If you fail to register, you will not be provided the USB drive which contains data, as well as Word versions of the Scope and Interrogatives. Identification includes the name of the Proposer, address, telephone number, email address and name of primary contact. Entities that will not propose but that instead monitor RFP publication to inform potential Proposers, shall self-identify, and in addition shall identify all the potential Proposers represented by the entity. A confidentiality agreement will be emailed to each potential Proposer. It must be signed by an authorized officer of the potential Proposer and delivered to the email address specified on the cover page of this RFP. Middlemen or agents of potential Proposers may not sign the confidentiality agreements and may not pick up USB drives. Registered Proposers will be invited to pick up, in person at the address specified on the cover page of this RFP, a USB drive with census data for all Agencies and claims data (e.g. de-identified historical claims for prior periods, etc.). Further, registered Proposers will receive email notification of addenda to the RFP.

A firm may propose as part of a joint venture or independently as a single Proposer, but not as both. If a joint venture proposal is rejected, a firm which has participated in the joint proposal can be considered to provide Services separately as if it had submitted a proposal only if its portion of the joint venture proposal is complete and responsive in all respects. A “partnership,” “joint venture,” or “sole proprietorship” operating under an assumed name must be registered with the Illinois County in which located, as provided in the Assumed Business Name Act (805 ILCS 405.0.01, et. seq.).

The contract with each Agency will commence as of a Commencement Date for that Agency. It is anticipated that the Commencement Dates will generally be January 1, 2021 (December 1, 2020 for Cook County), although commencement dates may vary by Agency and may be postponed by an Agency. If any Agency finds it necessary to continue its present plan of benefits in order to comply with existing collective beginning agreements, the Agency reserves the right to continue to offer its present plan of benefits through its current provider for the term required under the collective bargaining agreement and upon termination of the collective bargaining agreement begin to offer the newly selected services.

The contract term for which the Agencies are seeking proposals is, unless otherwise specified, three years plus two renewal terms of one year each exercisable at the option of the Agency. The City of Chicago is seeking such proposals and is also seeking proposals for a five year term with three renewal terms of one year each exercisable at the option of the City.

For each service (e.g., medical PPO, dental HMO, etc.) there is no guarantee that all of the Agencies will select the same Proposer as the others. Individual Agencies may select a Proposer based upon the proposals and the need for a particular service. The selected

Proposer will be required to enter into a separate contract with each individual Agency to provide the Services in accordance with terms and conditions acceptable to that Agency.

Incumbents who wish to be considered for future services are not automatically considered in the absence of a proposal. All current providers of any service within the ambit of this RFP for any of the Agencies who are interested in the future in providing those services must submit a proposal.

Responsibility for Monitoring Website. Proposers waive their right to have clarifications and/or addenda sent to them. Those desiring to submit a proposal shall be responsible for checking the website for clarifications and/or addenda. Failure to obtain clarifications and/or addenda from the website shall not relieve Proposers from being bound by additional terms and conditions, clarifications, addenda, or from considering additional information contained therein in preparing proposals. Note that there may be multiple clarifications and/or addenda. Any harm to a Proposer resulting from failure to so monitor shall not be valid grounds for a protest against award(s) made under this solicitation.

Pre-Submittal Conference. A pre-submittal conference will be held from 1:00 p.m. to 3:00 p.m. on Wednesday, August 14, at the Cook County Building, 118 N. Clark St., Chicago, IL 60602 in the 4th Floor Conference Rooms A and B. Attendance is optional. If you wish to attend, please arrive by 12:30 p.m. to sign in, and bring a business card.

Addenda to this RFP. If a Proposer is in doubt as to the meaning of a part of this RFP, a written request for interpretation thereof may be submitted to the email address specified on the cover page of this RFP. Telephone or personal correspondence with any Agency regarding the RFP is prohibited and will receive no response. Any revisions of this RFP deemed necessary by the Lead Agency will be made only by an addendum issued by the Lead Agency, posted on the website. Notification of any addendum may be emailed to each Proposer who has registered via email as described above (but need not be as potential Proposers are responsible for monitoring the website). Failure on the part of the Proposer to receive any written addendum will not be grounds for any consideration including but not limited to extending any deadline, changes in or relaxation of any requirements of the RFP, or withdrawal of the RFP. Oral clarifications offered by any Agency or any representative or employee of any Agency will not be binding on the Lead Agency or any of the Agencies.

Questions: All questions regarding the RFP shall be submitted via e-mail to the email address specified on the cover page of this RFP by the questions deadline set forth on the cover page of this RFP. In your email identify the name of the Agency for which the question is intended if it is intended for fewer than all Agencies. Answers to questions received by the deadline will be posted on the website and notification may be e-mailed to potential Proposers who have registered (but need not be as potential proposers are responsible for monitoring the website). Questions received after the deadline will not be answered.

Termination of RFP. The City reserves the right to terminate this RFP solicitation in part or in whole at any stage if the City determines such action to be in its best interest. The receipt of proposals or other related submittal documents will in no way obligate the City to enter into any contract of any kind with any party.

Contracting. The selected Proposer shall perform its services in accordance with the terms and conditions of an insurance contract (policy) issued to the Agency or a written contract (professional services agreement) entered into between the Proposer and the individual Municipal Agency, in either case pursuant to negotiations between the Proposer and the Agency. The contract shall meet the minimum requirements for the services described in this RFP, and shall include, if any, additional enhancements offered in the selected Proposer's proposal. In no event will a Municipal Agency enter into any contract offering fewer services than required by this RFP or at greater costs than offered in the selected Proposer's proposal or as the proposal is modified through subsequent submissions to the Agencies.

Terminology. The terms used in this RFP shall have the meaning assigned to them by the respective Agencies' benefit plans, unless defined differently in context.

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Scope of Services

This Section is also provided in Microsoft Word

This Scope of Services contains provisions specific to each of the solicited services:

Healthcare PPO / HMO, Medical Review Services, Vision, Dental PPO / HMO / EAP.

In addition, it contains provisions of general applicability to all solicited services.

This Scope of Services is also provided in Microsoft Word format. Your response shall include a copy of the Scope, with your response to the General Scope of Service and the Scope of Service for each Service on which you are proposing. In each case, Proposer shall answer whether Proposer will satisfy the below requirements. Proposer shall answer "yes" or "no." If the answer is no, or is neither yes nor no, include a cross reference to a footnote or separate page in which you explain your response. For the general scope questions, answer in the appropriate column (for example, if proposing only for the dental HMO, there is no need to respond in any other column). The response must be submitted in Microsoft Word (and a hard copy), and in your response the scope paragraphs (the left column) shall not be reworded, deleted or changed in any way. If an answer is "no," Proposer shall explain in a separate page at the end of the responses to the Scope, and/or propose alternate wording to the Scope item such that the proposer would respond "yes." This list is not exhaustive, and the Agencies reserve the right to add additional requirements with respect to the proposals as necessary.

Merely because a requirement is not set forth in the Scope of Services does not mean the requirement does not exist; this Scope of services is not exhaustive. It is supplemented in all cases by the Agency Exhibits and the Agencies reserve the right to add additional requirements to the Scope as necessary or as collectively bargained.

General Scope of Service Matters.

	Medical PPO	Medical HMO/EPO	Dental PPO	Dental HMO	Vision	Medical. Review Services.	Employee Assistance Program
a. Proposer shall offer such services in conformance with federal and state laws, regulations and ordinances, and, in accordance with the personnel policies, procedures and rules of each individual Agency. Services shall only be offered by persons or organizations authorized and duly licensed by the appropriate regulatory agencies when such licensing or authorization is required.							
b. Proposer shall be appropriately licensed, insured, and meet all other requirements specified in this RFP.							
c. Proposer must specifically represent and warrant that all participating providers meet all of the Proposer's credentialing requirements and that an ongoing quality assurance program is maintained.							
d. Proposer shall review and advise the Agencies on the plan designs set forth in the Agency exhibits. No Proposer is expected to provide legal advice to the Agencies; however, the selected Proposer promptly shall advise the Agency of all present or future changes or pending proposed legislative changes that may affect coverage provided under the Agency's Benefit Plan or the operations, financing, administration, or terms thereof.							
e. Proposer shall provide any information that is necessary for the effective operations of the Services, including administrative advice and							

	Medical PPO	Medical HMO/EPO	Dental PPO	Dental HMO	Vision	Medical. Review Services.	Employee Assistance Program
assistance as needed and notice of changes in law that might affect the operations of the plan and services provided under the contract.							
f. Proposer shall perform any and all administrative functions necessary to ensure appropriate financial control. If it is determined that Plan coverage has been provided to an individual or individuals ineligible for coverage, the selected Proposer will reimburse the Agency for claims paid in error whether or not Proposer has recovered payment from claimant (for self-funded benefits), and will remove said claims from the experience of the Agency to the extent that the Agency is fully or partially insured.							
g. Proposer shall receive, maintain, and process the Plan participant and dependent eligibility files in an accurate and timely manner, and in a format and time frames established by the Agency.							
h. In the event Proposer's organization is currently providing services to an Agency of the type procured under this RFP and is not selected to provide those services to that Agency under this RFP, the Proposer agrees to cooperate fully and take all actions necessary to smoothly transfer the services to another carrier or service provider selected by the Agency. If Proposer is not currently providing Services to an Agency answer "N/A".							
i. Proposer shall perform services in compliance with the plan of benefits of an Agency, including medical necessity review even where Agency has some services pre-certified by an outside entity.							
j. Proposer shall maintain confidentiality of employee and Agency records. Census information of participant employees and their dependents will be provided by the individual Agency in a frequency to be determined between the Agency and the selected Proposer. This information will be used to determine eligibility for benefits. While in the possession of the selected Proposer, these records will remain the property of the Agency and are thereby returnable upon completion or termination of the contract. While in use, the confidentiality of these records must be maintained in accordance with all applicable laws and regulations. This confidential information, including personal data and demographics derived, may not be used by the selected Proposer for purposes not contract-related and may not be sold, marketed, furnished or otherwise made available to others for any purpose unless specifically directed by the Agency in writing to do so.							
k. All records are the property of the Agency and shall be returned to the Agency upon the completion or termination of the contract.							
l. Proposer shall permit periodic audits of work performed by Agency staff or Agency appointed auditors.							
m. Proposer shall promptly rectify errors and resolve disputes in a manner satisfactory to the Agency.							
n. Proposer shall comply with the MBE/WBE requirements of each Agency as set forth in this RFP.							
o. Proposer shall complete the disclosure documents pertaining to each individual Agency as set forth in the Agency Exhibits (Documents vary by Agency: e.g., the Economic Disclosure Statement, Contractor Disclosure Form, Contractor's Disclosure Affidavit, Disclosure of Retained Parties, etc.) and to promptly update such documents when any material aspect of the submitted disclosures change.							

	Medical PPO	Medical HMO/EPO	Dental PPO	Dental HMO	Vision	Medical. Review Services.	Employee Assistance Program
p. Proposer shall develop employee communication brochures, pamphlets and materials, subject to the Agency's approval, which the Agency considers necessary to communicate the benefits of the Plan. The development, production and distribution of materials shall be at no cost to the Agency. Proposer is responsible for the accuracy, completeness and compliance with all legal requirements of the materials. Proposer shall provide required notifications to employees on a timely basis at no cost to the Agencies.							
q. Proposer shall assist the Agency in the drafting and review of revisions to Plan documents and summaries.							
r. Proposer shall offer plan participants appropriate web-based applications, as well as apps for online mobile devices, that include plan design information, eligibility information, provider network information, cost comparison tools (if appropriate), key contacts, and other information pertinent to the plan, and that allow participants to request identification cards.							
s. Proposer shall use standardized enrollment data files or other forms as may be required for the administration of the Plan, subject to the individual Agency's approval							
t. Proposer shall undertake all other necessary tasks to properly administer the Services, including but not limited to, recording eligibility based upon the Agency provided eligibility information, sending I.D. cards, communications and brochures to employees, responding to telephone inquiries and appeals, and directing employees to the appropriate use of Plan benefits.							
u. Proposer shall provide, at no cost to the Agencies, training materials and on-site training sessions necessary for implementing the Plan benefits.							
v. Proposer shall provide reporting needed on an ad hoc basis for collective bargaining purposes and, if requested by the Agency, shall participate in collective bargaining sessions as an expert source for the particular benefit.							
w. Proposer shall attend open enrollment or special enrollment meetings as required. The Agencies will be reasonable in their requests for attendance at such meetings. However, the Proposer shall acknowledge that many of the Agencies have multiple work sites and that certain employees work non-standard hours in locations that span the City (or in the case of Cook County, that span the County).							
x. Proposer shall provide employees, their dependents and the Agency with prompt, accurate and courteous service. Timely service specifically includes prompt issuance of identification cards. Each Agency reserves the right to provide the selected Proposer with its own custom generated set of unique identification numbers							
y. Proposer shall provide management information reports as requested by the Agency. See Interrogatives, Reporting Requirements, which outlines minimum reporting criteria. The Agencies reserve the right to make changes in the content and frequency of reporting requirements.							
z. Proposer shall ensure that any participating providers meet all other requirements (i) specified in this RFP or (ii) proposed by the Proposer.							

	Medical PPO	Medical HMO/EPO	Dental PPO	Dental HMO	Vision	Medical. Review Services.	Employee Assistance Program
aa. Proposer shall have telephone service available for members twenty-four hours per day, 7 days per week.							
bb. Proposer shall provide specified services without regard to any waiting period.							
cc. Proposer shall provide specified services without regard to any pre-existing condition.							
dd. Proposer shall provide continuation coverage in accordance with each Agency's continuation of coverage programs, including but not limited to employees who are on inactive status due to medical leave of absence, ordinary leave of absence, suspension, Workers' Compensation, pension disability, personal disability, or a temporary lay-off.							
ee. If proposing an insured arrangement, Proposer shall provide a conversion option to the extent required by law for employees who have exhausted COBRA (PHSA) coverage eligibility. Enter n/a if proposing a non insured arrangement.							
ff. If proposing an insured arrangement, Proposer shall provide Services in the event that an employee has a potential work-related injury or illness (to the extent required by law). In the case of self-insured proposals, to provide services in accordance with the policy of that Agency regarding potential work related injury or illness.							
gg. Proposer shall provide subrogation services and workers compensation reimbursement services, and provide reports to each individual Agency on a monthly, quarterly or semiannual basis as required by that Agency except for the City of Chicago which has have carved out this service to a third party with respect to medical PPO services.							
hh. Proposer shall attend Agency health and wellness fairs at no additional cost							
ii. Proposer shall work cooperatively and diligently with an Agency to achieve its goals for its benefit programs. The Agency is party to one or more collective bargaining agreements, and as such, the Agency may be limited in its ability to change the terms of its benefit programs during a particular collective bargaining contract period unless such change is required by law or court order. The selected Proposer must specifically acknowledge that it understands the limits of the collective bargaining process and that in offering to provide services, it will not demand or otherwise attempt to change any benefit plan provision in effect at the time of award. Further, the proposer shall acknowledge that it prepared its pricing proposal with full knowledge of this requirement. Proposer shall also confirm that it understands that if a benefit term is changed during the collective bargaining process, it will do what is required to effect any such changes without additional cost to the Agency							
jj. Proposer shall represent and warrant to the Agency that it is appropriately licensed, insured, adequately staffed and ready, willing and able to provide the requested services in a professional, highly competent manner. Proposer must agree that it understands that the Agency substantially relied on its statements and representations provided in its response to the RFP and subsequent submissions to the Agency during the RFP process.							
kk. Proposer shall work creatively and cooperatively with the Agency to insure that the benefit program offers good value to the Agency and its plan							

	Medical PPO	Medical HMO/EPO	Dental PPO	Dental HMO	Vision	Medical. Review Services.	Employee Assistance Program
members.							
ll. Proposer shall include in its cost proposal an offer to underwrite a portion of, or all of, the cost of any computer programming or systems development on an Agency's benefits management information system, or that of its benefits management outsourced vendor, that is necessary to implement the services being proposed.							
mm. Proposer shall propose an initial contract term of at least three years.							
nn. Proposer shall propose two renewal terms of one year each, exercisable at the unilateral option of an Agency, the cost of which may be proposed to differ from the initial contract term.							
oo. Proposer shall propose to provide that all renewal information including costs, benefit levels, etc. to an Agency at least 120 days prior to the expiration date of any contract period.							
pp. Proposer shall propose that an Agency, by written notice given prior to the expiration of then current term of the agreement with the Proposer, may exercise its renewal option.							
qq. Proposer shall provide the services at a cost most advantageous to the Agency and its member..							
rr. Proposer shall review all exclusions to coverage and make an affirmative statement to the Agencies regarding the ability to administer the benefits.							
ss. Proposer acknowledges that any contract executed by the individual Agency with the selected Proposer may be subject to and contain mandatory terms and conditions. The terms and conditions may include the terms and conditions set forth in the Agency Exhibit for that Agency, although the precise language and detail may differ. Nothing here represents a restriction on an Agency or prevents an Agency from requiring fewer, different or additional terms and conditions in the contract.							
tt. Proposer shall work cooperatively with any outside service provider selected by the Agency to insure timely and accurate claim payment and prior authorization if required by the Agency's plan of benefits.							
uu. Proposer shall provide claim and eligibility files to an Agency's selected service providers in a frequency and manner to be determined jointly by the other service provider and the Proposer. (For example, if an Agency has outsourced subrogation or Medical Review Services (e.g. utilization review), the Proposer shall provide all data needed by the service provider to timely and accurately complete its services.							
vv. Proposer shall provide data files to the Agency, upon request, of claim, and if applicable, enrollment data in a frequency no less than monthly.							
ww. Proposer shall specifically represent and warrant that facilities and professional providers of services shall be insured at a minimum by the amounts and kinds of insurance specified herein by each Agency, if specified by the Agency in its Agency Exhibits.							
xx. Proposer shall perform its services directly. For example, proposals by brokers not capable of directly performing the services specified herein shall be deemed non-responsive.							
yy. Proposer shall ensure that any participating providers of the Proposer's network shall be appropriately licensed, insured, of high quality,							

	Medical PPO	Medical HMO/EPO	Dental PPO	Dental HMO	Vision	Medical. Review Services.	Employee Assistance Program
and meet all other requirements specified by the Proposer. (This scope requirement does not apply to Medical Review Services).							

Healthcare PPO (Medical PPO) Scope

The Agencies are seeking organizations to provide Medical Preferred Provider Organization (PPO or Medical PPO) Services. With two exceptions all of the Agencies have carved out from the medical PPO, prescription drug /pharmacy, dental and vision care services; the Agencies are not soliciting proposals for these services as part of the medical PPO. Solicitations of proposals for dental and vision services are set forth elsewhere in this RFP. This RFP does not solicit prescription drug /pharmacy services. The first exception concerns the Park District's high deductible health plan, which has fewer than 50 covered employees; in order to properly accumulate toward the deductible, the Park District has designed this plan to include pharmacy benefits. See Agency Exhibit for the Park District. The second exception concerns Agencies which have not carved out vision care but rather include vision within the Medical plan. See the Agency Exhibits, e.g., for the Chicago Park District and the Cook County Pension Fund. In particular note that the Park District has a carved out vision plan available for all employees, and under the Medical HMO also provides vision benefits.

The Agencies' goals for the PPO Services are:

a. To permit employees and their dependents to obtain comprehensive, high quality Medical care services that are easily accessible and provided in accordance with the terms of the respective plans of benefits from preferred providers.
b. To permit employees and their dependents to obtain comprehensive, high quality preventative health care services to improve and/or maintain their health status and prevent the worsening of chronic disease.
c. To ensure that the programs are administered effectively, efficiently and responsibly at the lowest possible cost to the Agencies.
d. To engage employees and their dependents in making healthy choices to improve their quality of life and reduce the incidence of chronic and/or avoidable diseases.

Proposers shall submit PPO proposals to provide benefits and administrative services in accordance with each Agency's Agency Exhibits. Note that Agencies' benefit plans as described in the Agency Exhibits are primarily collectively bargained and may differ from standard products Proposers may be accustomed to administering. This RFP requests proposals that conform to the Medical plans set forth in the Agency Exhibits.

