



HAMILTON COUNTY GOVERNMENT

Group Health Plan

Request for Proposal # 707-1

June 26, 2007

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I. BACKGROUND

Hamilton County Government is requesting proposals from health plans for its employee group medical benefits for the plan year beginning January 1, 2008. The County would like to receive proposals for HMO, POS and PPO products, both fully-insured and self-funded, for a three year period if possible.

Hamilton County Government currently has 1,765 employees and retirees eligible for Medical Insurance.

We have two fully-insured Medical Plans:

- 1) a Co-Pay PPO plan through BlueCross BlueShield of Tennessee which has been in effect since **1/1/04**. Employees in this plan were employed prior to 9/6/06. Total number of enrollees in this plan is 1,560.
- 2) the County began offering a high deductible Co-insurance PPO plan through BlueCross Blue Shield of Tennessee which is the only plan offered to employees employed as of **9/6/06**. Total number of enrollees in this plan is 104.

The distribution of enrollees, monthly premiums, and % of employee contribution are as follows:

	PPO Co- Pay - Emp Pays 11% of Premium				PPO Co-Insurance - Emp Pays 6% of Premium			
	Single	Single-Parent	Emp-Spouse	Family	Single	Single-Parent	Emp-Spouse	Family
Premiums	\$ 400.62	\$ 720.73	\$ 840.77	\$1,200.90	\$ 304.37	\$ 547.48	\$ 638.65	\$912.15
No. of Emp.	362	151	436	611	39	19	18	28

- 3) the County has 101 retirees covered under the Co-Pay PPO plan.

	PPO Co- Pay				PPO Co-Insurance			
	Single	Single-Parent	Emp-Spouse	Family	Single	Single-Parent	Emp-Spouse	Family
No. of Retirees	61	4	29	7	0	0	0	0

- 4) the County has five COBRA participants in the health plan.
- 5) the County is planning to give its employees a monthly discount on premiums for non-tobacco use beginning July 1, 2007.
- 6) the County is considering implementing Health Risk Assessments with biometrics.
- 7) the County is currently in the planning stages of implementing a disease management program similar to the Asheville Project for its employees.

II. SCHEDULE

Evaluation

Hamilton County Government is a member of the HealthCare 21 Business Coalition (HC21) and, as such, will utilize recent health plan data from HC21's recent RFI (eValue8 and the supplemental questions) to analyze the quality and operational components of health plans.

Proposals will be accepted only from companies that have participated in HC21's eValue8 and supplemental questionnaire.

The following criteria will be used to evaluate each proposal. The questions in this proposal will be incorporated into the scoring and may be incorporated into the criteria as determined by the evaluation committee.

- ❖ Cost Effectiveness of the Proposal
- ❖ Provider Network
- ❖ Experience, References, and Answers to Questions
- ❖ Customer Service
- ❖ Financial Information
- ❖ Ability to Follow Directions

Anticipated Timeline

1. RFP released on June 26, 2007.
2. Dead line for written questions and clarification requests is 4:00 p.m. EDT July 16, 2007.
3. County issues responses to clarification requests by 4:00 p.m. EDT on July 20, 2007.
4. Deadline for submittal of proposals is before 10:00 a.m. EDT on July 25, 2007.
Note: Hamilton County will **not** accept late responses.
5. County opens proposals on July 25, 2007 at 10:00 a.m. EDT.
6. County completes evaluation of proposals by August 10, 2007.
7. Recommendation of finalist submitted to County Commission on August 30, 2007.
8. Contract development completed by September 30, 2007.
9. Open enrollment meetings conducted the last week of October and first week of November.
10. Employee enrollment completed by November 9, 2007.
11. Implementation January 1, 2008.

NOTE: Any material departure(s) from this proposed schedule will be brought to the attention of all affected parties.

III. GENERAL INSTRUCTIONS AND REQUIREMENTS

Guidelines

Questions

We reserve the right to schedule face-to-face meetings with any and all respondents, both to confirm qualifications and to be introduced to the facilities and personnel that will be working with us if you are the successful Proposer. Proposals are to be submitted with any subcontracted work clearly identified. The County reserves the right to approve each subcontracting party both before and after award of the contract.

We appreciate brevity and encourage you not to provide substantial volumes of internal and external reports unless specifically asked for in another section of this document.

Interpretation and Clarification

No oral interpretation or clarification will be made to any firm or any individual as to the meaning of the RFP document.