A Medical PPO (aka a Healthcare PPO) is an organization that, on behalf of an Agency's Medical plan, contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Eligible Agency employees and dependents (Participants) pay less (incur a reduced cost-share) when using providers that belong to the PPO's network, but can also use doctors, hospitals, and other providers outside of the network at an additional cost (higher cost share). The health care professionals that participate in a PPO are usually called preferred providers and are considered in-network. Health care professionals that are not a part of the PPO are considered out-of-network. A PPO may be two tier: in-network and out of network. A PPO may be three tier: inside a narrow network, in-network, and out of network. It is possible PPOs with more tiers may also be desired. See Agency Exhibits for information about which Agencies are soliciting which type of network.

PPO plans of the Agencies currently do not require a plan participant to select a primary care physician who would be responsible for coordinating health care needs and providing required referrals to specialists or other providers. See Agency Exhibits to determine if any Agency seeks such a feature.

A PPO deductible is a fixed amount of money members are required to pay out of pocket toward certain medical expenses before the PPO plan will pay for covered services. A copayment is a set fee, typically a flat dollar amount that a Participant pays the medical provider for a covered medical service. Depending on the Agency's plan of benefits, a copayment may or may not be in addition to the deductible, and if not may or may not count toward the out of pocket maximum. Copayments are also referred to as copays. Coinsurance is the percentage of medical costs that the Participant pays after the deductible has been met. An out-of-pocket maximum (OPX), is the maximum amount of money a Participant has to spend on medical expenses each calendar year before the PPO plan will pay for all remaining medical expenses. Typically deductibles and co insurance count toward the OPX. Copayments may or may not count toward the OPX depending on the Agency's plan of benefits. See Agency Exhibits for each Agency's particular deductible, copayment, coinsurance and OPX requirements.

Each Agency reserves the right to outsource subrogation services. If you are proposing subrogation services, describe in full. If you are unwilling to allow an Agency to directly contract for subrogation, so state and provide an explanation of why you would not permit such contracting by an Agency.

Medical HMO Scope

The Agencies are seeking organizations to provide Health Management Organization ("HMO") and/or Exclusive Provider Organization ("EPO") Services referred to herein collectively as "HMO". (All of the Agencies have carved out separately Prescription Drug / Pharmacy and are not soliciting proposals for these service as part of the HMO. See Agency Exhibits.)

A health maintenance organization is a system for organizing, delivering, administering and financing health care. As an alternative to the traditional fee-for-service method of health care delivery, these organizations provide a comprehensive range of health care services, either directly or under arrangements with doctors, hospitals and other licensed healthcare providers, to an enrolled population usually on a "capitation basis" (i.e. for a fixed per capita fee with certain limited cost pass-throughs for hospitalizations and other healthcare providers other than medical care (e.g. physical therapy) and in certain cases for medical care in excess of certain specified attachment points or limits). An exclusive provider organization is similar but typically will not involve a fixed per capita fee and instead is typically self-insured with an administration fee. Health maintenance organizations and exclusive provider organizations are similar in that out of network providers are normally not covered except in certain emergencies, in the case of services outside the geographic area, or in other limited circumstances. As used in this Request for Proposal, the term "HMO" includes both health maintenance organizations and exclusive provider organizations unless the context clearly states otherwise. An HMO provides benefits in accordance with the individual Agency's plan of benefits or with the certificate of coverage on file at the Illinois Department of Insurance for the proposed program subject at all times to the individual Agency's approval. The term "Certificate of Coverage" includes the Agency's plan of benefits as determined by the Agency. If the HMO is insured the term is Certificate of Coverage.

Proposer shall administer a self-insured plan of benefits, administer an insured plan of benefits, or administer a partially self-insured and partially insured plan of benefits, in accordance with the Agencies' Agency Exhibits, including the Schedule of Benefits as outlined in the plan of benefits, the Certificate of Coverage (or in the case of an EPO, the benefit description). Proposer shall propose on each of the specified services specified by each Agency in its respective Certificate of Coverage.

Within the HMO services, the Agencies are also soliciting proposals and rates for ambulatory and hospital care services in accordance with the attached schedules of benefits on a capitation basis (e.g. an EPO, a hospital and medical provider group, etc.), on a cost plus administrative fee basis, or on a blend of capitation and cost plus administrative fee basis. The purpose of this request is to obtain quality medical care and adequate access to that care for employees and their dependents.

For an Agency's self-insured HMO, and for an Agency's self-insured portion of a partly insured and partly self-insured HMO, the Agency reserves the right to out-source subrogation services and at least one Agency currently does so. If you are proposing subrogation services, describe in full. If you are unwilling to allow an Agency to directly contract for subrogation, so state and provide an explanation of why you would not permit such contracting by an Agency

The HMO options proposed by Proposer for some of the Agencies must include Services with and without vision benefits. See Agency Exhibits.

The Agencies' goals for the HMO services are:

a. To permit employees and their dependents to obtain comprehensive, high quality health care services that are easily accessible and provided in accordance with the terms of the Agency's Plan of Benefits and the Certificate of Coverage and by HMO network providers to the extent feasible;

b. To permit employees and their dependents to obtain comprehensive, high quality HMO preventative health care services to improve and/or maintain their health status and prevent the worsening of chronic disease.

c. To engage employees and their dependents in making healthy choices to improve their quality of life and reduce the incidence of chronic and/or avoidable diseases.

d. To ensure that the programs are administered effectively, efficiently and responsibly at the lowest possible cost to the Agencies.

If benefit requirements have been changed by legislation (e.g.. changes in the HMO code), those additional requirements or changes in requirements shall be considered as added to the plan of benefits (and thus to this Scope) and where applicable to the Certificate of Coverage. Proposer shall list separately other services that must be added to the Certificate of Coverage provided and the effective date of the statutory change in coverage requirements. Each proposer should make clear whether its offering is an insured product or available to be offered as a self-funded program not subject to the Illinois insurance code.

Vision Scope

The Agencies are soliciting proposals and rate quotations for Vision Benefit Services in accordance with the attached Agency Exhibits. Proposals are solicited on both an administrative services only (ASO) basis or fully insured basis unless otherwise indicated by the Agency. The goals of the vision portion of this RFP are:

a. To permit employees and their dependents to obtain comprehensive, professional vision services that are easily accessible and provided in accordance with the terms of the Agency Exhibits.
b. To ensure that the programs are administered effectively, efficiently and responsibly at the lowest possible cost to the Agencies.

Dental PPO and DMO (Dental HMO) Scope

The Agencies are soliciting proposals and rate quotations for Dental Benefit Services in accordance with the attached Agency Exhibits. Proposals are solicited on both an administrative services only (ASO) basis or fully insured basis unless otherwise indicated by the Agency. Agency Exhibits may request proposals for a dental PPO, a DMO, or both.

If dental requirements have been changed by legislation, those additional requirements or changes in requirements shall be considered as added to the plan of benefits (and thus to this Scope) and where applicable to the Certificate of Coverage. Proposer shall list separately other services that must be added to the Certificate of Coverage provided and the effective date of the statutory change in coverage requirements. Each proposer should make clear whether its offering is an insured product or available to be offered as a self-funded program not subject to the Illinois insurance code.

The goals of the dental portion of this RFP are:

a. To permit employees and their dependents to obtain comprehensive, professional dental services that are easily accessible and provided in accordance with the terms of the Agency Exhibits.
b. To ensure that the programs are administered effectively, efficiently and responsibly at the lowest possible cost to the Agencies.

EAP Scope

Cook County is seeking proposals for an EAP (Employee Assistance Plan). The EAP scope and interrogatives are located at the end of this document.

Medical Review Services Scope

The Agencies are seeking organizations to provide medical review services descried below. Proposer will agree to supply all the personnel, materials and equipment necessary to perform the Services

All Services shall be performed in accordance with the Agency's plan of benefits. Services vary by Agency:

	City of Chicago PPO	Cook County	County Pension	Chicago Park District	City Colleges
Is a Proposal Requested for any Medical Review Services (Yes/No)? If Yes, more detail may be provided below and in the Agency Exhibits.	Yes	No	Yes	no	no
Utilization Management Services, including autism.	x				
Specialty Review Services	x				
Case Management (Care Coordination) Services.	x				
Disease Management Services	x				
Maternity Management Services	x				
Diabetes Management as part of Agency's wellness program.	x				
Predictive Modeling Services: advice and guidance to the Agency regarding clinical programs to improve patient outcomes and efficiency.	x				

A. Utilization Management Services.

1. **Requests for Utilization Management (UM) Services.** Proposer will accept medical information via live call, secure voice ports, web-based forms, fax and hard copy. All hard copy medical record information will be scanned and electronically attached to the case record in Proposer's medical management software with destruction of hard copy information in a form and manner that meets HIPAA privacy and security standards and subject to the terms of the Business Associate Agreement

2. **Precertification.** Depending on the Agency, Utilization Management Services may include but are not limited to precertification of the following medical services, treatments and/or procedures in accordance with the Agency Plans as they are amended from time to time as well as any other services, treatments, and/or procedures for which precertification is required under the Plans:
    a. Inpatient confinements including:
        i. Hospital admissions;
        ii. Acute rehabilitation;
        iii. Chemical dependency; and
        iv. Mental health.

    b. Ambulance transfers;

    c. Hospice: inpatient and home;

    d. Inpatient skilled nursing facility confinements;

e. Outpatient chemical dependency and mental health programs including group therapy, except that with respect to Actives and their Dependents, precertification is only required after a number of visits per calendar year specified by the Agency's plan document.

f. Residential treatment facilities;

g. Partial Hospital Programs ("PHP") and Intensive Outpatient Programs ("IOP");

h. Therapies for in home and outpatient services, except that with respect to Actives and their Dependents, precertification is only required after a number of visits per calendar year specified by the Agency's plan document.

i. Review Occupational or Speech therapies to determine whether treatment is provided in order to allow the patient to acquire function or to maintain a level of functioning for a person who has not previously reached the level of intellectual, speech, motor or physical development normally expected for the member's age.

j. Imaging (CT, MRI, PET scans).

k. Procedure Review
   a. Abdominoplasty or abdominal lipectomy;
   b. Breast augmentation, mammoplasty, mastopexy, reconstruction or reduction;
   c. Gastric bypass;
   d. Lipectomy;
   e. Mandibular or maxillary augmentation, fixation, osteotomy or reconstruction;
   f. Penile implantation;
   g. Rhinoplasty;
   h. Blepharoplasty;
   i. Septoplasty;
   j. Submucous resection;
   k. Sclerotherapy, and other varicose vein treatments;
   l. Uvulopalatopharynegeoplasty ("UPPP"); and
   m. Durable Medical Equipment (DME) costing over $500

Note: Proposer's services should include making recommendations to the Agencies as to any changes to the above list.

3. **Prospective and Concurrent Review.** Services include prospective review of proposed services, procedures and/or equipment and concurrent review as requested by the Agency or as otherwise required under the Plans of benefits for ongoing determinations of Medical Necessity (as defined by the respective Plan).

4. **Retrospective Review.** Services include retrospective review for inpatient admissions and ambulance transfers and retrospective review at the request of the Agency for contracted outpatient services and emergency services.

5. **Determinations of Medical Necessity.** Services include using evidenced-based criteria in the evaluation of Medical Necessity to the extent such criteria is consistent with the Plan's definition of Medical Necessity. Should a request meet criteria upon review by one of Proposer's nurse coordinators, the service will be approved. Should a request not meet criteria, it will be reviewed by Proposer's consultants for a determination of Medical Necessity.

6. **Notification of Medical Necessity Determinations.** Services include providing the Agency's claims administrator with a daily electronic transmission file of review decisions in a mutually agreeable format for incorporation into claim processing. Proposer will work collaboratively with the Agency's claims administrator to ensure the accuracy and timeliness of this transmission.

Proposer will make available to Members, either online, by fax, or by phone, the current status of his or her outstanding reviews. Proposer will assign a unique reference number to each participantwith a pending determination of Medical Necessity, which will enable the participantsto receive the status of the determination.

Proposer will provide timely written notification (in compliance with applicable law and benefit plan terms) of its Medical Necessity determinations to the Member, Provider and facility, as appropriate. The Agency may customize these notification letters as mutually agreed; however, Proposer is solely responsible for the content of any letters regarding review decisions and conformance with URAC standards.

7. **Appeal of Determinations of No Medical Necessity.** An appeal may be requested by a member or their representative, Provider and/or facility. Proposer will review specified plan/group members in identifying first and second level of appeal requirements for reviews of determination of no Medical Necessity. Proposer will use a provider consultant who has not been previously associated with the case and who is of like specialty as the condition or service under review to evaluate an appeal of a determination of no Medical Necessity. With respect to the timing and notification of appeals of determinations of no Medical Necessity, unless otherwise specified in the Agency Plans or directed by the Agency in writing, Proposer will comply with the appeal procedures set forth in the Agency's Plans as well as applicable law. Proposer also will cooperate with the Agency and any applicable claims administrator as necessary on any internal appeals or external review of an internal adverse benefit determination.

8. **Autism.** Proposer shall provide autism review in connection with all services currently provided under this agreement to Agency in connection with Illinois law. Proposer shall review these cases to make sure the patient meets the diagnosis of autism as based upon the guidelines set forth in such Illinois law. Proposer shall also ensure appropriate testing was completed before diagnosis.

   Proposer shall review autism cases to ensure treatment meets medical necessity guidelines under applicable law. Proposer will validate the required physician credentials for an autism review and determine if Proposer currently has peer reviewers that meet the standards outlined for these appeals. If Proposer does not have peer reviewers that meet the standards outlined in the law, Proposer shall recruit for this expertise. Proposer shall provide this review as a part of its UM PEPM fee.

B. Specialty Review Services.

1. **Specialty Review Services for Determinations of Medical Necessity.** Medical Necessity reviews where the Agency is requesting a third party opinion will be handled as a Specialty Review Service. Agency appeals after the 2nd level of appeals is exhausted and where the Agency is requesting a third party opinion will also be handled as a Specialty Review Service. The Agency may request this review to be done by Proposer's provider consultants, or the Agency may independently request an opinion from an Independent Review Organization ("IRO"). Depending on the Agency, Proposer will communicate the decision to the Participant, or Proposer will deliver its Specialty Review recommendations to the Agency to provide support for appeal decisions rendered by it. In the event the Agency seeks the opinion of an IRO, Proposer will cooperate with the IRO and provide any relevant case information it has in its possession to the IRO.

   Proposer will contract with three separate IROs that will be available upon request to administer an eligible request for external review of an internal adverse benefit determination made by the applicable Plan claims administrator in a manner consistent with any applicable state or federal law and the Plan document. Proposer will cooperate fully with the Agency and provide any relevant case information it has in its possession to the IRO.

C. Care Coordination Services

Proposer will provide the following Care Coordination Services.:

- Case Management Services
- Disease Management Services
- Maternity Management Services
- Claims Data File

The range of Care Coordination Services provided to the Agency may vary according to the status of any given participant pursuant to the Agency Plans (Active, Seasonal or Retiree). Proposer will maintain a profile of services for each category of participantunder the Agency Plans that corresponds to the Care Coordination Service requirements for each subset of participant. Proposer will provide the Agency with reporting capabilities specific to each category of Member, as requested by the Agency and mutually agreed upon by Proposer.

Proposer will dedicate staff to the Agency account for the provision of Care Coordination Services. Members may not simultaneously be receiving similar Care Coordination Services in more than one program that is billed at an hourly rate with the exception of those participating in specialty programs as agreed to by the Agency in writing. Due to specific alerts and outcomes associated with the programs, a member may be active in two care management programs simultaneously, as approved by the Agency. Nothing in this paragraph prevents or precludes a person from receiving Care Coordination Services. If a participant is eligible for more than one type of Care Coordination Service program, such Care Coordination Services will be consolidated and provided through a single Care Coordination Service program to provide continuity of care and to prevent duplicative or overlapping services or charges for the same member.

In order to establish successful participation levels in the Case Management and Disease Management Programs, Proposer will provide the Agency with the design of a customized brochure and flyer. Proposer will reimburse the Agency for the production costs of the customized brochure for a program introduction mailing. This is a one-time cost to Proposer, unless otherwise mutually agreed upon. The Agency will provide the Proposer with an invoice for payment.

Care Coordination: Case Management Services

Proposer will provide the following Case Management Services to participants with catastrophic and/or acute events (e.g., burns, spinal cord injuries, life-threatening injuries), participants discharged with home care needs, and participants with transplant or transplant-related medical interventions:

1. Case identification using medical guidelines developed by Proposer. Such case identification will occur on an on-going basis and will include consideration of any relevant medical information obtained since the last screening occurred;

2. Assessment of identified cases to determine whether intervention, monitoring and patient education would be cost effective, medically appropriate, and provide a benefit to the member;

3. For those cases identified as appropriate candidates for Case Management Services, Proposer will develop individualized plans to improve medical outcomes and reduce and/or eliminate the escalation of health care service costs;

4. Collaboration with providers, treatment team, patient and appropriate family members during the period in which Case Management Services are being provided to evaluate care needs, maximize services available through the benefit plan, and facilitate adherence with the treatment plan.

5. Individual reports on each active case reporting gross savings and/or value statement regarding program impact;

6. On-going follow-up with the patient and attending physician to facilitate compliance and continual evaluation of care alternatives during the period in which Case Management Services are being provided to the participant;

7. Medical Necessity review for the following services, supplies and equipment:
    a. Durable Medical Equipment (“DME”) costing more than $500 will be included as part of the Utilization Management Precertification Services set forth above;
    b. Human Organ Transplants;
    c. Infertility treatments;
    d. Home nursing visits; and
    e. Private nursing visits.

8. Specialty Case Management. Specialty Case Management Programs to be made available at an hourly fee to be proposed. Programs might include:

a. Renal Care Program, including:

   i. The use of a software tool to proactively identify dialysis patients;
   ii. The promotion of the Medicare application and payor/client notification of Medicare effective date;
   iii. Steering patients to a network provider and obtaining future discounts and re-pricing of claims for both in network and out-of-network providers, as desired by the Agency;
   iv. Staff with dialysis expertise will review the treatment plans and work with the providers to ensure highest quality and effective care is given to the patient;
   v. Provide patient education and support to promote adherence;
   vi. Collaboration with physician team to determine if patient is a potential transplant candidate and, start the evaluation process; and
   vii. Collaboration with physician to discuss referral to home dialysis providers for cost reduction.

b. Oncology Care Program, including:
   i. The use of a software tool to proactively identify oncology patients;
   ii. A thorough review of the treatment plan for medical necessity, efficacy and identification of non-FDA approved medications would be performed;
   iii. Staff trained in oncology care providing referrals to network providers and specialty pharmacy as appropriate;
   iv. Performing claims negotiation per client contract;
   v. Collaboration with attending physician; and
   vi. Providing education and support to the member and family, and referrals to community resources.

c. Emergency Department (ED) Reduction program including
   i. Identification of members with 3+ ED visits in one calendar quarter from the medical claims;
   ii. Assessment and collaboration with the member and provider to determine root cause of ED visits and proposed treatment plan; and
   iii. Education on disease process and ED alternatives.

d. Transitional Care Management, including:
   i. Identification of acute medical conditions (e.g., Myocardial Infarction, Congestive Heart Failure, Atrial Fib, Pneumonia, Asthma, COPD, Diabetes) to ensure the coordination and continuity of health care as patients transfer from acute care settings to home;
   ii. Assessment, collaboration and coordination of care;
   iii. Educational components including:
      A. Medication reconciliation
      B. Red flags/ warning signs
      C. Use of Personal Health Record
      D. Primary care physician follow up
      E. Additional interventions as special needs occur

9. Predictive modeling services.

10. Future Programs. Future Programs as developed will also be available at an additional hourly fee.

Care Coordination: Disease Management Services.

1. **Identification.** Proposer will identify employees and their dependents for Disease Management Services through the addition of a software tool which utilizes claim data and provides referrals plus referrals from other programs or the Agency. The software tool will assist with identification of at risk participants with expectations of escalating health cost and care gaps. Participantsare not only identified for program participation but their medical service utilization information and claims analysis information is made available to health coaches to initiate interventions consistent with their medical needs and health improvement goals.

2. **Disease States.** Members diagnosed with following disease states such as, but not limited to the following, are eligible for Disease Management Services:
   a. Asthma;
   b. Chronic Obstructive Pulmonary Disease (“COPD”);

c. Coronary Artery Disease/Congestive Health Failure ("CAD/CHF");
e. Diabetes;
f. Sleep Apnea ;
g. Diseases requiring Chronic Care interventions (hereinafter referred to as "Chronic Care") identified in the following manner: Evaluation of participantsidentified through risk stratification of claim data with a primary condition and multiple affecting conditions contributing to continued health deterioration with opportunities for improving health outcomes.

3. **Stratification**.

Disease Management Services are stratified for program participants based on medical and pharmacy claim history identified through the software tool for a rolling 12 month period and assessment with corresponding interventions tailored for the program participant. Identifiers for program participation may include:

a. Inpatient hospitalizations
b. Number of chronic conditions
c. Number of treating providers
d. Number of pharmacological agents
e. Risk of readmissions
f. Risk for increased projected cost(medical and pharmacy)
g. Number of emergency room visits/hospital admissions.

4. **Disease Management Program Interventions**.

a. **Non-Chronic Care Interventions**. For participantsidentified for participation in the Asthma, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease/Congestive Health Failure and Diabetes Programs, the following program interventions can apply, although participation in Disease Management Services is solely at the option of the Member:

Moderate and high risk participantsare contacted by Proposer. Proposer will make three contact attempts at no cost to the Agency.

Once Proposer successfully contacts the participantsand such participantagrees to participate in the Disease Management program, Proposer will mail to participantsan introduction letter, educational materials, and an enrollment form; Member may also confirm program participation via phone call which will be documented in Proposer's medical management software.

Upon confirmation, a health coach will initiate a clinical assessment, Provider collaboration and provision of educational materials to support primary disease condition management and affecting co-morbidities.

b. **Chronic Care Interventions.** For Members identified for participation and who agree to participate in the Chronic Care program, interventions will consist of the following:
(i) Upon phone contact, health coach will obtain verbal confirmation for program participation;
(ii) Individualized/customized treatment plans designed to reduce and/or eliminate continued escalation of health care service costs;
(iii) Prioritization of the Member's impacting conditions and factors;
(iv) Collaboration with Providers and appropriate family members;
(v) Education of member with inclusion of individualized short-term health improvement goals;
(vi) Monitoring and ongoing follow-up of medical conditions and identification of exacerbations for care coordination; and
(vii) Intervention frequency dependent on severity of conditions with anticipated monthly contact to monitor conditions, goals, exacerbations.

4. **Refusal of services.** Should a participantrefuse Disease Management Services, Proposer will conclude that case in accordance with its standard operating protocol, which adheres to URAC standards and specifications.

5. **Communications.** Communication to targeted participants will include verbal and/or written confirmation of their program participation. All such communications will be documented in Proposer's medical management software. Educational communications and mailings, created with the purpose of reinforcing participants' health improvement goals and

informing participants of current treatment standards for their disease state, will be sent to participants identified for participation in the Asthma, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease/Congestive Health Failure, and Diabetes and Chronic Care Disease Management Services programs.

Care Coordination: Maternity Management Services

Proposer will provide Maternity Management Services program for pregnant participants. Maternity Management Services will include an initial clinical assessment by one of Proposer's health coaches. Participation in Maternity Management Services is voluntary on the part of the pregnant participant.

Members for whom no apparent risks are identified during the initial clinical assessment will receive in the mail a packet containing information regarding pregnancy, and the packet will also include a phone number and instructions on how to contact a health coach should complications or health concerns arise during the course of the pregnancy. Participants identified during the initial clinical assessment as having high risk factors for pregnancy complications and/or utilization of high cost or high volume medical services may elect to receive Case Management Services specific to their pregnancies.

Care Coordination Services: Claims Data File Analysis

The Agency or its designee will provide Proposer with a paid medical and pharmacy claims file for a rolling twelve month period on monthly basis in a mutually acceptable format for use by Proposer for the following purposes:

1. Identification of participants eligible to receive Care Coordination Services;
2. Utilization information and reports for initiation of Care Coordination strategies; and
3. Calculation of program impact/savings.

D. Other Services and Responsibilities

Reports

Proposer will provide the Agency with its standard report package and the following customized reports for Medical Management and Care Coordination Services at no additional charge:

1. Weekly Report of Inpatient Confinements at or over fifteen days;
2. Monthly Medical Management and Care Coordination Program Activity Report;
3. Monthly Third Party Liability Report;
4. Monthly Readmission Report – report of all re-admissions at an acute or skilled level that have occurred within thirty days prior to the reporting start date;
5. Reports specific to Member status (Active/Seasonal or Annuitant), as requested by the Agency;
6. Quarterly Disease Management Report;
7. Monthly Report for Appeal Meetings
8. Monthly Transplant Report;
9. Quarterly and Annual Report (on entire program activity);
10. Monthly Utilization Management Review Savings Report;
11. Monthly Disease/Case Management/ Other Programs/Savings Report;
12. Monthly Utilization Management Report; and
13. Reports required as supporting documentation are attached to monthly invoices and include:
    - Monthly Utilization Management Special Review Summary
    - Monthly Care Coordination Programs Summary

Should the Agency request customized reports in addition to the reports provided by Proposer and described here, Proposer will inform the Agency whether an additional charge for the programming of such customized report is necessary. Proposer will not initiate programming without written approval from the Agency.

Proposer also shall provide reports as needed on an ad hoc basis for collective bargaining purposes at no additional charge.

Release of Medical Information

As directed by the Agency, Proposer will coordinate the electronic exchange of data, discussion of benefits and claims processing with other Agency vendors. This coordination will involve, at a minimum, the Agency Plans' medical and pharmacy claim administration vendors.

It will be the responsibility of the Agency to ensure Proposer the ability to access protected health information ("PHI") of Members. This access will be solely and only to the extent required for the implementation of the services provided by Proposer, and shall be in compliance with the requirements of the Business Associate Agreement executed with the Agency.

General Communications

1. Communications with Members, Providers and Facilities.

Proposer will provide a toll free phone number for participants, providers and facilities which shall maintain normal business hours of 7:30 AM – 7:00 PM Monday through Friday, excluding major holidays. Outside of normal business hours, the toll free phone number will be answered by an answering service with access to a nurse for urgent services 24 hours per day, 7 days per week. The line will be staffed by Proposer staff who are familiar with the Agency Plans. The Agency, as mutually agreed upon by Proposer, may customize the specific call center language to be used with participants. Additionally, Proposer will provide a translation service, on an as-needed basis, to callers to aid the intake of information for Medical Management and Care Coordination Services. After normal business hours, the toll free phone number for the Agency will be answered by a medical answering service which will have access to Proposer personnel in the event of an emergency.

2. Communications with the Agency and its Vendors

A Proposer representative will be available at monthly meetings with the Agency to discuss case findings and to answer questions from Agency representatives, and at collective bargaining sessions or LMCC meetings as requested by the Agency. Additionally, Proposer representatives will be available to the Agency for onsite visits, including at health and wellness fairs at no additional cost, and/or telephonic discussion of Service reports and outcomes, design of the Agency Plans, and the cost effectiveness and service quality of Medical Management Services and Care Coordination Services.

Proposer will receive a weekly electronic eligibility file on a regular basis from the Agency or its designee for loading into Proposer's medical management software. Proposer will use information contained in the Agency-provided eligibility file to contact and communicate with Members in order to provide those Services required herein. The eligibility file will contain those differentiators necessary to enable Proposer to provide appropriate Medical Management and Care Coordination Services as specified by the Agency Plans. In turn, Proposer will provide the Agency, the Agency's eligibility vendor, the Agency's wellness vendor, or any other Agency vendor, as requested by the Agency, with participation files on any disease management program.

Proposer will appoint a designated account representative who is appropriately authorized to monitor and coordinate services, and who is positioned to either bind Proposer or obtain the authorization of someone so positioned.

Proposer key personnel will be available as needed for meetings. These meetings shall be held telephonically or on site as mutually agreed upon.

Proposer will provide, at no cost to the Agency, training materials and on-site training sessions as needed for purposes of implementing services provided under the Agreement. Additionally, Proposer will provide any information that is necessary for the effective operations of the services including administrative advice and assistance as needed.

Proposer will notify the Agency within one business day of any situation of which it becomes aware with respect to which litigation or risk to the Agency Plan could be present.

E. Compliance with the Patient Protection and Affordable Care Act of 2010 ("PPACA")

Proposer will comply with all provisions of PPACA and any implementing rules and regulations which apply to the provision and administration of the services the Proposer is providing under this Agreement. To the extent a mandate of PPACA applies to the Agency but not to the Proposer, the Proposer will fully cooperate with the Agency so that the Agency may fulfill its obligations under PPACA.

Interrogatives

This Interrogatives Section is Also Provided in Microsoft Word

Each Interrogative is Applicable to all Services (Medical PPO, Medical HMO, Medical Services Review, Dental PPO, DMO (aka "Dental HMO") and Vision) Unless Otherwise Stated.

Answer all interrogatives applicable for the Service which you are proposing (e.g. Medical PPO, Vision, Dental HMO, Medical Review Services, etc.). Answer each interrogative specifically for the Service for which you are proposing. Many questions will require that you gather data specific to the individual service (PPO, HMO, dental, vision, etc.). Do not combine data for individual Services into a single answer. For example, if you are asked for the number of clients/lives for which you offer services and you are proposing to offer four Services, then you must provide four answers, one for each service, which contains the number of clients/lives for each of the four individual services. For any question identified to be answered for Medical PPO and HMO, it is meant to include EPO Medical Services proposals as well. Any references to "you" or "your" are meant to apply to the organization that is responding to this RFP.

GENERAL*:*

1. Provide the full name and address of your company (headquarters) and the address(es) of your Chicago metropolitan area offices or the address of the location where the Agency accounts would be administered.

2. Identify which Services you are proposing to offer. If you are not proposing for all agencies, specify which services you are proposing for which agencies:
    - Medical PPO
    - Medical HMO
    - Medical EPO
    - Vision Services
    - Dental PPO services
    - DMO Services
    - Medical Review services
    - EAP

3. What year was your company founded?

4. DMO and Medical HMO Only: When did the organization receive its Certificate of Authority from the Director of the Illinois Department of Insurance? Provide a copy of this Certificate. Provide the history of your company.

5. Describe the organization (organizational structure and lines of supervision) and capitalization of your company, listing all principal owners and shareholders and the percentage (if any) of ownership interest held by a corporation or other legal entity, including its relationship to you, and identify your company's subsidiaries.

6. Is your organization licensed to do business in Illinois for the services for which you are proposing? Are you in compliance with all requirements of the insurance laws and the requirements of the duly constituted insurance regulatory authority of the State of Illinois or any other state in which your company operates? Please specify.

7. Do you now or have you ever had a contract with any of the Agencies to provide any product or services? If so,

list each such contract identifying the start and stop dates and the product or service offered.

8. Is your organization currently engaged in or do you have any pending service contracts which may result in a conflict of interest with any of the Agencies? If yes, describe the potential or actual conflict of interest.

9. Has any part of your company including, but not limited to, the parent company, a subsidiary or division of your company or any officer filed for bankruptcy or reorganization within the last five (years)? If yes, provide pertinent details of these actions.

10. Is your organization, including but not limited to the parent company, a subsidiary or division of your company or any officer involved in any litigation that could affect its ability to meet the requirements as stated in this RFP? Are there any planned or pending agreements or negotiations to merge or sell your company? If yes, include agreements, letters of intent, or comparable documents pertaining to such agreements or negotiations.

11. Stability, Narrative: Describe your organization's financial stability.

12. Stability, Ratings: Submit your three most recent annual financial stability ratings (e.g. Best's, Moody's, Standard & Poors).

13. Size and Experience. Answer the this entire question separately for each Service (e.g. medical PPO, Medical Review Service, dental DMO, etc.) with respect to which you are proposing:

    a. For how long have you been providing the Service? How many employer groups currently offer your Service? What benefits are unique to your organization and how do you differ from your competitors?
    b. What was the total enrollment for your Service on January 1 for each of the past three years:
        1) In the metropolitan Chicago area, provide both the number of employees and the total number of covered lives.
        2) In Illinois, provide both the number of employees and the total number of covered lives.
    c. What is the projected enrollment for next year? Provide both the number of employees and the total number of covered lives.

14. How many of your employees if any, work within the City of Chicago? Cook County? How many if any, reside within the City of Chicago? Cook County?

15. Indicate the number of people you employ in each of the following areas:

    a. claims processing_____;
    b. provider relations/management_____;
    c. information technology function commonly known as "systems"_____;
    d. customer service/eligibility units_____; and
    e. quality assurance_____.

16. Indicate for what period of time this proposal is binding. (The period must be no less than two hundred and seventy days.)

17. Although no Agency maintains a grandfathered plan, confirm that you are poised to correctly provide services to plans for which the ACA has no or limited applicability, such as the Cook County Pension Fund and City retiree plans. Please confirm you wil be able to administer a plan in which the Agency retains complete control over its own plan design, covered services, and exclusions.

18. Quality Based Plan Design - The Agencies' collectively bargained plan designs may or may not be revised in future collective bargaining. Proposers shall review the existing plan designs and A) propose any changes that may be

appropriate to provide healthy outcomes and quality benefits consistent with prudent employer and employee expenditures of financial resources, including but not limited to recommended incentives and/or disincentives if any, and B) provide an estimate of the improvements in healthy outcomes and the financial savings related to such proposals. In particular, please review the existing benefit plans and make recommendations for changes that would:

a. Improve participation in wellness and chronic disease programs;
b. Improve the health of the population;
c. Encourage ownership of personal health;
d. Appropriately balance employer and employee spending;
e. Suppress or reduce trend;
f. Produce desired results within three years, and
g. Quantify any increased expenses or cost reductions associated with your recommendations.

Provide examples of employers who have adopted similar strategies and provide an estimate of results that might be obtained if your recommended strategy were adopted. You may suggest phased changes if such are appropriate.

ADMINISTRATION AND OPERATIONS

For each Service with respect to which you are proposing answer separately:

Provide an organizational chart of the administrative and medical management of that part of your organization that will provide the Services. Also, provide a description of the resources the organization expects to commit in order to perform the services required. Include the expected staffing levels to be utilized and number of full time equivalent employees.

List the names, qualifications and a brief biography of all key personnel that will be committed to perform on this contract, include his/her experience with public sector employees. Also provide the names and telephone numbers of the individuals (exclude marketing representatives and account executives) within your organization who are able to answer technical and professional questions.

Discuss how your organization would implement the addition of a significant number of new employees and dependents to your client base. Include in your statement, how you will transition this group from the existing carrier to your organization, if your organization is selected. Be specific as to what data you would require from the current carrier(s)/administrator(s)/service provider(s) in order to assure a smooth transition. Provide a copy of your Transition of Care protocols for ongoing medical and dental services (e.g. continuing home care needs, orthodontic treatment, etc.).

Provide a detailed timetable (Gantt Chart) geared toward a January 1, 2021 implementation date (12/1/2020 for Cook County), indicating the earliest completion dates your organization would be able to implement all significant tasks. This timetable must serve as an actual work plan and must include, but not be limited to:

a. Initial planning meeting;
b. Coordination with Agency staff;
c. Customer service training;
d. Communications development and production;
e. Network development;
f. Development of systems capabilities;
g. Contract development and execution;
h. Answer the following 3 questions for all Services other than Medical Review Services:
    - How will you assign unique ID numbers;

- How will you produce and issue Enrollment: (membership) cards prior to Commencement Date; and
- How will you engage in appropriate transition of care planning including approval of continuing care plans?

For all Services other than Medical Review Services: Provide the following sample forms and or standard materials used in administering the Services: Member EOBs; invoices and backup documentation sufficient for your customer to verify the accuracy of the invoice. Please confirm that you will provide a claim file with the invoice for services paid with any invoice; the file will be in a format mutually agreeable to the Agencies and the selected proposer.

If you provide identification cards for members, how are they created and distributed? What constitutes the employee member number? Will you pay all costs associated with identification card distribution? If no, why not? Can the ID card be customized with a logo/seal? Can you provide a combo card to include prescription drug ID card information?

Will you agree that if an Agency has selected a PBM or selects a medical services provider that is other than your firm, you will allow the PBM and medical services provider information to appear on the ID card at no cost to the Agencies?

Customer Service:

a. What are your general business hours? Hours for customer service? Where is your customer service function located?
b. Do you have an 800 number or other toll free number? Do you propose a separate 800 number for each Agency? Is there an automated attendant? If so, how many choices is the caller offered via the automated attendant? How many people are available to answer telephone calls during your hours of operation? Will you allow an agency to customize the automated attendant?
c. Do you offer separate phone numbers for providers and members?
d. When a plan member calls the toll free number, what are the qualifications of the person who answers the call?
e. Describe your customer service representative training program.
f. Describe the minimum qualifications, including educational credentials for selection as a customer service representative.
g. Do you have a website for enrollee inquiries? If you have a test site or "test ID" that the Agencies can use to review your website, please provide a list of user IDs and passwords. Please include screenshots of the five most used functions of your web-based and/or phone apps. Of your customer base, how many unique individuals use your electronic services?
h. How do you ensure the privacy of member information?
i. How do you educate new members about the availability of member facing web opportunities?
j. Do you have a cell phone text message function, an iPhone, Android or other smart phone app? How do you ensure privacy?

Record Keeping:

1. Describe your record keeping system and the process by which you manage record keeping services at the customer (Agency) level and at the individual member/dependent level.
2. Provide samples of standard reports that you use in the administration of the program. For example, edit reports used to process a client eligibility file, membership reports, and client reporting for financial and medical utilization purposes.
3. Describe how and when you communicate to members about available programs and services. Do you have an annual communication plan? Do your member communications only go to members registered on your participant applications? Do you mail any communications other than paper EOBs? If yes, describe the content and circumstances under which your firm would distribute these mailings.
4. How do your administrative systems support health and wellness?

5. What changes have you made in administrative systems within the last three years? How did employees/dependents, employers and providers benefit from the changes?
6. How do you handle any errors made in the administration of the program? How are errors detected? Provide examples of administrative errors that have been made and describe how the errors were corrected. When are errors reported to the client?
7. Describe:

    a. All internal and external audit processes conducted by your organization to continuously maintain the integrity of the plan.
    b. Who conducts the internal audits?
    c. How often are internal audits conducted?
    d. How frequently are clients provided with internal quality control audit reports?

FINANCIAL

1. For each Service with respect to which you are proposing, what percentage of your gross revenues and enrollment come from the following sources (percentages should total 100%):

    a. Medicaid;
    b. Medicare;
    c. Employer group accounts; and
    d. Others (explain).

2. Medical PPO and HMO only: Describe your reinsurance program, if any, including stop loss limits.

3. Medical PPO and HMO only and separately: What percentage of the your total annual expenditures for each of the past three fiscal years are for the following:

    a. payment to acute care hospitals (exclude out-of-plan providers);
    b. payment to physicians or physician groups (exclude out-of-plan providers);
    c. capitation payments to primary care physicians and/or groups;
    d. specialty care (excluding mental health/substance abuse);
    e. capitation (total);
    f. fee-for-service to plan providers;
    g. payment to out-of-plan providers (e.g., out-of-state emergency and hospital services);
    h. payment to providers for inpatient medical services for mental health, alcohol and substance abuse (exclude out-of-plan providers);
    i. payment to intermediate care facilities, nursing homes, rehabilitation hospitals and other long term care providers (exclude out-of-plan providers);
    j. payment for DM program;
    k. payment for CM program;
    l. payment for wellness program; and
    m. payment for healthcare results, quality outcomes, decreased burden of illness, reduced readmission rates, etc.

4. Medical PPO and HMO only: What percentage of annual expenditures have been paid to related parties (i.e., subsidiaries or affiliates or parent company; joint venture partners or firms in which you hold an interest greater than 10%) for each of the past three years? Describe these related party relationships.

5. Medical PPO and HMO only: Does your plan provide protection against the risk of insolvency by continuing benefit payments for the term of the agreement for which premium payments have been made or until members are discharged from inpatient facilities? If yes, describe the protection mechanism.