Direct comments and questions regarding the content of this RFP, in writing, (fax or email) by 4:00 p.m. EDT on July 16, 2007 to:

Donna Garrison, Benefits Manager
Hamilton County Government
117 East 7th Street, 2nd Floor
Chattanooga, Tennessee 37402
Phone: (423) 209-6136
Fax: (423) 209-6121
Email: donnag@.hamiltontn.gov

Direct comments and questions regarding the process of this RFP in writing, (fax or email) prior by 4:00 p.m. EDT on July 16, 2007 to:

Linda Chumbler
Hamilton County Purchasing Department
117 East 7th Street
Chattanooga, TN 37402
Fax: (423) 209-6351
Email: lindac@hamiltontn.gov

(This point of contact shall hereinafter be referred to as the RFP Coordinator.)

A response will be issued in the form of an addendum to the RFP if clarification is in order.

Proposal Formatting and Contents

Provide the plan's accreditation status, i.e., URAC, JACHO, and NCQA.

The plan's response to the RFP must include:

- Use attachments to verify questionnaire responses. All attachments should be tabbed, numbered (e.g., Attachment). Insert attachments directly behind the related section.
- Responses to questions should be in the order they appear in the RFP. **Each question must be restated before the response, and all attachments must be labeled.**
- Insert the Plan's name (not logo) next to the page number in the footer of the document.
- Plans offering HMO, POS, and PPO product lines should answer in the format below:

Sample Answer Format

HMO answer:
Provide your answer

POS answer:
Provide your answer or in bold print type "same as HMO above"

PPO answer:
Provide your answer or in bold print type "same as HMO/POS above"

All RFP responses should be provided in three ring binders with all attachments separated by marked tabs. Insert attachments directly behind the related section, not under separate cover. Provide four (4) hard copies of the entire response. If you wish to have the RFP document emailed to you, send an email to [Linda Chumbler at linda@hamiltontn.gov](mailto:Linda.Chumbler@hamiltontn.gov).

RFP Number

The County has assigned the following RFP identification number--it should be referenced in all communications regarding the RFP, and included on the outside of the response envelope(s):

RFP# 707-1

RFP Submission

To be considered, responses must be received in the Hamilton County Purchasing Office no later than 9:59 a.m. EDT on July 25, 2007. All responses shall be submitted to the Hamilton County Purchasing Director at the address specified below:

Ken Blankenship
Purchasing Director
Hamilton County Purchasing Department
117 East 7th Street
Chattanooga, Tennessee 37402

The responder shall clearly mark its response envelope as RFP# 707-1 – Group Health Plan Proposal.

It is the sole responsibility of the responder to ensure that its response is delivered by the date/time, and at the place specified, in this RFP. Any response received contrary to this requirement will be returned to the responder, unopened.

The response filing deadline is important. Any response submitted at or after the moment designated for response opening will be deemed to be late and will not be accepted. The clock-in time will be determined by a clock maintained by the Hamilton County Purchasing Department. No other clock or timepiece will have any bearing on the time of response receipt. Since parking can be a problem or responders may not be familiar with the building to which responses are to be delivered, responders are advised to avoid waiting until the last minute to deliver their responses.

Failure to submit all information requested in the RFP may result in the County giving a lowered evaluation of the response.

References

Please provide your company's experience in working with both self-insured and fully-insured clients as well as with clients having a high deductible or consumer driven health plan with over 1,000 employees in the past three years. Provide a list of three current accounts and two accounts that are no longer clients, preferably similar in size to Hamilton County Government.

Lead Contact and Staff

Please list the names of all professional staff, including the lead contact, which will be assigned to work on the Hamilton County Government account and a brief resume of their background and experience. Explain the duties each person will perform.

Proposal Withdrawal

To withdraw a proposal, the vendor must submit a written request, signed by an authorized representative, to the RFP Coordinator. After withdrawing a previously submitted proposal, the vendor may submit another proposal at any time up to the deadline for submitting proposals.

Proposal Amendment

The County shall not accept any amendments, revisions, or alterations to proposals after the deadline for proposal submittal unless the County requests such in writing.

Proposal Errors

Proposers are responsible for all errors or omissions contained in their proposals. Proposers shall not be allowed to alter proposal documents after the deadline for submitting a proposal.

Insurance

The apparent successful Proposer may be required to provide proof of adequate workers' compensation and public liability insurance coverage before entering into a contract. Additionally, the County may, in its sole discretion, require the apparent successful Proposer to provide proof of adequate professional services liability or other forms of insurance. Failure to provide evidence of such insurance coverage is a material breach and grounds for termination of the contract negotiations. Any insurance required by the County shall be in form and substance acceptable to the County.