6. Medical PPO and HMO only: Define and disclose administrative expenses, retention rates, medical loss ratio and profit margin for the last three years for which information is available. What percent and dollar amount of the Proposer's book of business goes to patient care, to administrative expense and profit?

PROVIDER NETWORK MANAGEMENT

1. Medical PPO and HMO only: Provide a data file of physicians by specialty, Illinois license number, hours worked, office location, whether employee or independent contractor, at which hospitals the physician maintains staff privileges, board certification or eligibility. Also include contract of employment effective and termination dates. This list shall be in an Excel format (e.g. PDF is not acceptable). All Services other than Medical Review Services: Do you currently have an operational provider network in the Chicago metropolitan area? If so, describe the provider network in detail, and provide a map indicating the locations of the facilities and providers.

2. All Services other than Medical Review Services: Do you currently have an operational provider network in the Chicago metropolitan area? If so, describe the provider network in detail, and provide a map indicating the locations of the facilities and providers.

3. Each Agency has provided information on their most utilized providers. Please determine if these top utilized providers are included in your network for each service for which you are proposing.

4. Medical HMO and PPO: Provide a list of hospitals where members can obtain services. Any directory information shall be provided in an Excel format including the effective date for each provider, the provider name, the provider type, and the address where the provider performs medical services.

5. Medical PPO and HMO Only: Using the census provided by each Municipal Agency, provide a geo-access analysis of primary care physicians for the population. The geo-access report shall be provided for each Agency, and shall provide detail on a zip code by zip code basis. Further, the report shall detail the number of physicians available in the given zip code. The standard of access for purposes of the report is three primary care physicians within five miles and one hospital within ten miles. For zip "606" please use five digits.

6. Medical PPO and HMO Only: What is the percentage of Board eligible and Board certified physicians as compared to total physicians?

7. Medical PPO and HMO Only: Describe your methods for capturing medical encounter data. Is submission of medical encounter data required? If no, why not? If yes, what methods do you use to ensure provider compliance with your requirements? What percentage of patient encounters are with:

    a. primary care physicians;
    b. specialists;
    c. nursing personnel; and
    d. other medical professionals (explain).

8. All Services except Medical Review Services: How do you use medical encounter data to manage or evaluate provider behavior? Describe incentives/disincentives for provider behavior.

9. All Services except Medical Review Services: During the last three years what programs or process changes or improvements have you initiated as a result of analysis of captured encounter data? Describe the results of any such improvements or changes. Have these programs and processes been focused on cost containment, improved health outcomes, or both? How do you share such data with providers?

10. All Services except Medical Review Services: For what reasons can the network terminate agreements with providers?

11. Medical PPO and Medical HMO Only: Under what conditions may enrollees change physicians? What procedures must they follow and how often can a member change physicians?

12. Medical PPO and HMO Only: What has been the turnover in primary care physicians for each of the last three years? What is the percentage of primary care physicians whose contracts were terminated by you in each of the last three years? How many physicians/physician groups voluntarily left the PPO or HMO provider panel?

13. Describe the availability of around the clock emergency services.

14. All Services except Medical Review Services: Describe how an employee or dependent that requires care while outside of the metropolitan Chicago area will be provided services. Example: a dependent who requires care over an extended period of time while away from home (student attending college). Do you have "guest" or "visitor" status programs for people who are temporarily domiciled outside of the service area (including while out of the country)? What are the terms and conditions of such programs?

15. Medical PPO and Medical HMO Only: How much time is scheduled per patient for a physician visit? A pediatric routine visit? An internal medicine visit? A routine well baby care visit? Are there any contractual standards related to the frequency or timing of medical services for enrollees?

16. Medical HMO only: What is your program's policy regarding a patient's continued treatment when their physician leaves the plan? If the answer differs due to either diagnosis or confinement status, explain. If an obstetrician leaves the plan, how is care for patients in the third trimester of pregnancy handled? Do you have a transitional care protocol? Do your member hospitals use laborist physicians?

17. Medical HMO only: How does a member obtain a referral? Who is responsible for obtaining any needed pre- authorizations? Are primary care physician referrals required for all specialty care? If not, to which, if any, specialists can a member self refer? If the primary care physician refers to non- network provider without HMO approval, is the member responsible for charges?

18. Medical PPO and HMO only: Provide your policy on referral to medical specialists.

19. Medical HMO Only: Provide the HMO's policy related to medical diagnostic tests. (i.e., MRI, CT scans, PET scans, etc.). Are medical scans reviewed for appropriateness prior to the performance of the procedure? Why or why not? Who is responsible for the payment of scans?

20. Medical HMO only: Are there any medical services such as disease management, case management, wellness etc. that are subcontracted to another vendor? If yes, please describe in detail.

21. Medical HMO only: Provide a description of how HMO physicians/physician groups may use nurse practitioners, physician assistants and other physician extenders. By what criteria is a patient referred to a physician assistant rather than a physician?

22. Medical HMO only: Do you utilize Urgent Care Centers? How does a patient access a provider for urgent or emergency care outside of normal business hours?

23. Medical HMO only: Do you allow patients to use the services of nurse practitioners located in retail pharmacies, big box stores, or other locations for urgent/emergent care? Why or why not? Is a referral required? How are members informed of your policies with respect to these new sites of care? Describe such locations and if possible list the locations in the Chicagoland area.

24. Medical HMO only: Do you have any contractual requirements that would ensure that diagnostic test results are available to the physician prior to a patient's follow up visit or requirements on how patients obtain test results?

25. Medical PPO and HMO only: Do you have any contractual requirements related to electronic medical records? Do you have any contractual incentives that would support physician adoption of electronic medical records? Do you conduct audits of individual patient medical records to determine that they are appropriate and completed in accordance with medical standards? If yes, describe your program. If no, why not?

26. Medical PPO and HMO only: If an enrollee wishes to obtain a copy of his/her medical records, how would the enrollee do so? Is there a charge for copies? If yes, what is the charge? Are your answers different if such records are required for a transition of care plan?

27. Medical PPO and HMO only. Do you utilize preferred providers for home health care firms, durable medical equipment, alternative treatment centers, mental/chemical dependency treatment centers, hospice, skilled nursing facilities, and home infusion therapy providers? How are they selected?

28. Medical PPO and HMO only: With regard to mental health and chemical dependency treatment, what are your plan's established standards for access? Provide documentation as an attachment. What is the typical wait time for a member to see a mental health specialist after referral? Does this differ for pediatric mental health specialists?

29. Medical HMO and dental HMO only: How do you notify enrollees of changes to the HMO provider network? Describe the process for updating your online and print directories.

30. Medical HMO and dental HMO only: If a primary care physician or dentist ("PCP/PCD") terminates his/her participation and subsequently joins the network again, do you notify former patients? In what time periods? Do you allow them to enroll again with the former PCP/PCD? How do your answers differ for specialty care physicians/dentists? How long after a provider enters or leaves the network is the directory updated?

31. Medical PPO and HMO only: Can your plan produce a list of the physicians who are affiliated with a specific hospital? A list of specialist at PPO hospitals who are not in the PPO? A list of specialists at HMO hospitals who are not in the HMO?

32. Medical HMO only: How do you notify members of a change in hospital affiliation by a PCP? Do you require that PCPs have admitting privileges to more than one network hospital?

33. Medical PPO and HMO only: May a physician refer a patient to an ambulatory surgical treatment center in which he/she has a financial interest?

34. Medical PPO and HMO only: May a physician refer a patient to a diagnostic testing facility in which she/he has a financial interest?

35. Medical PPO and HMO only: Do you require that a physician must disclose any interest she or he holds in an ASTC or diagnostic facility?

36. Medical PPO and HMO only: What degree of choice do you allow members regarding the place of hospital services?

37. Do your answers to any of the above listed questions differ if the provider is capitated on a full risk basis or a partial risk basis, i.e., hospital and physician risk versus physician only risk?

38. Medical PPO and HMO only: From a contractual perspective, do you have a single model for physicians? Do you have both capitation contracts and fee for service contracts with the same type of physician?

39. Network Management:

    a. How do you communicate to members which stand-alone immediate care providers truly bill as urgent care facilities versus billing as an emergency room?
    b. Do you have any secondary networks that wrap around your primary network? If so please describe.
    c. To the extent that you do have such secondary networks, how are they reflected in your geo-access results?

COMPENSATION

(Question 1. To Be Answered By Proposers For All Services, Other Questions Under Compensation To Be Answered By Proposers For Medical PPO And HMO Only)

1. Provide a sample contract for each type of provider, e.g. hospital, physician, dentist, optometrist, etc.

2. How are primary and specialty physicians compensated? Be specific. If you have a compensation plan for physicians, describe. Are there financial incentives to modify physician behavior? Does quality assessment affect physicians" compensation?

3. With respect to physician compensation:

    a. Do you have one schedule of compensation that applies to all physicians in a geographic area? For example, would all physicians in Chicago receive the same compensation for CPT 99212? If no, how do you determine payment amounts? Do you use Medicare rates as a starting point? Are your payments based on resource utilization? Please be specific.

    b. How are your mental health providers compensated compared to primary care physicians or other specialists?

4. Do you have a bonus or risk pool arrangement as part of the physician compensation package? What have the pay outs been for the last three (3) years as both a dollar amount and as a percentage of the total eligible pay out?

5. Explain your methodology for developing capitation rates for Physician only capitation and full capitation (all services) or other variants that is reflective of your contracting methodology. Specify those services that are included in the capitation payments.

6. For those entities which contract on a full capitation basis, describe bonus or risk pool arrangements. Provide an illustration of how financial performance is determined. Also illustrate how surpluses and deficits are accounted for.

7. Provide a listing of all hospitals with which the HMO contracts. Detail the fee arrangements for each hospital by service provided. How often are these contracts renegotiated? What contracts are in place for non-hospital, non-physician services? How is the rate of increase in hospital reimbursement determined?

8. Do you base part of physician compensation on consumer satisfaction? If yes, describe criteria used to measure satisfaction. If not, why not? Provide the appropriate measurement criteria for other compensation factors.

9. Do you base part of provider compensation on medical outcomes? If yes, describe criteria used to measure outcomes. If not, why not?

10. Is any part of compensation based on health improvement in the provider's census? On provision of preventative services?

11. What aspects of health care delivery do you believe are relevant to patients? Do your contracts reflect or require any of those items you believe relevant to patient satisfaction? If yes, describe. If no, why not?

12. Do you allow providers with whom you contract to benefit from your contracts with providers? For example, if you had a contracted relationship with a prosthetics manufacturer and a PHO or physician group did not have such a contract, could the PHO or the physician group take advantage of any discounts or price reductions under your contract?

13. To what extent do you monitor the cost of services provided under capitation arrangements? How do you evaluate the cost efficiency of contracted providers?

Credentialing (All services except Medical Review services)

Provide your hospital selection criteria. What criteria are used to recruit, select and credential physician providers and medical groups?

Do you credential providers in accordance with NCQA standards?

Do you have a process for re-credentialing physicians? Describe in detail.

Do you conduct on-site evaluations? Does your plan verify state licensure with primary sources; hospital admitting privileges; current malpractice insurance coverage and claim history?

How often is malpractice insurance information verified?

How do you evaluate provider performance? Describe your evaluation process. Have you established minimum performance standards?

Do you maintain corrective action process for providers? How does it operate? How many providers have been terminated for poor performance?

Do your credentialing standards differ if the entity with which you are contracting is a PHO or other organizational form that provides the full spectrum of care?

Claims Administration

1. All Services except Medical Review Services. Which claim payment functions have you delegated to providers? For which services? How is information shared between the providers and your claim systems?
2. All Services except Medical review Services. For those functions which you have delegated, how do you insure accuracy and timeliness of service?
3. Medical HMO only: Certain dental procedures are covered under some of the Agencies‟ HMO programs such as accidental injury to sound natural teeth. Describe how you will implement these dental benefits within your provider network. Also describe how you will inform subscribers of this benefit. How will you pay such claims? Who will determine the services which will be paid and how much will be paid for them? What referral forms or procedures are required?

Questions 4 through 15 below to be answered for all Services except Medical Review Services:

4. Describe your organizations experience processing claims for large-sized clients. Describe policies and procedures for processing claims and handling customer and provider inquiries on claims. Provide a flow chart diagramming how claims will be processed including control procedures, estimated time frames from initial receipt of a claim through pending, final resolution, issuance and mailing of payment and/or explanation of benefits ("EOB").
5. Provide a sample EOB and a list of all EOB messages.
6. What percentage of your claims is filed electronically? What percentage of your claims is adjudicated electronically? What percentage is routed to claim staff for further consideration?
7. How do you define errors in claim payments? Do you have an on-line documentation system to monitor and track inquiries for both individual follow-up and closure as well as trend analysis over time? How will you insure that the claim payment for the treatment of a given medical condition represents payment of the least costly, effective form of treatment? Explain. Will you allow the Agencies to recover based on the results of an audit for extrapolation?
8. Provide the guidelines you use for determining Reasonable and Customary ("R&C") charges for providers who are not in your network. How often are these R&C files updated? What is the data source for these amounts? Provide a copy of the language you have filed with the State of Illinois for out-of-network payment levels.
9. If a claim is received with missing information, explain how such a claim will be handled. What information (or lack of information) on a paper claim form would delay payment? What steps do you take to obtain missing information (provide a sample of the currently used forms or form letters mailed to subscribers eliciting additional information when submitted claim forms are inadequate for adjudication)? What percentage of your paper claims are delayed because of missing information?

10. What is your average days claim inventory? Indicate number of working days. Of your current claims inventory, what is the number of claims and percentage of total claims for:

    a. 1 - 7 working days;

    b. 8 - 10 working days;

    c. 11 - 14 working days; and

    d. + 15 working days.

11. The performance standards for claims processing which includes claims turnaround time, financial (payment) and procedural accuracy is 98%, 99%, and 98% respectively. Can you meet these standards? Are you willing to guarantee your performance with liquidated damages? If so, what do you propose? What is your actual turnaround time for claims?

    a. 90% of claims processed and sent within ___ business days of receipt.

    b. 99% of claims processed and sent within ___ business days of receipt.

    c. Claims pended for investigation (i.e., reimbursement requests for repeated tests) by claim adjudicators.

12. What aspects or areas of each claim do you investigate? What claims require a separate supervisory authorization prior to payment? How do you flag accident related claims to avoid duplicating medical coverage? Will your system identify any procedures that are being repeated or any indications of unusual patterns of treatments or non-compatible services?

13. Does your system maintain historical information on submitted expenses and paid claims? How long is this claim history maintained on-line? What procedures do you have in place within the system to avoid paying duplicate bills submitted at separate times? Explain how your system identifies duplicate charges.

14. If a claim has been established in a year for a participant, and subsequent bills come in without a claim form, what is your normal procedure? What R&C schedules are used to pay a bill submitted two years after the claim is incurred?

15. Under what circumstances may the provider bill the patient directly for any portion of the services provided?

16. May an individual agency elect whether subrogation is “pay and pursue” or “pursue and pay”? If no, why not?

17. The City of Chicago uses an outside service provider for subrogation claims on a “pursue and pay” basis. The current carrier has implemented a process whereby claims subject to subrogation are pended until the outside service provider releases them or directs that they cannot be paid because the participant did not respond to the subrogation questionnaire issued by the outside service provider. Daily files of potential subrogation claims are sent to the outside service provider. Will your organization agree to manage this process as described above?

18. Explain in detail your procedures for Coordination of Benefits (“COB”). Describe how COB accumulators function. Are all services subject to COB, or only those above a certain dollar level? Are your rates adjusted to reflect these offsets? Explain your internal procedures for detecting and handling such claims. How does your system calculate claims, apply and maintain COB credits and COB savings? Does your system require an affirmative override action to pay new claims after COB had previously been involved?

19. Certain retired former employees of the City are allowed to continue to participate in the same plan as active employees. However, as they are retired, they are reported to the MSP COBA coordinator as retired employees; this means that if the participant has Medicare coverage either through age or disability status, that Medicare is primary. How will your COB process insure that these persons are correctly coded as secondary to Medicare Part A and Part B? Do you have a different COB process when Medicare is primary?

20. Medical PPO and HMO: Is your organization’s COB recovery done by in-house staff? Does the system maintain a history of COB occurrence and alert the examiner to previous COB activity within the participant’s family upon claim entry? When are COBs occurrences cleared?

21. Medical HMO only: Does your organization's system maintain the premiums? COB savings on a year-to-date basis and provide for carryover? Is the name and address of the other carrier and an indication of a primary or secondary status maintained? Is this status maintained for each covered person?

22. Medical PPO and HMO: Describe the success and provide the results of your COB recovery program, using the following data for your book of business for the last three (3) years:

    a. dollars recovered;
    b. dollars recovered as a percent of gross charges; and
    c. dollars recovered as a percent of potential recoveries.

23. Medical PPO and HMO: How do you allocate COB recoveries back to the account, particularly if premiums are based on experience?

Questions 24 to 31 to be answered by all except Medical Review Services:

24. If you intend to subcontract any part of the claims processing function, include the subcontractor's claim processing standards for production, procedural accuracy and financial accuracy. How will you audit and ensure quality and timeliness of payment?

25. Are there limitations on services related to the diagnosis or treatment of chronic illnesses? If so, provide details.

26. Provide a sample of the monthly claims summary that would accompany your invoices. How are out-of-pocket maximums maintained?

27. Describe your ability to archive and retrieve claim files for up to seven years.

28. Give a precise explanation of your methodology for the calculation of the incurred but not reported ("IBNR") claim reserve.

29. For medical emergency services:

    a. How do you administer emergency claims?
    b. Can a patient who uses an out of network provider for emergency services be balanced billed by the provider? If yes, is there a limit on the amount the member must pay?
    c. If a person uses an emergency room service for a non-emergent condition, what are your payment policies?

30. Does your organization offer other claim services such as medical bill audits, discount negotiation on out of network claims, special payment arrangements? Are there fees associated with these services? If yes, what are the fees?

31. Is the claim system able to process the following types of pricing arrangements:

    ^ Reference pricing for a particular service or class of services

    ^ Bundled pricing for certain surgical procedures

    ^ Case rates for certain services such as MH/SA courses of treatment

32. Medical PPO and HMO: For ACA required preventive services, does your claim system include age, gender and frequency edits to insure that required services are paid in accordance with the USPHSTF recommendations for A & B preventive services? Describe your system's functionality in this area.

33. The following questions pertain to adjudication of Medicare claims

    a. Please explain the steps and work flow involved for claims in which Medicare is primary.
    b. Please provide a sample EOB for a claim in which Medicare is primary.
    c. What percentage of your network providers accept Medicare?
    d. An agency with a large Medicare primary population uses the Exclusion Method for claims integration between the agency's plan and Medicare. The carrier determines

contractually allowed charges and then subtracts what Medicare pays. Then the balance is subject to the participant's remaining deductibles/copays/coinsurance. Please confirm that you can process Medicare primary claims using this method of Medicare integration.

e. For one agency's EPO plan, Medicare primary claims from providers not contracted with the network are excluded from plan liability, even though Medicare covers a portion of the claim for Medicare primary participants. Please confirm that you can administer Medicare primary claims such that no claims are paid by this agency if a participant uses a non-network provider in their EPO plan

f. What percent of clean Medicare primary claims are processed within 10 working days?

g. What percent of all Medicare primary claims are processed within 30 working days?

THIRD PARTY LIABILITY (MEDICAL HMO/EPO AND PPO ONLY)

1. Describe your third-party liability recovery program.
2. Describe your administrative procedures for identifying such claims, and provide your methodology for processing.
3. Do you use an outside source for third-party liability? If so, please identify and advise if you would use this subcontractor on the Agencies account? How are they compensated? Describe the success of your program and provide the following data for your book of business for the last three years:
   a. dollars recovered;
   b. dollars recovered as a percent of gross charges;
   c. dollars recovered as a percent of potential recoveries; and
   d. the number of and dollar amounts of outstanding liens.
4. If the Agencies or an Agency requests, will you use another subcontractor as directed by an individual agency?
5. Are there any fees associated with such services? Please specify. If attorney services are required, how are the attorney fees billed and paid?
6. Will you agree to waive fees for recoveries related to Workers' Compensation and Public Safety Worker's injuries for the Agencies?

CUSTOMER SUPPORT SERVICES

1. What are the hours of the customer service unit? Describe your customer service department, providing the role and responsibilities of the customer service representative. Describe the telephone system and work flows. How will employees be notified of changes to the provider network? Will there be a dedicated customer service unit for the Agencies?
2. On average, how many formal complaints and appeals per 1,000 members are filed by members?
3. What were the two (most common areas reflected in those complaints?
4. Describe your system for tracking inquiries, complaints and appeals. What are your standards for follow-up and resolution? What is the percentage of inquiries and complaints that become appeals? What percentage of appeals is resolved in favor of the plan member? What percentage of appeals involve providers?
5. Describe the grievance procedures in detail for the enrollees, for the provider and any role the Proposer or provider would expect the Agencies to take in the process. Indicate under what conditions a subscriber could be terminated from coverage. What means of appeal are available to the subscriber?
6. Provide the following statistics:
   a. Number of grievances submitted in each of the past two years.

b. Subjects of the grievances (e.g., provider courtesy, quality of care, access to specialty care, claim denial); and
c. results of grievances by subject:
    i. denial upheld;
    ii. denial modified;
    iii. denial overturned; and
    iv. other.

7. Provide a statement of how your company expects to resolve:

    a. employee complaints;
    b. provider complaints; and
    c. Agency complaints.

8. How does your organization monitor enrollee satisfaction regarding promptness, courteousness and accuracy?

9. Provide the results of any member surveys conducted over the past two years.

10. Do your web-based apps/portals have a "chat" function to resolve claim inquiries?

11. Please describe the on-site support offered at an agency's open enrollment events, including clinical program support and program referrals.

12. Do you have a separate Customer Service Unit with people trained and dedicated to work with Medicare primary participants?

13. If so, please describe the training requirements, and the years of service of the manager of the Unit who will be assigned to an agency with a large Medicare primary population.

14. Are you able to customize messaging, materials and images to be appropriate for a retiree only population?

MENTAL HEALTH CHEMICAL DEPENDENCY PROGRAMS

1. Medical PPO/HMO: Do you out-source Mental Health/Chemical Dependency care? If yes, to whom? Identify the essential staff members in your organization and the sub-contractor organization who will be responsible for the administration of the Managed Mental Health/Chemical Dependency Program.

2. Medical PPO/HMO: Provide a current list of participating mental health/chemical dependency providers by area of specialty. Provide a geo-access analysis based on two (2) providers within five miles, using zip codes provided in Exhibit census diskette. The geo-access report shall provide detail at the zip code level for Chicago, and shall include the number of providers in the zip code.

3. Medical PPO/HMO: Describe the quality assurance program in place to monitor your mental health/chemical dependency providers and the health services they render.

4. Medical PPO/HMO: Who performs utilization management services for mental health/chemical dependency services?

5. Medical PPO/HMO: What standards or criteria are used to determine appropriateness of admission, length of stay, treatment protocols, additional inpatient days and/or outpatient visits, for psychiatric, chemical dependency and detoxification treatment?

6. Medical PPO/HMO: Under what circumstances and/or for what diagnosis will you either provide very limited or no care at all?

7. Medical PPO/HMO: Do the criteria used to certify psychiatric and chemical dependency hospital admissions for adults and adolescents differ?

8. Medical PPO/HMO: What criteria do you apply for autism spectrum disorders? What criteria do you apply for Applied Behavioral Analysis ("ABA")? Are services provided under the (formerly $36,000) state mandated benefit tracked? How? Who is financially responsible for these services? Do you have contracted providers for ABA?

9. Medical PPO/ HMO: Describe your appeals mechanism when the patient disagrees with any utilization determination made by your organization. When the attending physician disagrees.

10. Medical PPO/HMO: What is your procedure when a dual diagnosis (both psychiatric and chemical dependency) exists? Describe what criteria you use to determine medical necessity and appropriateness of care for such cases.

11. Medical PPO/ HMO: How is aftercare handled? Provide details, if appropriate, how alternative facilities or vendors are selected. How are they monitored and how often?

12. Medical PPO/ HMO: Describe in detail your procedures for establishing and maintaining a network of treatment providers and programs for persons covered under your MH/CD programs.

13. Medical PPO/HMO: Describe any protocols you have for prescribing psychiatric drugs. Do you allow all physicians to dispense such medications? Do you allow physicians to dispense such medications even if pharmacy benefits are carved out?

14. Medical PPO/HMO: Certain employees of the City (and possibly other Agencies) provide public safety services. As such, they are exposed to a variety of circumstances that can have a deleterious effect on their health, including their mental health. Do your programs have any special features or recognize unique risks for this population? Do you have alternative access mechanisms that allow direct contact without referral to appropriate providers?

UTILIZATION / MEDICAL REVIEW

(To Be Answered By Medical Plan Proposers, e.g. PPO, HMO And EPO)

1. Describe the components, philosophy and processes for each of your review programs listed below. Include a flow chart indicating the professional qualifications of the staff involved at each step of the process. Provide an estimate of the percentage of cases which are reviewed at each review level, for your book of business and the results of those reviews.

   a. Pre-certification of elective procedures
   b. Urgent admissions
   c. Emergency admissions
   d. Concurrent review
   e. Chiropractic service review
   f. Podiatric service review
   g. Home Health services review
   h. Residential Placement review
   i. Early Discharge Planning
   j. Second opinion
   k. Early maternity Management (High Risk Pregnancy)
   l. Hospice review
   m. High Dollar diagnostic tests
   n. Outpatient surgical procedures
   o. High cost prescription medication
   p. Specialty referrals

2. How do you determine whether a prescribed therapy is unnecessary or inappropriate? Are medical outcomes measured and tracked? If yes, how? If no, please explain?

3. How is quality assurance data used to improve performance?

4. Describe the criteria you use in determining medical necessity and appropriate lengths of stay.

5. Describe your on-going activities related to adjustment of length of stay criteria. Did you develop or purchase the criteria? If you purchased the criteria, please provide from whom?

6. On what basis does the organization determine a procedure to be experimental or investigational? Have you ever made exceptions and provided coverage on investigational or experimental procedures?

7. Do you consider autologous bone marrow transplantation with high dose chemotherapy for the treatment of multiple sclerosis or systemic sclerosis to be experimental or investigational procedure? For the treatment of sickle cell anemia?

8. How do new transplant procedures become covered services?

9. Describe how you identify and treat high risk patients.

10. What does the plan do to assess coordination of care between providers and institutional settings?

11. The City of Chicago currently works with a second opinion provider for mandatory second opinions prior to certain surgeries. Those same surgeries are subject to prior authorization so that the patient is appropriately aware of the existence of the mandatory requirement. Can your program accommodate this requirement? Can your program accommodate a similar second opinion model that you prefer to recommend? If so provide details regarding the second opinion program you recommend.

QUALITY ASSURANCE / REVIEW

(This Entire Section Is To Be Answered by Medical HMO Proposers Only Unless Otherwise Indicated)

1. To what extent, if any, do you survey members to determine their comprehension of and satisfaction with your program? Do you track and report on disenrollment rates? Conduct post-termination member surveys? If yes, how do you follow up on the results of post termination member surveys?

2. All Services: Describe your Quality Assurance/Review process, detailing the procedures in place for establishing, maintaining and evaluating the Services.

3. By what mechanism do you ensure that provider financial incentives do not compromise the quality of medical treatment?

4. Describe your program for peer review and on-going quality of care assessment and monitoring of each of the following provider types:

    i. Physicians;
    ii. nursing personnel;
    iii. ancillary service providers;
    iv. psychiatric services providers;
    v. hospitals; and
    vi. other inpatient facilities.

5. All Services: Provide the names and qualifications of the individuals who perform the reviews, and how frequently they occur, indicating the methods and standards used to check: a) subscriber fraud and abuse; b) appropriateness of care; and c) up-coding or unbundling.

6. Describe any (internal and external) audits conducted by the HMO to maintain the integrity of the HMO and its operations. Describe your accuracy standards with regards to pre-payment and post-payment reviews.

7. All Services: Has your firm had an SSAE no. 16 audit conducted in the last two years? If no, why not? If yes, did you receive an SSAE no. 16 type 2 report? If it was only an SSAE No. 16 type 1 report, explain why a type 2 report was not obtained. In either case please provide a copy of the most recent SSAE no. 16 audit report.

8. Please confirm that you can provide SOC-1 reports that an Agency may require or request in conjunction with its annual audit.

9. All Services: Who conducts internal audits and how often are they conducted? Are clients provided information regarding the internal quality control audit reports?

10. All Services: Do you develop utilization profiles for your providers? Describe your use of such profiles for monitoring under and over utilization of medical services and diagnostic tests.

11. All Services: How many physicians have you identified as under or over-utilizing diagnostic tests in the past year? What course of action was taken?

12. All Services: What are your standards for telephone access during normal working hours? After normal working hours? Are you meeting them? If not, what is your plan of action to meet these standards?

13. Describe the five most important actions your HMO plan has taken in the last year to improve:

    a. quality of medical services;
    b. financial performance; and
    c. customer service.

14. Medical PPO and HMO: Do you provide comments to physicians on results from practice pattern analysis? Do you provide individual comments, peer comparisons? Continuing education? Cost and financial information?

15. Medical PPO and HMO: Describe how you evaluate a physician's practice patterns. What important aspects of care are being monitored and evaluated on an on-going basis? In which areas does your plan perceive problems?

16. Medical PPO and HMO: During the past two years, have you conducted any studies of the health status of members? For your book of business? For a particular client? If yes, describe.

17. If you have done aggregate or client specific health assessment studies, what actions have you taken as a result of your analysis of the collected data? Have you modified any HMO practices? Initiated disease specific programs or protocols?

18. All Services: Describe your system for evaluating the effectiveness of your quality assurance programs, indicating how the program examines the results of utilization review activity to ensure that appropriate determinations were made.

19. Is the HMO NCQA qualified? If yes, for what period of time? If no, what is the status of the application? In what areas do you feel you improve performance in order to be certified?

20. Are you doing HEDIS reporting based on sample data? If yes, describe process.

SYSTEMS SUPPORT

1 The selected Proposer shall have the computer capability to use an Agency provided computer data file containing information regarding employees eligible for the medical plan. Proposer shall be capable of receiving files via electronic transmission (not tapes, disks or CDs). Some Agencies may wish to enter information into the Proposer's secure online portal and the selected Proposer shall support that function also. Eligibility shall be maintained at the dependent level. Proposer shall have the ability to accept a positive notice of termination at the dependent level (i.e. Proposer shall not require "term by absence" from the data file). State your capacity to manage eligibility in accordance with these requirements.

2. All Services except Medical Review Services: Describe dependent eligibility processing in detail. Provide sample screens from your eligibility system.

3. Provide a system flow diagram of how your system would be updated upon receipt of an eligibility file. Specify the time frames required to incorporate an Agency's data.

4. List key operational software and identify if the software is purchased, leased or was developed by your organization. Further, describe the operational function the software supports. Indicate the software used to measure medical outcomes and whether it is purchased, leased or developed in-house.

5. How does your systems staff interact with your eligibility and customer service staffs? For example, if eligibility files have been received but not yet processed, how are service inquiries for newly eligible (but not processed) enrollees responded to?

6. All Services except medical services review: How long has your claims system been operational? Within what time frames from receipt of data (both initial and ongoing) would eligibility data be loaded into your database? Describe both your system's software and hardware.

7. Provide a detailed history of significant systems and methodology changes and enhancements over the last three years (or since system implementation if less than three years. Do you have plans to significantly alter or enhance your claims administration capabilities? If so, describe.

8. During the last two years, have you experienced an episode of downtime which lasted more than twenty-four consecutive hours?

9. Describe your disaster recovery program, and the procedures followed when your system fails. Is any portion of the current day's input lost if there is a power failure or system failure affecting work stations but not the central system? What historical or current data would be lost due to a power failure or other system failure affecting the central system? How quickly can the backup system be put in place? How would lost files be recreated? Describe the backups: i) If backups are to media, to what media (tape, RAID storage, etc.) are backups written? State whether backups to media are taken to a secure off-site storage location and if so how often? ii) If backups are electronically transmitted to an enterprise class backup service, describe.

10. Describe your computer security system. Who would have access to the Agencies data?

11. What restrictions are there to computer access? Are passwords stored in an encrypted form? Are they changed on a regular basis? Where is the central system located?

12. What reports are used to reconcile eligibility changes? Who prepares the reports? How are they used in eligibility processing?

13. During the past twenty-four months, have you experienced any data breaches or had to provide notice to members of privacy violations? If yes, please explain.

14. Please provide a copy of your notice to members about your privacy practices.

15. Do you allow claim processors to work from home?

16. Please confirm that you can terminate coverage upon passing of a term date one time only.

17. Medicare Eligibility:

    i. How will the agency be able to make real-time eligibility updates for Medicare age-ins?

    ii. How does carrier's eligibility lay-out indicate Medicare as primary?

REPORTING REQUIREMENTS/RECORD KEEPING PRACTICES

1. The selected Proposer shall provide the Agencies with management information reports on a monthly and quarterly basis or access to the same or similar reports through a client facing reporting tool. Confirm your ability to provide the requested information. The monthly reports must include, but are not limited to the following data:

    a. Services received by each employee or dependent (include a count of services by CPT code);

    b. Number of enrollees who received no services from an HMO provider during the reporting period;

    c. Name, and date of birth of person served, as well as unique identifier such as an employee ID or dependent ID, (and if requested by an Agency Social Security number).

    d. Eligibility status of person served (i.e. employee, spouse or dependent;

    e. Date(s) of service;

f. Name of provider;

g. Co-payment revenue collected by providers from Municipal Agency enrollees; and

h. Cost of service provided to member.

i. What are the standard utilization activity and management reports that would be produced or otherwise made available at no additional cost? If you offer a client facing reporting tool, how many persons will be allowed access to the reporting suite at no cost to the Agency?

j. Indicate whether you have the capacity to generate the following reports. Include a sample report package for a specified period.

k. R&C savings, which lists number of charges received, number of charges reduced, percentage of total, total charges received and amount saved.

l. Claims distribution, which lists the number, percent of total, average charge and average paid.

m. Benefits summary, which lists charges, ineligible amounts, basic deductibles (if applicable) co-insurance, COB credits and amounts paid.

n. Audit savings, which separately lists charges and savings from bill review and specialist fee review due to audit findings. Be specific as to how savings were achieved.

o. Third Party Recoveries, which lists participants, claimants, total charges and total recoveries for each incident caused by a third party.

2. Can an Agency design its own reports? Is there additional charge for these reports? How are savings on the reports calculated? If there are additional charges, how are the fees calculated and limited?

3. State the number of genders your information management system can accommodate in addition to male and female. If zero, describe your plans, if any, for adding this function.

4. Is there a portal for the employer to run its own standard reports? Please describe the portal's functions and list the types of reports that are available.

5. Does the employer have the option of running its own ad-hoc reports through such a portal? Describe the type of report detail available.

6. Please delineate any fees associated with a portal or any other method you have available that allows the employer to access and run its own reports.

7. An agency may have a significant number of retirees over 65, but not eligible for free Medicare Part A due to their initial hire date. Are you able to break out this group separately for reporting purposes?

8. Describe your data analytics capabilities and how they will be used to help the agencies.

DATA REQUESTS

(Please Observe Suggestions When Responding To These Quantitative Questions)

1. Indicate the number of clients to whom you provide services.

2. What is the total number of employee lives and covered lives in your programs?

   i. Medicare
   ii. Medicaid
   iii. Private pay individual

iv. Employer groups

3. For your five largest employer groups, indicate clients with: (indicate the Services allocation of this population (e.g. HMO, PPO, medical review services, dental HMO, etc.).

    a. employee population greater than 25,000
    b. employee population greater than 25,000 with collective bargaining agreements

4. Name the five largest accounts that have not renewed their contracts over the last three years. Provide the following:

    a. an explanation as to why they did not renew;
    b. names, addresses and telephone numbers of contacts;
    c. number of eligible employees; and
    d. number of employees enrolled.

5. For your five largest employer groups list the following:

    a. anniversary date;
    b. current rates, if applicable, announced future rates;
    c. total enrollment for each group;
    d. difference in benefits from those provided to;
    e. City or County employees and dependents;
    f. contractual period; and
    g. references, with phone numbers, for each of these groups.

6. Medical PPO and HMO: For your book of business, provide the following:

    a. mortality rate per 1000 enrollees;
    b. the number of medical malpractice claims made by members in the past two years; and
    c. the number of medical malpractice awards made to members in the last two years.

7. Medical PPO and HMO: The number of medical malpractice claims pending with the estimated liability of each claim. If Proposer has subcontracted for any specific services (e.g., physical therapy, or home healthcare) that subcontractor needs to respond to items number 6. a, b, and c above.

8. Medical PPO and HMO: Indicate your average length of stay ("ALOS") for members including acute care, but excluding well baby care, neonatal, ICU and psychiatric/substance abuse care.

9. Medical PPO and HMO: Provide the following statistics with supporting documentation for the last three calendar years for non-Medicare primary enrollees.

    a. Admission rate per 1000 members.
    b. Inpatient days per 1000 members.
    c. Outpatient encounters per 1000 members
    d. Average patient length of stay for medical/surgical, pediatrics, and ob/gyn.
    e. Overall average length of stay.
    f. Number of inpatient surgeries performed per 1000 members.
    g. Number of outpatient surgeries performed per 1000 members.
    h. Number of physician contacts per member per year.
    i. Number of specialist physician contacts per member per year.
    j. Number of Emergency Department visits per 1000 members per year

10. Medical HMO: For the hospitals, indicate the HMO contracts which provide inpatient care the following items for the last three calendar years:

    a. number of admissions;
    b. number of inpatient days;
    c. average length of stay;
    d. percentage of total HMO admits; and
    e. average cost per admit (actual cost not billed charges).

QUALITATIVE QUESTIONS

1. If you are selected to offer services to Agency employees beginning January 1, 2021 (December 1, 2020 for Cook County), how will you ensure that they:

    a. Understand their benefits; and
    b. Take an owner's interest in their health.

2. Many employees and their families will perceive that a change in carrier will have no effect on them e.g. same doctor, same benefit terms, etc. and may not perceive any substantive difference. From your perspective, is this a desirable conclusion for them to reach? Is it a reasonable conclusion? State whether employees perceive differences in the following areas from an existing carrier:

    a. Medical management
    b. Web-applications
    c. Wellness efforts
    d. Chronic disease management
    e. Quality or quantity of plan communications to members
    f. Value-added services for life management

3. Many of the same physicians and physicians' groups are in multiple networks. What is different about your efforts in the following areas that would be apparent to the physicians?

    a. Medical management
    b. Data integration.
    c. Plan and healthcare provider communications
    d. Plan and patient communications
    e. Healthcare provider and patient communications
    f. Compensation arrangements
    g. Chronic disease management
    h. Account transition (from carrier X to Carrier Y)

4. Medical PPO and HMO only: Provide a copy of your Health Risk Assessment ("HRA") form and describe how the results are integrated into the management of care at the physician office.

5. Provide examples of a successful transition of a small, medium and large sized case from another carrier. A successful transition would include at a minimum:

    a. No disruptions in care;
    b. Improved health status of participants or maintenance of status if improvement is not possible;
    c. Increased employee/family satisfaction with their health benefits;
    d. Trend reduction or suppression; and
    e. For purposes of this answer, provide quantitative and qualitative assessments of the key components of a successful transition. Be specific as to what time frames are applicable for a given dimension of success.

6. Describe your efforts to engage low-risk, medium-risk and high risk members. Provide specific examples of positive results from your engagement with members.

7. Do you believe that network size or composition has an effect on the cost of care? Why or why not? Can you quantify your opinion?

8. How is your management of high cost providers different than that of other health plans?

9. Medical HMO only: Some of the Agencies have insured HMO contracts, others have a cost-plus arrangement (partially insured) and others may have a self- insured or EPO arrangement. Why should these Agencies consider switching to different basis (e.g. from insured to a self-insured or cost plus basis, or vice versa)? What are the advantages? Disadvantages? If you are offering an insured product, what do you perceive to bet the advantages to a fully insured basis?

10. Medical HMO only: Describe five instances in which an insured contract with another insurer switched to a self-insured contract or cost plus contract with your organization. What were the results of the switch? Provide as much detail as possible including information on network changes (if any) and financial results.

11. Medical HMO only: If an Agency elects to switch to a self-funded or cost plus arrangement, are you willing to provide any performance guarantee related to the switch? If yes, please specify. If no, please explain?

12. Medical HMO: To the extent that an Agency has been offering insured HMO benefits which include capitated physician services, it is arguable that the gain-sharing (pay for performance/ quality incentives, etc.) have helped maintain the cost of medical services for HMO participants and/or limited trend in the HMO programs. If you are proposing on a fee-for- service basis, how do your compensation, medical management and/or gain-sharing programs help avoid unnecessary or unnecessarily complex care?

13. If you are proposing an EPO or an HMO with all services paid on a fee-for-service basis (aka-no physician capitation), what has the financial experience of the entity been without MD capitation as compared to when MD capitation was in place?

14. Medical HMO only: Will you allow an Agency to carve-out mental health and substance abuse services? Are there any additional charges to carve out these services?

15. Will you allow an Agency to carve out hospital administered prescription medications (e.g. example high cost specialty medications) or services with little free market competition (e.g. dialysis services). Are there any additional charges to carve out these services?

16. Medical HMO and PPO: If you are proposing a fee-for-service model of physician compensation, how do you avoid overutilization of diagnostic testing, particularly for high-dollar diagnostic tests provided by physicians who own such equipment?

17. Medical PPO and HMO: What peer reporting do you provide to the fee for service physicians? Provide a copy of a sample report and sample communications to an outlier physician.

18. Medical PPO and HMO: Do you conduct retrospective analysis to identify potential avoidable complications? If yes, how do you communicate the results of such analysis to your physicians? If no, please explain? What software do you use to identify potentially avoidable complications?

19. Medical PPO and HMO: Do you reimburse your providers for never events? What is your definition of a never event? Do you use Medicare's definition or have you created your own? If you pay for never events, explain why.

20. Medical PPO and HMO only: Do you engage in predictive modeling to identify potentially at risk patients? If yes, how are the results of the profiling shared with providers and patients? What software do you use to conduct such analyses?

21. Medical HMO only: On what legal basis do you offer a self-funded HMO product? Do you believe that this offering is in accordance with the Illinois Insurance Code? Does Illinois license Exclusive Provider Organizations?

22. Medical HMO only: What is the future of the HMO industry nationwide and in Chicago?

23. Medical PPO Only: With respect to Second Surgical Opinion/Complex Case Assessment Programs:

24. Does your organization offer a formal second surgical opinion program? Under these circumstances, "formal" means that a cadre of specialist physicians has been contracted with to provide medical opinions as to the need for and appropriateness of a suggested surgical procedure and that there are administrative processes in place to correctly direct the patient to an appropriate second opinion physician.

25. If your organization does not offer the program directly, do you have vendor relationships in place to provide such services? If yes, with which firms do you have a relationship? What is the nature of the relationship?

26. What is the compensation paid for SSOs? Do you impose an administrative fee for the services? If yes, what is it?

27. If yes, can an employer elect to require second surgical opinions for certain procedures? For example, an employer may wish to identify by CPT or by “body part” certain procedures that would require a second opinion prior to a surgical procedure being approved. Do you have administrative processes in place to administer such a program?

28. If you offer a formal program, where in care process do you believe such a requirement should be implemented? For example, immediately prior to surgery, or, upon request for a high dollar diagnostic test, or, upon receipt of an x-ray, etc.?

29. Describe the processes in place to administer a formal second surgical opinion program.

30. Does your organization offer a service to do a de novo assessment of complex medical cases for patients? For example, if a patient had multiple co-morbid conditions and felt that the complexity of her/his medical needs is not being adequately assessed and managed, does your organization offer a service whereby the patient could have a review of medical records to determine the appropriateness of care recommendations? How would the patient access the service? What would be the cost of the service?

31. Certain patients with complex needs might wish to seek the services of physicians skilled in the management of patients with complex needs. Such patients might wish to have assistance beyond the simple "look up a doctor in the network" system interface. Does your organization offer any physician referral services for such patients? Similarly if someone moves into the area and doesn't have a physician but has a complex medical history, does your organization offer other than the system interface to locate physicians? How does your organization support appropriate patient choice of providers? If you offer such services, is there an additional charge for the services?

32. Medical PPO: With respect to telemedicine:

    a. If an agency wished to offer telemedicine services, is your organization able to administer a telemedicine benefit?
    b. If any agency elects to not offer telemedicine services, is your claim system able to block CPT codes associated with telemedicine services?
    c. Have you developed your own telemedicine network? If no, why not?
    d. Does your organization contract with any firm to provide telemedicine services? If yes, what is the name of the firm(s) with which you contract? Was the firm(s) selected as a result of a competitive bidding process?
    e. If you are using a telemedicine service vendor, would that vendor be a sub-contractor if you are selected to provide services to an agency?
    f. Are telemedicine providers licensed in Illinois?
    g. How are telemedicine providers credentialed?
    h. What scope of services do the telemedicine providers offer?
    i. Does the telemedicine provider offer both medical and psychological services? If an agency wished to not offer psychological services, would that be permitted?
    j. How are telemedicine providers compensated?
    k. Do you retain any part of the compensation billed to an agency for telemedicine services?
    l. Do you limit the CPT codes that telemedicine providers may bill? If yes, what are the codes and what is the maximum allowable amounts you will pay for those CPT codes?
    m. Do you require that an employer offer a co-pay for telemedicine services? Is co-insurance for services permitted?
    n. Do you have a “preferred design” for telemedicine services to encourage use of the services?
    o. How many of your clients offer telemedicine services as a benefit in their medical plans?
    p. Do you charge an administrative fee for telemedicine services in addition to fee charged for the actual telemedicine service? If yes, what is that fee?
    q. Do you evaluate the effectiveness of telemedicine services? If yes, what are the results of those studies?

r. Have you done any studies to track the use of primary care, urgent care and emergency room utilization following a telemedicine visit for the same/similar diagnosis? If yes, what were the results of those studies?
s. Have you conducted any studies related to the pharmacy dispensing patterns of telemedicine visits versus in person visits?
t. Does the telemedicine service require that a member keep a credit card on file?
u. How do you or the telemedicine vendor insure security of personal financial and medical information?

33. Medical PPO: With respect to second surgical opinion / Complex case management:

a. Does your organization offer a formal second surgical opinion program? Under these circumstances, "formal" means that a cadre of specialist physicians has been contracted with to provide medical opinions as to the need for and appropriateness of a suggested surgical procedure and that there are administrative processes in place to correctly direct the patient to an appropriate second opinion physician.

b. If your organization does not offer the program directly, do you have vendor relationships in place to provide such services? If yes, with which firms do you have a relationship? What is the nature of the relationship?

c. What is the compensation paid for SSOs? Do you impose an administrative fee for the services? If yes, what is it?

d. If yes, can an employer elect to require second surgical opinions for certain procedures? For example, an employer may wish to identify by CPT or by "body part" certain procedures that would require a second opinion prior to a surgical procedure being approved. Do you have administrative processes in place to administer such a program?

e. If you offer a formal program, where in care process do you believe such a requirement should be implemented? For example, immediately prior to surgery, or, upon request for a high dollar diagnostic test, or, upon receipt of an x-ray, etc.?

f. Describe the processes in place to administer a formal second surgical opinion program.

g. Does your organization offer a service to do a de novo assessment of complex medical cases for patients? For example, if a patient had multiple co-morbid conditions and felt that the complexity of her/his medical needs is not being adequately assessed and managed, does your organization offer a service whereby the patient could have a review of medical records to determine the appropriateness of care recommendations? How would the patient access the service? What would be the cost of the service?

h. Certain patients with complex needs might wish to seek the services of physicians skilled in the management of patients with complex needs. Such patients might wish to have assistance beyond the simple "look up a doctor in the network" system interface. Does your organization offer any physician referral services for such patients? Similarly if someone moves into the area and doesn't have a physician but has a complex medical history, does your organization offer other than the system interface to locate physicians? How does your organization support appropriate patient choice of providers? If you offer such services, is there an additional charge for the services?

MISCELLANEOUS

1. Describe your commitment to the public employee market.

2. Why should the Agencies select your organization? On what basis do you distinguish your organization from other organizations?

3. What specific steps are you taking to improve provider performance in the areas of health status management, financial performance and quality of care?

4. For each of the next four years, what would you estimate the trend to be? How much of your trend estimate is the result of contractually required cost increases?

5. What is your organization doing to create value in health care for employer sponsored plans?

6. Do you believe that your organization will be sold or merged within the next four years?

7. What are your profit goals for the next four years?

8. Medical PPOs and HMOs: What is your view of the future of ACOs? How many ACOs do you currently have in network, ahat types of performance data do you monitor, and do you measure the performance of specific ACOs? What methodology do you use to attribute a member to an ACO?

9. Are you able to provide vision coverage under the medical PPO and HMO plans beyond basic eye exams? Do your medical and vision programs coordinate for care management purposes?

10. Please confirm that you will notify agencies of any change in clinical rules or coverage policies (for example – new gene therapies such as CAR-T).

11. For prescription drug services paid under the medical plan (e.g. chemotherapy administered in a physician's office):

    a) What steps has the carrier implemented to manage the cost and utilization of pharmacy services paid under the medical plan?

    b) Does the carrier share drug rebates with the agency for drugs delivered in the outpatient/physician setting

Disease Management Specific Interrogatives

(Questions in this portion to be answered by those proposing for the following Services: Medical Review Services, medical HMO/EPO and medical PPO)

1. Please describe your current disease management process and how you plan on incorporating disease management into the current programs. How do you propose to utilize point solutions? What disease states do you currently have formal programs for? How will you determine which disease states should be the focus of future developmental efforts and when will they be ready?

2. How will you work with information collected via the screening process to identify the disease types that will most likely benefit from disease management and then work quickly with the clients to design and deliver programs for access by the appropriate participants?

3. Please describe what will trigger an invitation for an individual to participate in a disease management program. Describe the risk levels that your organization typically uses to classify individuals when assigning a risk status and describe the criteria for risk classification.

4. Describe your process for recruiting participants to your program, conducting the initial session and determining how often and when future contacts will occur?

5. How will the advocates interface unobtrusively with people who currently have serious health conditions and might believe they are getting the best possible care when in fact they are at risk?

6. How do you monitor a member's progress? How do you engage and partner with the participant's physician(s) to ensure effective communication and interaction?

7. How do you deliver appropriate support services such as nutritional counseling, stress management, etc.? How do you leverage other services available to employees through their employer (e.g. EAP, tobacco cessation, etc.)?

8. What is the average percentage of eligible participants who enroll in your programs?

9. Please provide descriptions and/or samples of the materials that you provide to disease management participants to educate them about and help them manage their condition.

10. How are the programs delivered to people? Do you do this in person, on the phone, via the web or a combination of these?
11. Many providers perceive the end result of disease management is to lose their patients. How do you address this concern?
12. How does your process foster an effective information flow between your organization, the individual's primary care physician and the specialist?
13. How do you perform quality control on your programs, processes and people?
14. Please provide samples of the reports that you provide to clients describing the results of your programs.
15. Effective disease management programs evolve over time. What feedback mechanisms and processes do you have in place to ensure the programs are fine-tuned and improved over time?
16. What is the benchmark for Return on Investment?
17. Are you willing to place fees at risk to guarantee performance to your programs and ROI level?
18. Does your solution include a 24 hour nurse information hotline?
19. What is the ratio of case nurses to participants?
20. How many nurses and physicians to you currently have on staff?
21. How many Disease Management clients do you currently have?
22. What do you consider to be your target market? What is your average client size?
23. What types of data are capture and tracked for disease management programs?
24. Describe the types of client reports available? How often are reports provided?
25. Please describe in detail wellness programs you have available for Medicare primary populations.
26. Will you provide a wellness allowance to help the agency cover the costs of implementing wellness programs? Address each of the following allowances: implementation, communications, wellness, pre-implementation audit, claim audit, and general program management.
27. How will you coordinate with carve-out Pharmacy Benefit Managers (PBM), to assure that drug claims are reflected in wellness and disease management program decisions? Will there be any additional fees for sending and/or receiving data files from an agency's PBM?
28. Are you able to coordinate and/or provide data feeds to third-party wellness vendors upon request? Would there be any additional fees for doing so?
29. Please describe in detail any programs offered specifically for cancer patients and their families.
30. Please explain how you address chronic kidney disease.

HIPAA COMPLIANCE

1. Describe the process used by your company to comply with HIPAA EDI, Privacy, and Security requirements. Have you received external or independent certification regarding your HIPAA compliance?
2. Who is the key individual in your organization responsible for compliance with the HIPAA Administrative Simplification provisions? Please identify that individual by name and title.
3. Describe your HIPAA EDI compliance solution relative to providing eligibility data to vendors.
4. Is your staff trained on all Privacy and Security requirements? Describe your training program and enforcement policy.
5. Does your system produce sufficient audit trails to satisfy the HIPAA Privacy and Security regulations?
6. How is security set up in the system? What are the different levels of security?

7. Is your system database encrypted?
8. Are system data backups encrypted?
9. Are all electronic transmissions of PHI, including eligibility files, authorizations, reports, etc., encrypted or sent via secure means? Which encryption methods do you support for e-mails and file transmissions? Please describe.
10. What are your procedures for data destruction prior to hardware and media disposal?
11. Which EDI Transactions sets have you implemented and for those remaining, what is the target implementation date? If you plan to outsource to outside entity, who will be that business partner?
12. Describe your approach/plans to implement processing for both ICD-9 and ICD-10 codes in your administration system?
13. Have you had a HIPAA violation in the past three years? If yes, please describe.

CENTERS OF EXCELLENCE

1. Describe your transplant programs, including organ transplants available, criteria for provider eligibility, and list of Chicago, Illinois and nationally contracted providers.
2. Please list the criteria whereby travel costs are reimbursed for the patient and family members.
3. Do you have available Centers of Excellence programs for joint (i.e. knee and hip) replacements, bariatric surgeries, etc.? Please list your Chicago, Illinois and nationally contracted providers.
4. For your Centers of Excellence programs please describe any bundled payment arrangements that exist.
5. Describe your selection, credentialing, and termination processes for network providers, hospitals, and facilities in the centers of excellence networks. Are all the facilities in your network identified as a "Center of Excellence" by any State or Federal agencies, or a nationally recognized accrediting organization? If so, please describe.
6. What guarantee can be provided that there will be no signification disruptions to the network in terms of numbers of providers?
7. Describe in detail your transition process for members currently in a transplant phase. If the Agency determines it wants to eliminate or minimize disruption for members, would your organization agree to negotiate individual contracts with the current medical transplant facilities for members currently in a course of care? What criteria are used to develop and maintain the transplant network?
8. Do you subcontract or lease all or any portion of your Centers of Excellence network? If so, please explain.

DENTAL INTERROGATIVES

These interrogatives are also provided in Microsoft Word

Instructions to Proposers:

- To be completed only by those who are offering to provide Dental PPO and /or Dental Maintenance Organization Services.
- Reproduce all the interrogatives, do not change the numbering, and answer those which are applicable.
- If you are proposing on both the Dental Maintenance Organization and Dental PPO, answer all Interrogatives.
- If you are proposing on the Dental Maintenance Organization only, answer **Both DMO and D-PPO Interrogatives** and then answe**r DMO Only Interrogatives.**
- If you are proposing on Dental PPO only, answer **Both DMO and D-PPO Interrogatives** and then answer **D-PPO Only Interrogatives.**
- Provide your answers in hard copy, and on USB drives in Microsoft Word format.
- A note about terminology. in communications to an Agency's employees, for a Dental Maintenance Organization ("DMO" in this RFP) an Agency might in some cases use the term Dental HMO or D-HMO.

Both DMO and D-PPO Interrogatives 1 to 83

1. What was total enrollment (number of employee units and total covered lives) on January 1 for calendar years 2017, 2018 and 2019:
    a. For your Dental Maintenance Organization products.
    b. For your insured Dental PPO Product(s)?
    c. For ASO Dental PPO clients?
2. What is the projected enrollment (number of employee units and total covered lives) for 2021 for each line of business?
3. How many employer groups currently offer your:
    a. Dental Maintenance Organization product?
    b. Insured Dental PPO product?
        i) Dental PPO with differing benefit levels for in-network care
        ii) Silent dental PPO with no penalty for using an out-of-network provider?
    c. ASO Dental PPO services?
4. What is the total number of employees lives and covered lives your organization provides services for each of the following:
    a. DMO program/plans
    b. PPO programs/plans
    c. ASO program/plans
5. If you currently provide dental benefit services to any of the Agencies, in the event you are not selected to continue to provide these services, describe your transition of services process and procedures.
6. Describe how an employee or dependent that is temporarily domiciled outside the metropolitan Chicago area and who requires services can receive care. An example would be a student attending college.
7. What is your plan's policy regarding a patient's continued dental treatment when their dentist leaves the plan? Is the answer different depending on the point in treatment or any other factors?
8. Provide a description of how the DMO and the dental PPO use dental hygienists. By what criteria is a patient referred to a hygienist rather than a dentist?
9. Describe the availability in-network of around the clock emergency services. How does a patient access a provider for urgent or emergency care outside of normal business hours? Are dentists required to be available on a 24-hour basis to direct emergency care?
10. Do you use preferred providers for dental appliances and materials? How are they selected? Are participating dentists required to use preferred or contracted providers or purchase of materials?
11. How do you ensure that dentists use high quality and appropriate materials?
12. How do you notify an enrollee of changes to the DMO and or PPO provider network?
13. What are the Proposer's general business hours during which telephone support is provided?
14. Will the Proposer:
    a. Assign a service representative to an individual Agency's accounts?
    b. Make the representative available to meet with an individual Agency on a regular basis?
    c. Assign a person with the ability to interpret utilization and cost data and to describe ways the plan can improve access, service and quality of care to an individual Agency?
15. Will the Proposer make a plan representative who has authority to correct specific problems available to each Agency on a regular basis? Describe the process for accessing the service representative.
16. Provide a sample contract for each type of provider for each product for which you are proposing.
17. How do you recruit, select and credential:
    a. Individual providers

b. Group practices
c. Specialty providers
d. Laboratories

18. Do you credential providers in accordance with NCQA requirements? If no, why not?

19. How do you re-credential providers? Describe in detail.

20. What are your minimum professional liability (malpractice) insurance requirements for (i) general dentists and (ii) specialty providers? Do you verify this insurance coverage? How often? Do you verify claim history? How often?

21. Do you conduct on-site evaluations of dental providers? What is the purpose of the site visit? Provide documentation as to how you conduct site visits.

22. Does your plan verify current state licensure with primary sources?

23. Prior to admission to your network, what information do you obtain from the dentist regarding his/her practice patterns and philosophy of care? How do you insure that a provider practices safe dentistry? Have you established standards on the use of protective materials for the patient and the dentist for a given episode of care?

24. If a dentist is applying to become part of your network, do you review any claim/payment history you have on file before selecting the dentist? If a dentist appears to practice dentistry in a manner that is not consistent with your quality standards, will you allow the dentist entry to the network? Do you offer the dentist any services to improve the efficiency of his/her practice? Provide examples.

25. Do you target a particular level of reimbursement per chair hour? If yes, what is the target and what percentage is expected to come from capitation payments and what percentage from co-payments? If no, how do you develop compensation targets?

26. Has Proposer established standards (either contractual or administrative) for how much time is scheduled per patient for a dental visit? For a specialty care visit?

27. Individual Agencies have provided a listing of the Tax Identification Numbers and name of the providers used by their members. Indicate for each identified entity (Individual dentist or group practice) whether they are in or out of network. If you offer multiple dental networks, indicate in which networks the dentist/dental group participates.

28. How do you evaluate provider performance? Describe your evaluation process. Have you established minimum performance standards? What are they?

29. Describe your program for peer review and on-going quality of care assessment and monitoring of each of the following provider types:

a. general dentists
b. orthodontists
c. periodontists
d. endodontists

30. Do you conduct post-treatment member surveys? How do you follow up on the results of post-treatment member surveys?

31. How many complaints have been filed against your organization with the Illinois Department of Insurance in calendar years 2016, 2017 and 2018? With respect to each year:

a. How many were member initiated?
b. How many were provider initiated?

32. Is any dental plan of the Proposer under review or currently subject to sanction from any state insurance or consumer protection agency?

33. Do you maintain a corrective action program for providers? How does it operate? How many providers have been terminated within the last twelve months for poor performance?

34. Describe your method for capturing dental encounter data.

35. What percentage of patient encounters are with

    a. General dentists?
    b. Specialists?
    c. Others?

36. Describe the five most important actions your plan has taken in the last two years to improve:

    a. quality of dental services
    b. financial performance
    c. customer service
    d. member use of preventive services
    e. network participation

37. Do you provide comments to dentists on results from practice pattern analysis? Do you provide individual comments, peer comparisons? Continuing education? Cost and financial information?

38. Describe how you evaluate a dentist's practice patterns. What important aspects of care are being monitored and evaluated on an ongoing basis? In which areas does your plan perceive problems?

39. How does the Quality Assurance Program examine the results of predetermination review activity to ensure that appropriate determinations were made?

40. Describe your system for evaluating the effectiveness of your quality management efforts.

41. Give three examples of dental outcome measurements and improvements that are relevant to your enrollees which have been the focus of your plan.

42. Briefly, describe provider participation in all quality management efforts. How do you disseminate information on quality improvement initiatives and results to members, providers, and purchasers?

43. How do you do to encourage quality providers to continue to participate in your network?

44. List currently used dental practice guidelines. Explain how guidelines are disseminated to providers and provider compliance is measured. Explain how much flexibility is provided the dentist to exercise his or her judgment in deviating from the guidelines. Who developed the guidelines?

45. Describe the most important clinical and service improvements initiated as a result of your quality improvement program during the last two years.

46. Describe your dental records system in detail, including a description of your standards for establishing and maintaining individual patient dental charts. Do you conduct audits of providers? Record the receipt of co-payments received from participants?

47. Do you provide identification cards for members?

    c. If no, why not?
    d. If yes, within what time period do you provide identification cards for members? How are identification cards created and distributed? What constitutes the employee member number? All of the Agencies (except City Colleges) have already established their own unique identification number systems. Confirm each Agency may retain that number for purposes of plan membership identification and if an Agency may not, explain why not. With respect to City Colleges,
    e. The incumbent dental vendor for City Colleges establishes unique identification numbers; confirm that if you are selected you will establish unique identification numbers for these members at no additional charge.

48. In the event you fail to establish a newly-eligible member on your system within five business days, are you willing to waive premium payments and/or ASO fees for the first month of coverage? For any month thereafter in which the member has not been reported to a participating dentist as a participant in your plan?

49. Do you provide all dentists online access to eligibility and plan data, in lieu of paper or electronic membership files or rosters? If no, why not? If yes, how often is the online database refreshed? Daily? Multiple times per day?

50. What has been the turnover in general dentists in the network for each of the last three years?

51. What is the percentage of general dentists whose contracts in the network were terminated in each of the last three years?

52. For what reasons can the network terminate provider agreements?

53. Recruitment, in general: Describe your typical methods for recruiting new providers.

54. Recruitment, special cases: In the event that your organization is awarded a contract for dental services, will you agree to recruit dental providers that are currently providing services to Agency members that are not as yet network providers? If yes, how will you recruit providers? Do you believe that your efforts will be successful?

55. How often are online provider directories updated? When a provider leaves the network are participants who are using the dentist notified of the termination? If a provider who previously left, returns to the network, are former patients notified?

56. Describe the types of marketing/promotional and educational materials your company would use (i) for ongoing promotion of the program and (ii) if you are not the incumbent for implementation. Include sample materials for each portion of the program for which you are proposing to provide services.

57. How does the plan make its descriptive materials thorough and user-friendly? Will the Proposer make all descriptive materials available to the Agencies in advance of open enrollment? How do materials highlight covered services, exclusions, procedures to follow for urgent care, accessing out-of-area services for urgent and emergency care and routine care for children away at college?

58. If enrollee wishes to obtain a copy of his or her dental records, how would they do so? Is there a charge for copies? If yes, what is the charge?

59. Describe in detail the communication and service strategies applicable to new enrollees.

60. The Agencies wish to encourage members to seek regular preventive dental services, including both children and adults. What communication services do you provide to encourage the use of preventive care? How do you identify those who have not received appropriate care? How do you message to encourage preventive care? Please include any results related to your communication campaigns.

61. What programs do you have to support appropriate use of dental services for medical conditions? For example, do you have any special messaging or programs for pregnant women? For those with cardiac conditions? For those undergoing radiation therapy? Please describe your program in detail. Please include any results.

62. What are your current standards for claim processing administrative and financial accuracy; telephone average speed to answer; dropped call rate; web-inquiry response time; and, paper correspondence response time. Provide your actual performance for 2018.

63. Does the claim system include an electronic tooth chart? If no, how are services tracked to avoid duplicate payments? If yes, how would you incorporate data from the current administrator in the event the current administrator is not selected?

64. How do you flag accident-related claims or other services that might be covered under a medical plan to avoid duplicating medical or other coverage?

65. Do you use a dental consultant to review more difficult and /or complex claims? What role does a dental consultant play in the pre-determination of large dollar expenses?

66. How do you insure that the least costly method of treatment is paid? What claims for service are referred for treatment plan analysis or post-treatment review?

67. Describe specific ADA codes do you review to determine the under and over utilization of services?

68. If a member elects to have dental implants instead of a bridge, would you develop an alternative benefit amount to apply towards the dental implants?

69. Does your grievance procedure have in place a process for reviewing and adjudicating complaints or decision related to administrative and benefit issues? A process for patient appeal of clinical decisions related to the efficiency of a given treatment plan? An expedited process for emergency cases?

70. Do you allow providers to waive required co-payments? Why or why not?

71. If a provider offers to a member services which are not covered by the plan of benefits of the employer, are there any limits on the amount the provider may charge the patient? Do you require dentists to report services that are not covered by the plan but for which the patient has nevertheless agreed to pay? Do you monitor the billing levels for these services? If there is a plan deductible and services are applied towards the deductible, does the member receive the benefit of any PPO allowable amounts?

72. There are many new dental technologies or treatments that have not as yet been accepted and/or recognized as the standard of dental practice and have not received a CDT code. Yet, the technologies are sold by their manufacturers' and are offered by dentists to their patients, many of whom simply trust their dentist to provide only necessary services. Does your organization do anything to prevent abuse, misuse or harmful treatment in these circumstances? If so, what? If no, why not?

73. Is your claims system software custom developed or a purchased software package? If yes, what package? What release number or generation? If no, who developed the software?

74. Do you consider dental implants to be an experimental or investigational procedure? List all those dental treatments you consider to be investigative and/or experimental treatments. Are these treatments covered by the Plan under any circumstances? How will these definitions be highlighted in the Certificate of Coverage or in other plan material?

75. How does the Plan encourage the appropriate use of preventive care? Does the plan provide any support to member dentists to encourage routine care? If yes, how? If no. what standards, if any, relate to the provision of routine care?

76. Do any services require pre-approval or authorization by the Plan's dental director? What services?

77. Does your organization require that network dentists adhere to the American Dental Association's 2016 Statement on the Use of Opioids in the Treatment of Dental Pain? How do you monitor compliance with these standards? Do you offer supportive educational materials and/or compliance instructions? If you find a dentist is not in compliance, what steps do you take?

78. How does your organization track opioid prescribing by your network dentists? Must a dentist report opioid prescribing?

79. Does your organization require that network dentists adhere to the recommendations promulgated in the 2018 American Dental Association Policy on Opioid Prescribing? How has your organization integrated the policy recommendations into your network operations? Has your organization taken any affirmative steps to combat opioid overuse?

80. What are the standard utilization activity and management reports that would be produced at no additional cost?

81. Indicate whether you have the capacity to generate the following reports. Include a sample report package for specified period.

    a. Number and type of services received by enrollees that would include a count of services received by ADA code
    b. Number of enrollees who received no services from a DMO provider during the reporting period.
    c. Co-payment revenue collected by providers from enrollees by ADA procedure code
    d. Coordination of Benefit savings
    e. Audit Savings
    f. Third Party Recoveries

82. Can the Agencies design their own reports? Is there an additional charge for these reports? How are savings on the reports calculated? If there are additional charges, how are the fees calculated and limited?

83. Are claim detail reports available in a machine-readable format? Will you agree to submit a claim an electronic claim detail file with your invoice for services at no extra charge?

D-PPO Only Interrogatives 84 to 94

84. What percentage of the Proposers' total annual expenditures for each of the past three fiscal years are for the following:

    a. payment to PPO dentists, split by specialty
    b. payment to providers not participating in any plan
    c. administrative and overhead expenses

85. What percentage of annual expenditures has been to related parties for each of the past three years? Describe related party relationships. (Related parties are subsidiaries or affiliates or parent company; joint venture partners or firms in which you hold an interest greater than 10%.)

86. Define and disclose administrative expenses, retention rates, dental loss ratio and profit margin for 2017 and 2018. What percent and dollar amount of the Proposer's book of business goes to dental care, to administrative expense and to profit?

87. Provide an organizational chart including administrative, managerial, dental care management and quality assurance functions.

88. Provide summaries of the education, training & and experience of all essential administrators, and executive staff. For the dental care management and quality assurance director(s), provide a detailed resume or vitae.

89. What is the current number of people employed by Proposer in claims administration; provider contracting; management; customer service; performance and quality management; sales and marketing; administrative and managerial functions; and, in all other categories?

90. Describe the manner in which the Proposer provides services and/or manages the provision of services to participants, including both dental and administrative services.

91. How many PPO pricing schedules do you administer? Are there different networks associated with the different pricing schedules? If you do not apply one schedule to all participating dentists (other than for geographic area differences), please explain your pricing methodology-on what basis do you set reimbursement for individual dentists and group dental practices?

92. Some Agency dental plans require that the out of network benefit be paid using the PPO allowable amount as the allowable amount for an out of network claim for dental services. Are you able to administer this provision? If you do not use a single schedule for services and/or for a geographic service area, what would be the basis of payment that you would use for out of network services? If you are not able to administer this provision, what would be the basis for out of network allowable amounts? Do you have more than one out of network payment schedule available? If yes, in what ways do they differ? Will you insure that no out of network provider is paid more than an in-network provider for the same service?

93. For each of the last three years, what is the rate of increase you have applied to PPO allowable amounts? Do your network contracts provide for an annual increase in compensation? If yes, what do you expect the compensation increase to be for the base term of any contract with an Agency (2021, 2022, 2033)?

94. For each of the last three years, what is the rate of increase you have applied to the allowable amounts for out of network providers? Do you increase the out of network rates at the same time you increase PPO provider rates? If yes, what do you expect the compensation increase to be for the base term of any contract with an Agency (2021, 2022, 2033)?

DMO Only Interrogatives 95 to End

95. If an enrollee fails to select a dentist, do you assign the enrollee to a practice and what is the method for doing so? How is the capitation revenue associated with that member (and family members) accounted for? Do all general dentists share in such revenue? Is it reserved or kept by the Proposer?

96. If a member is under the care of specialist, must he or she get a referral from his or her general dentist for each specialty visit?

97. Must family members select general dentists within the same practice group or select the same general dentist (if the dentist is a sole practitioner)?

98. Give a precise explanation of your methodology for the calculation of the (IBNR) incurred but not reported claims reserve.

99. What percentage of the Proposers' total annual expenditures for each of the past three fiscal years are for the following:

    a. capitated payments to providers in the DMO product(s)
    b. payments to specialty providers in the DMO products(s)
    c. payment to providers not participating in any plan
    d. administrative and overhead expenses

100. What factors and/or dental professionals to enrollee ratios do you use to determine the number of full time equivalent dentists and other support personnel necessary to provide services in your dental maintenance organization product? Your PPO product? Explain in detail.

101. With respect to the DMO product, define emergency care and provide examples of emergencies that are and are not covered by the plan when services are provided by an out of network dentist. How will this definition be highlighted in the Certificate of Coverage or in other plan material? What are the limits to out of network palliative care?

102. For the past five calendar years, 2013-2018, what increases have you made in provider capitation for your benefits offering most similar to the Plans of benefits requested in this RFP? Are scheduled capitation increases required under your provider contracts? When will the next increase to providers be effective?

103. How can a member access a specialty dentist in the DMO network? What is the referral process? What periodontal services may be provided by the general dentist? What endodontic services?

104. Who makes referral decisions regarding specialty care within the DMO network? What are minimum professional qualifications for persons making referral decisions? By what criteria are such decisions made?

105. Provide the DMO's policy on referral to specialty dentists, including pedodontists.

106. Under what conditions may an enrollee change their general dentist? What procedures must she or he follow to change dentists? With what frequency can an enrollee change dentists? When is a change effective?

107. If a general dentist terminates his/her participation and subsequently joins the network again, do you notify former patients? In what time periods? Do you allow them to enroll again with the former dentist?

108. How are dentists compensated? Do you have a compensation plan for dentists? If yes, describe. Be specific.

109. Do you have a bonus or risk pool arrangement as part of the compensation package? What have the pay-outs been for the last three years as both a dollar amount and as a percentage of the total eligible for pay out? On what basis are payments made?

110. Which services are covered under the capitation payment? Explain your methodology for developing capitation rates.

111. Does your organization contract for bundled or per procedure arrangements for services which are not covered by the capitation payment? What services do your bundled fee arrangements include?

112. Detail the fee arrangements for specialty care provided. How often are these contracts renegotiated?

113. Do you base part of dentists' compensation on consumer satisfaction? If yes, describe criteria used to measure satisfaction. If not, why not? Provide the appropriate measurement criteria for other compensation factors.

114. Do you base part of dentists' compensation on outcomes? If yes, describe criteria used to measure outcome. If no, why not?

115. Are dentists contractually required to reach out to newly enrolled patients for a "welcome" visit? Are dentists contractually required to remind members about preventive services?

116. In the event you were awarded a contract (and do not currently have one), what instructions would you provide to dentists on members whom they currently see with another dental carrier? How would you assure appropriate continuity of services? How do you assure completion of orthodontic treatment plans?

DENTAL GEO-ACCESS INTERROGATIVES

117. The submittal requirements state you must provide geo-access data. For general dentists the standard for all Agencies will be three general dentists within five miles. For specialty dentists (orthodontists, periodontists, oral surgeons and endodontists) the standard will be two within twenty miles for all Agencies other than Cook County for which the standard will be two within ten miles. Do you meet those minimum standards? Do you exceed them; if so by how much? If you do not meet those minimum standards, by how much are you deficient and will the deficiency be remedied prior to February 1, 2020?

VISION CARE INTERROGATIVES

Introduction

The Agencies have various vision benefit packages, some of which are included in a medical plan option and some of which are stand-alone. Benefit designs may vary and may include an annual eye exam, with or without co-payment, materials or discounted materials, and other combinations of co-payments and/or discounts. Also, at least one agency has included the vision component as part of the wellness benefit. Please describe your ability to administer this type of benefit. One Agency does not currently offer vision benefits but is interested in obtaining price/plan offers from responsible vendors based on the theoretical plan design provided in the RFP.

Vision Proposer's Background

Complete this section if Proposer wishes to provide The Agencies Vision care services through a network of optometrists.

a. Does your organization currently have an operational network in the metropolitan Chicago area?
b. If so, please provide a map of the facilities and describe the facilities and provider networks in detail.
c. When was the network first effective?
d. Provide sample contracts for vision care providers
e. What has been the total enrollment on January 1st for the past five years? What percentage of total enrollment is in the Chicago metropolitan area?
f. What has been the total number of covered lives on January 1st for the past five years? What percentage of total covered lives is in the Chicago metropolitan area?
g. How many employer groups currently offer your network? How many of these are in the Chicago metropolitan area?
h. If you do not currently have an operational network in the metropolitan Chicago area, please indicate in what other major metropolitan areas you have a network and the date on which each began operations.
i. If the Proposer expects to offer vision care services directly to Agency employees or through an arrangement with participating Ophthalmologists or Optometrists, the proposal should include a listing of sites where the services will be offered, a listing of services to be offered at each site and the names of any participating Ophthalmologists and Optometrists. The proposal shall describe what procedures will be

used in order to assure that the services offered to Agency employees, and their dependents are of high quality. The proposal should also detail the selection procedures for becoming a participating Ophthalmologist or Optometrist. Provide a map of the facilities

j. Using the census data provided on the USB Drive, provide a Geo-Access analysis of your vision care network, using a two-mile radius. Provide a separate analysis using five-mile as the radius.

k. Some Agencies have retirees located outside of metropolitan Chicago and outside of Illinois for whom they must provide vision benefits. If you do not have a nationwide network, how will you insure that these out of area participants receive good quality services at a fair price?

l. For those Agencies with an existing vision care plan, the USB drive includes a file of its high volume vision providers. Return the file with an indication of whether the provider is in your network in the appropriate column on the worksheet. If your network is not a good match for the existing network, what steps will you take to insure that you add additional providers so as to reduce disruption in the event the existing vision provider is not again selected to provide services to a particular agency?

Vision Provider Network Management

a. Describe your process for adding providers to your network. Provide sample vision care plan contract, and the standards used for selection and credentialing optometrists.

b. How many optometrists are in your network? How many ophthalmologists? Under what circumstances may a participant visit an ophthalmologist for no additional charge?

c. Do you have any special or different programs for those persons with chronic conditions that may involve frequent vision changes or may need more frequent examinations? If so, for what conditions would you recommend that an Agency consider offering more frequent access to eye exams or materials?

d. Do you have any pediatric ophthalmologists in your network?

e. Do you conduct on–site evaluations? If yes, what is the purpose, scope and frequency of the on-site evaluations?

f. Describe your quality assurance and quality management procedures.

g. Describe through narrative and a flow chart how network services are provided to eligible persons from the point of calling for an appointment through in-office delivery of materials.

h. Do you develop utilization profiles for your providers? If so, how do you use profile data to insure appropriate treatment?

i. How do you insure that optometrists and or other vision care providers are charging the correct co-payments? Provide the schedule of employee co-payments by procedure code that will be charged by network providers.

j. Explain how the service providers are compensated (e.g., salaried, fee for service, capitation, risk pool, administrative services only (ASO) or other arrangements).

k. For those services that are not covered by the plan but are offered by the office, do you limit the amount a network provider may charge?

l. How do you insure that the optometrists in the network are financially solvent and remain so?

m. If you require that providers maintain standard hours of operation, please indicate those hours.

n. How do you handle complaints regarding providers? For what reasons can the network terminate agreements with providers? What is the turnover of vision care providers for each of the last three years within the network? Explain?

o. For the last twenty-four months of operation, how many providers have you added to your network? How many have voluntarily stopped participation? How many have you removed from your network, and for what reasons have you done so?What insurance coverage (amount and type) do you require providers to maintain and how do you verify that this coverage is continually in force? Are you an additional insured? Do you have umbrella coverage? What amount?

p. Can providers use their own laboratories? If not, describe your contract arrangements with the laboratories to be used.

q. Describe your selection criteria and on-going quality monitoring procedures for laboratories.

r. Do you own a laboratory? If so, under what circumstances must a provider use your laboratory?

s. Some of the Agencies expect that employees and dependents that use network providers will be able to receive an exam and basic services with no out-of-pocket cost in some cases or at significant discounts in other cases. An exhibit is attached that details each Agency's provided vision benefit or prospectively provided benefit. Are you able to offer benefits under these various terms? Be specific as to any exceptions.

t. What are the components of an optical exam? What tests are performed in a standard examination? Are all network providers licensed to use testing solutions? Are fundus photos included for the standard rate? If no, how much extra cost is charged for this service? Do you recommend any tests or services in addition to the standard tests in the optical exam? If so, what tests or services? At what cost to the participant?
u. Do you offer guidance to participating providers on what tests should be offered with what frequency? Do the frequency of tests or the content of the initial exam visit differ by patient age, gender or disease status?
v. What are your minimum standards for record keeping for your providers?
w. If additional costs are expected beyond the exam fee and the materials and/or contract benefit, describe those costs and how they are determined.
x. With respect to frames, what frames are available at no cost to employees and dependents? How are such frames selected? What is the average retail and wholesale cost of such frames? How would a credit for the no cost frame be applied to a more expensive frame? Provide specific examples of how a more expensive frame and/or lens treatments would be charged to the participant. If you use retail cost rather than wholesale cost, provide a comparison that illustrates both retail and wholesale cost for a sample of frames that are above the "standard" cost reflected in your proposal. For this purpose, report on the ten most popular frames in your book of business that are not part of your "standard" package of frames (frames for which there is no additional cost to the participant). Provide a specific reference as to your source of data (date and source) for wholesale pricing. If you are able to do so, provide a sample of the ten most popular frames available for participants with no additional charge. Please include a return mail label so that the frames can be returned to you at the end of the RFP process. One physical sample is sufficient for this purpose. Please mark the box or other container clearly as "SAMPLE FRAMES FOR REVIEW BY THE AGENCIES."
y. For benefit plans similar to the plan offered by each Agency, what is the typical out of pocket cost a participant will pay for the combination of exam and materials, based on your book of business data? For an adult? For a child?
z. For lens treatments (e.g. plastic coating, multi-focal lens) do you require your network providers to use a standard pricing list? Why or why not? Are network providers required to limit a patient's out of pocket expense for such services?
aa. If the Proposer expects to directly or through a subcontractor relationship manufacture lenses, and or glasses, include a list of such vision laboratories with a listing of services provided by each laboratory.
bb. If an employee wished to "opt-up" to a more generous package of vision benefits than the employer provided, would you allow the employee to do so on a voluntary basis? What would be the minimum standards for participation? If your answer is yes, provide a sample plan description of the higher valued vision program, minimum participation standards, and proposed rates
cc. What options do you offer for a contact lens benefit? Do you require network providers to use a standard pricing list for contact lens? Why or why not?
dd. Would you offer a voluntary benefit for retirees (100% retiree paid)? If so, what would be minimum participation requirements and plan terms?
ee. Do you offer a surgical vision correction program, for example Lasik or other similar techniques? Do you offer a network of providers for a discounted price? IF yes, what would be the price and how would participants be informed of the network? If you offer such a program describe the program in detail.

Vision Quality Assurance Review

a. How often do you conduct on-site audits of provider locations to determine compliance with your contractual standards and employer plan terms? What is reviewed during an on-site audit?
b. How often do you conduct computer based data-analyses to determine compliance with your contractual standards and employer plan terms? What do you review? Do you share the results of any audit with plan sponsors?
c. How do you know that providers have met continuing education requirements?
d. Do you survey members to determine their comprehension of and satisfaction with your program? Describe and document your Quality Assurance/Review process, detailing the procedures in place for establishing, maintaining and evaluating the Vision Care Program.
e. Provide the names and qualifications of the individuals who perform the reviews.
f. How often do you verify your providers' insurance coverage?
g. Do you regularly obtain data regarding professional censure activity pertaining to Plan providers from available data sources, including state regulatory agencies and professional societies?

h. Describe the five most important actions your organization has taken in the last year to improve:
   i. quality of vision services
   ii. financial performance
   iii. customer/client service

i. What **is it** about your programs and services **that** distinguishes you from other vision service providers? What is unique about your offerings? What critical advantages do you have that other vendors do not?

Vision Claims Processing

a. Describe policies and procedures for processing claims and handling customer and provider inquiries on claims.
b. Describe your staffing and caseload for claims processing.
c. State your standards for financial and procedural accuracy.
d. If you intend to subcontract the claims processing function, state your subcontractor's claims processing standards for production, financial and procedural accuracy. How will you audit to ensure quality?
e. Provide a flow chart diagramming how claims will be processed including control procedures, estimated timeframes from initial receipt of a claim through pending, final resolution, issuance and mailing of payment and/or EOB.
f. How do you define errors? Do you have an on-line documentation system to monitor and track inquiries for both individual follow-up and closure as well as trend analysis over time?
g. Provide a sample of the utilization report that would accompany your invoices.
h. Does your system maintain historical information on submitted expenses and paid claims? How long is this claim history maintained on-line? What procedures do you have in place within the system to avoid paying duplicate bills submitted at separate times? Explain how your system identifies duplicate charges.
i. Describe your ability to archive and retrieve claim files for up to seven (7) years.
j. Can your claims processing system accommodate special plan design features that The Agencies may want tailored to individual plans only?
k. Monthly billing with the following information will be necessary:
   i. Group number
   ii. Member social security number
   iii. Member name
   iv. Patient name and relationship to employee
   v. Services
   vi. DOB
   vii. Provider Number
   viii. Provider Procedure
   ix. Provider amount
   x. Lab procedure
   xi. Non plan expense
   xii. Plan amount
   xiii. Patient amount
   xiv. Date(s) of service

Vision Reporting Requirements / Record Keeping Practices

The selected **Proposer** shall provide The Agencies with management information reports on a monthly and quarterly basis. The **Proposer** must provide a list of all available reports, frequency of reports, samples of these reports and describe your ability to custom design reports for specific client use. These reports shall include, but are not limited to the following data:

a. Services received by each employee or dependent
b. Name, Social Security number, and date of birth of person
c. Eligibility status of person served (i.e., employee, spouse or dependent
d. Date(s) of service
e. Name of provider
f. Expense incurred by the provider by name of employee and the person
g. Who received the service (if different from the employee)
h. Expense incurred by the provider

i. Provide a sample of each utilization report available and comment on how you and the Agencies can use the data to assess providers. Reports should be provided on a monthly basis showing the following for sworn employees/non-sworn employees and their dependents by eligibility category (employee, spouse, dependent).
    i. Total number of eligible
    ii. Total number of eligible served
    iii. Gross dollars paid for PPO Claims
    iv. Gross dollars paid for non-PPO claims
    v. Number of PPO claims
    vi. Number of non-PPO claims
    vii. Number of single vision lens
    viii. Number of contact lenses
    ix. Number of bifocal lenses
    x. Number of trifocal lenses
    xi. Number of frames
    xii. Number of eye exams

Vision Rate Quotes

a. If any rate quote includes fixed prices for optional services, provide the list of optional services, with the optional service cost to the participant. For what period of time can you guarantee the optional service price list?
b. Rate quotes may be offered on a per member per month basis, on a single/couple/family basis, on a single/employee+1/family basis, or on a utilizing member basis. Any utilizing member quote must provide detail that would allow the Agencies to "cross-walk" to a per member per month basis.
c. You must offer a price quote for each Agency's current plan and may offer price quotes on any additional benefit offerings that you believe would increase the value of the program to members and the Agency.

SUBMITTAL REQUIREMENTS AND PROPOSERS EXECUTION PAGE

General. Proposals shall be submitted in sealed boxes. The outside of the boxes must clearly indicate the name of the RFP:

Specification No.: CBO-2019-01 Request for Proposal for Healthcare PPO/HMO, Medical Review Services, Vision, Dental PPO/HMO

The outside of the boxes also must indicate the time and dates specified for receipt (see title page of this RFP) as well as the name and address of the Proposer. Personal delivery of proposals is recommended. Where proposals are sent by mail or other courier, the Proposer shall be responsible for timely delivery. If the delivery is delayed beyond the date and hour set for the proposal receipt, the proposal may not be considered. Read the Agency Exhibits and comply with Agency specific requirements.

Scope and Interrogatives. Reproduce each Scope requirement and confirm you propose to meet that requirement. Exceptions to your proposal to meet the Scope requirements shall be specific and shall be provided in the manner specified in the Scope. Reproduce each Interrogative and address it. Your electronic response to the Scope and Interrogatives may be in either Microsoft Word or Microsoft Excel.

Instructions on first page of RFP. Proposals shall be submitted in accordance with the instructions of the first page of this RFP (e.g. by the submittal deadline, in the form and manner and to the delivery address, as set forth on the first page of this RFP).

USB Drives. The USB drives shall be marked with Proposer's name. The files must be an exact copy (in the same sequence) of the original hardcopy proposal. The files must be searchable for both alpha and numeric characters

Hard Copy in 3 Ring Binder - Exception. Financial statements may, as an option, be provided electronically to the following email address: 2019BenefitsRFP@CityofChicago.org.

Proposers Execution Page. Proposals shall be accompanied by a Proposer's execution page, reproduced on the Proposer's letterhead, referring to Specification No.: CBO-2019-01, and signed by an authorized officer of Proposer, as follows:

"_____[insert name of Proposer] (A) represents and warrants that all responses to all interrogatives are true and correct, (B) proposes to perform each and every element of the Scope unless specifically excepted in its response, (C) hereby commits that, if selected will faithfully comply with all elements of its proposal unless otherwise accepted by the Agencies or with respect to an Agency by that Agency and *(D) authorizes release of information under the Freedom of Information Act to the extend not redacted in accordance with the submittal requirements of the RFP."*

Redacted Copies for FOIA. All material submitted may be made available in accordance with the Freedom of Information Act (FOIA) irrespective of whether the Proposal may contain trade secrets or other proprietary information. However, if the Respondent considers portions of its proposal to be confidential and not subject to FOIA, then such determination must be managed as follows:

- In addition to the proposal, provide two duplicates redacted for FOIA purposes, one in hard copy and the other on a USB drive, clearly labeled.
- The redacted content shall be blacked-out.
- Only content that is actually a trade secret or proprietary shall be redacted.
- Provide a key, describing what content was redacted and why the redacted content was redacted, citing the specific FOIA reference which justifies the redaction being made. Cite to the Illinois Freedom of Information Act 5 ILCS 140.
- Failure to follow this procedure will lead to release of data under a FOIA request.

- Overly broad or wholesale redacting of content that is not a trade secret or other proprietary data shall constitute failure to follow this procedure.

False Statements. Be advised, any person who knowingly makes a false statement of material fact to the city or any Agency in violation of any statute, ordinance or regulation, or who knowingly falsifies any statement of material fact made in connection with an application, report, affidavit, oath, or attestation, including a statement of material fact made in connection with a bid, proposal, contract or economic disclosure statement or affidavit, is liable to the city for a civil penalty of not less than $500.00 and not more than $1,000.00, plus up to three times the amount of damages which the city sustains because of the person's violation of this section. A person who violates this section shall also be liable for the city's litigation and collection costs and attorney's fees. The penalties imposed by this section shall be in addition to any other penalty provided for in the municipal code. (Added Coun. J. 12-15-04, p. 39915, § 1). Any person who aids, abets, incites, compels or coerces the doing of any act prohibited by this chapter shall be liable to the city for the same penalties for the violation. (Added Coun. J. 12-15-04, p. 39915, § 1). In addition to any other means authorized by law, the corporation counsel may enforce this chapter by instituting an action with the department of administrative hearings. (Added Coun. J. 12-15-04, p. 39915, § 1)

EVALUATION CRITERIA

Minimum Recommended Qualifications. Proposers which do not meet the minimum recommended qualifications listed below will not be considered:

- Currently serves, in the capacity for which it is proposing, at least three accounts, each having at least 25,000 employees per account;
- Currently serves in the capacity for which it is proposing, at least two accounts with at least 25,000 employees per account in which the majority of employees' employment is the subject of collective bargaining agreements;
- Has at least 5 years of experience as an organization in providing services of the type to be procured through this RFP;
- Is licensed in the State of Illinois and has other licenses and certifications as may be necessary to provide the proposed services
- Has annual gross revenues during either 2017 or 2018 of at least $100 million (if proposing for Medical Review Services, or Vision Services), $250 million (if proposing for Dental PPO or Dental DMO Services) and $2 billion during either 2017 or 2018 (if proposing for Medical PPO or HMO services).

General. The Agencies may consider any factors the Agencies deem necessary or desirable to determine the best overall value and most advantageous selection, based upon, and including but not limited to, the following criteria:

- Cost. Proposer's cost proposal and overall cost structure and approaches to controlling the cost of medications while providing appropriate access for members.
- Qualifications. Proposer's professional qualifications and specialized experience and local availability of key personnel committed to perform Services. Proposers should demonstrate having clients similar in size to the Agencies, or larger.
- Limited Scope of Service Exceptions. The degree to which the Proposer accepts the Scope of Service requirements as presented by the Agencies.
- Compliance with the Submittal requirements.
- Terms and Conditions. No exceptions to Sample Terms and Conditions to be Included in Professional Services Agreement to the extent included in Agency exhibits, or if exceptions are noted, the acceptability to the Agencies of those noted exceptions.
- Financial Stability. The financial condition of Proposer, including but not limited to factors indicating financially stability to ensure performance over the duration of the contract.
- Legal Concerns. Disclosed or undisclosed legal concerns regarding Proposer or any of its divisions, subsidiaries, or parent, or any affiliate.
- Conflicts of Interest. Anything that may indicate any conflicts (or potential conflicts) of interest which might compromise Proposer's ability to satisfactorily perform the proposed services or which might undermine the integrity of the competitive procurement process.
- MBE/WBE Participation. The level, relevancy, and quality of participation by MBE/WBE Agency requirements or policies.

Response. Proposers will also be evaluated on the quality of the response with regard to, *inter alia*, the following:

- "Will discuss" and "will consider" are not appropriate answers.
- A reference to the current contractual terms by any incumbent is not an appropriate answer.
- Proposers must be able to clearly demonstrate strength and experience, as Contractor, in its ability to:
    - Offer competitive performance guarantees to the Agencies related to implementation and on-going services
    - Be very responsive to changes in the health plan offerings required as the result of changes in collectively bargained benefits and/or arbitration awards and requests of the Agencies.
    - Rate quotations must include a minimum rate guarantee period of 36 months;

- Adhere to the data security requirements disclosed in the Agency exhibits (e.g. the City of Chicago's Information Security and Technology Policies)
- Sign each Agency's Business Associate Agreement

COST PROPOSAL

Full and complete cost proposals must be submitted.

1) Complete each data request on the USB-drive for the Services with respect to which the Proposer is proposing. Adhere to the format requirements. Responses must be in Microsoft Excel or such other program as may be permitted by the instructions on the USB drive.
2) You may optionally submit your cost proposal in a hard copy and electronic format you desire. However, rate information required to be submitted in the format set forth in 2) above is required. The Agencies may deem your proposal incomplete in case of failure to respond as set forth in 2) above.
3) For the electronic version of your cost proposal, use Microsoft Excel wherever appropriate. Microsoft Word can be used for narrative responses.

Cook County EAP

- Scope
- Interrogatives

Cost proposal Excel spreadsheet for Cook County EAP is located on the USB Drive

Cook County EAP Scope

- Provide a member portal which is user-friendly and thorough. The portal is to be available on all devices, offer online customer service chat, and provide access to tools, resources, and apps.
- Offer a base package of services including Critical Incidence Support, Management Support, Unlimited Wellness Coaching (phone and video), and a Bank of Work-Life Training Hours (40 hours).
- Make available a minimum of three (3) counseling sessions annually. Assistance is be provided through a range of methods including digital, phone, video, and face-to-face.
- Refer concerns that cannot be adequately addressed through the EAP to appropriate health plan, private or community resources.
- Offer a broad network of licensed clinicians.
- Maintain capacity to provide on-site critical incidence support.
- May offer additional buy-up resources for financial counseling and work-life services, among others.
- Provide periodic utilization reporting as well as ad-hoc analyses.
- Provide robust employee engagement materials in print and electronic formats.
- Integrate services as requested with other County benefits vendors, or complimentary services provided in-House or through unions.
- Conduct member surveys to assess program effectiveness.

Cook County EAP Interrogatives (Final)

1. Outline your base package of services. Confirm whether it includes Critical Incidence Support, Management Support, Unlimited Wellness Coaching (phone and video), and a Bank of Work-Life Training Hours of a minimum of 40 hours
2. What percentage of your clinical counseling is provided in-person, telephonically and web-based?
3. Identify the non-clinical concerns for which you offer resources / assistance: work / life balance, financial matters, legal matters, educational assistance, community resources, child care, elder care, pet care, temporary home care, adoption, parenting, special needs children, identity theft, product and service discounts, wellbeing information, other (please detail).
4. Describe your member portal. Confirm whether it is available on all devices, offers online customer service chat, and provides access to tools, resources, and apps.
5. Do you have experience offering counseling services to first responders? If so, explain.
6. Describe the options you offer with regard to the number of counseling sessions (clinical and non-clinical) offered per eligible individual. Address whether you offer an option for unlimited sessions, "x" number of sessions per concern, "y" number of sessions across all concerns, etc.
7. Confirm the maximum number of counseling sessions per member annually. Describe the methods in which sessions can be conducted. Can you make a representative available on-site for the County, or do you have offices in the Chicago area?
8. Does each counseling session generally last a set period of time (e.g. one hour)? If this differs based on type of counseling, please address.
9. Describe how concerns that cannot be adequately addressed through the EAP are handled. Where are they referred, and how do you match members with the most appropriate referral source? Do you monitor the progress of referrals beyond the EAP?
10. How do you interface with medical insurance benefits when clinical referrals are made beyond the EAP?
11. Describe your call center operation. Where is it located? How do you select and train your representatives? What is their average length of service? Is this team designated or dedicated to service the County? Please describe performance expectations and metrics.
12. What are the hours of operation for the call center? How are calls after regular business hours handled? Can you provide 24-hour crisis counseling, emergency triage and appointment scheduling?
13. Describe your access and intake system(s). Address whether there is a single phone number or access point regardless of type of assistance sought or separate phone numbers / access points based on type of concern.
14. Describe your member portal. Confirm whether it is available on all devices, offers online customer service chat, and provides access to tools, resources, and apps.
15. Once an appointment with an EAP provider is requested, what is a typical wait time for a routine appointment, an urgent appointment and a crisis appointment? If timing varies by type of assistance requested, please address.
16. Describe your process for providing an initial assessment of an individual's counseling or assistance needs.
17. Describe your network of clinicians. What are the different types of licenses that they hold? Describe your recruitment and credentialing process.
18. What is the size of the clinician panel that is available to the County to provide services? Is this a designated or dedicated panel? For children away at college, or living elsewhere, what national coverage is available?

19. Describe your network of non-clinical advisors. What licenses and credentials do they hold?
20. Describe your organization's capacity to provide on-site critical incidence support.
21. Do you offer wellbeing and life skills workshops, seminars and/or webcasts? If so, please an example list of topics available.
22. Describe your ability to offer consultation to supervisors of employees with job performance issues caused by unresolved personal or behavioral/medical concerns.
23. What types of training can you provide for supervisors, related to the referral of marginally performing employees to EAP services?
24. Do you offer services to support Human Resource development efforts of an organization (e.g. helping to design and implement policies and programs to address substance abuse, harassment, or aggression in the workplace)
25. What are your buy-up options? What types of services are included in each of the options?
26. How frequently do you provide utilization reports? Please outline the format and data included. Please provide a sample report. Confirm that you can also conduct ad-hoc analyses, and whether those are included or if there is an additional charge.
27. Do you offer an online reporting system that the client can access?
28. What is your approach to effective EAP promotion and employee engagement? Provide samples of your employee engagement materials. Are they available in both print and electronic formats? Are these included in the PMPM fee, or is there a separate charge? Will you develop targeted EAP promotion and communications materials based on the client's needs? Will you provide an annual credit for customized materials?
29. Describe your typical process for integrating services with other benefits vendors.
30. If a client has their own house EAP resource(s), how can you coordinate the use of these services?
31. How does your organization help promote use of EAP? Do you provide posters, materials, mailings? Please describe your communications abilities.
32. Confirm you will conduct member surveys to assess program effectiveness. If so, how frequently? How are those results shared with the County?
33. What professional standards, if any, does your EAP adhere to?
34. Specify any EAP quality indicators that you are capable of measuring and monitoring.
35. How do you evaluate success of your EAP?
36. Please describe any innovative offerings you are implementing over the next three years and their potential value to the client as a plan sponsor or its participants.
37. Will you provide the County with a designated account team? If not, how will the County interact with your organization regarding any concerns, reporting and other needs (e.g. participation at benefits/wellness fairs)?
38. Please provide an implementation timeline.