Commercial General Liability Insurance - \$1,000,000 per occurrence limit for property damage and bodily injury. The service provider shall indicate in its **proposal** whether the coverage is provided on a claims-made or (preferably) on an occurrence basis. The insurance shall include coverage for the following:

- ❖ Premise/Operations
- ❖ Products/Completed Operations
- ❖ Contractual
- ❖ Independent Contractors
- ❖ Broad Form Property Damage
- ❖ Personal Injury

Professional Services Liability (E & O Coverage) - \$1,000,000 per occurrence.

In addition, Hamilton County shall be listed as an additional insured on the above required liability insurance policies. A signed certificate of insurance shall evidence all policies and coverage shall not be cancelled without a minimum of thirty days cancellation notice to the Hamilton County Risk Management Office. All coverage shall be placed with Tennessee admitted insurers rated B+ 10 or better by A. M. Best's rating service or as approved by the Hamilton County Risk Manager.

There must be written confirmation that the Proposer shall comply with all of the provisions in this RFP. The written certification and assurance shall affirm the Proposer's compliance with:

- ❖ The laws of the State of Tennessee and Hamilton County;
- ❖ Title VI of the Federal Civil Rights Act of 1964;
- ❖ The Equal Employment Opportunity Act and the regulations issued there under by the federal government;
- ❖ The Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government;
- ❖ The condition that the submitted proposal was independently arrived at, without collusion, under penalty of perjury;

- ❖ The condition that no amount shall be paid directly or indirectly to an employee or official of Hamilton County as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor or consultant to the Proposer in connection with the procurement under this RFP;
- ❖ The drug free workplace statement; and
- ❖ The Hamilton County Disadvantaged Business Enterprise guidelines.

(Complete and return with your response the Certification of Compliance document provided as Appendix F of this document.)

Contract Approval

The RFP and the contractor selection processes do not obligate the County and do not create rights, interests, or claims of entitlement in the apparent best-evaluated Proposer or any vendor. A legally binding contract shall be established only after the contract is signed by the Contractor, the head of the procuring County agency and/or the County Mayor or other County officials as required by applicable state and local laws and regulations.

This RFP and the successful proposal shall be incorporated into the final contract.

Right of Rejection

The County reserves the right, in its sole discretion, to reject any and all proposals or to cancel this RFP in its entirety.

Any proposal received that does not meet the requirements of this RFP may be considered to be non-responsive, and the proposal may be rejected. Proposers must comply with all of the terms of this RFP and all applicable state laws and regulations. The County may reject any proposal that does not comply with all of the terms, conditions, and performance requirements of this RFP.

Proposers may not restrict the rights of the County or otherwise qualify their proposals. If a Proposer does so, the County may determine the proposal to be a non-responsive counteroffer, and the proposal may be rejected.

The County reserves the right, in its sole discretion, to waive minor variances in technical proposals, provided such action is in the best interest of the County. Where the County waives minor variances in proposals, such waiver does not modify the RFP requirements or excuse the Proposer from full compliance with the RFP. Notwithstanding any minor variance, the County may hold any Proposer to strict compliance with the RFP.

Disclosure of Proposal Contents

All proposals and other materials submitted in response to this RFP procurement process become the property of Hamilton County, Tennessee. Selection or rejection of a proposal does not affect this right. All proposal information, including detailed cost information, shall be held in confidence during the evaluation process.

Upon completion of the evaluation of proposals, as evidenced by the submission of a recommendation to the County's Board of Commissioners, the proposals and associated materials shall be available for public review.

Right to Further Negotiate

The County reserves the right to further negotiate, after proposals are opened, with any Proposer, if such is deemed necessary in the discretion of the County.

Any submitted proposal shall remain a valid proposal for three (3) months after the proposal due date.

Mandated requirements are those required by law or such that they cannot be waived and are not subject to negotiation.

Subcontracting

Subcontracting will not be allowed for any services in this RFP without prior written authorization by the County.

IV. ADMINISTRATIVE CAPABILITIES

A. Member Services

1. How does the member access the member services department **after hours** for member services issues? (Check all that apply)

- Message system; member can leave message with health plan call back next business day
- Recorded message by health plan (i.e., hours of operation and directions for emergency)
- Interactive Voice Response System (IVR)
- Other (specify): _____

2. Provide a comprehensive description of the member grievance procedure, including the process for filing grievances and turnaround time frames for resolution and appeals as **Attachment IV 1**. (Include a description for obtaining external appeals if applicable).

3. Indicate the health plan's standard and actual average turnaround time to issue member identification cards from the date the health plan receives complete and accurate enrollment information to the date the card is issued. Express in working days.

	Plan Standard	2006 Actual
Identification card turnaround		

If out-sourced, please indicate vendor: _____

4. Please provide the following customer service information

	Plan Standard	2006 Actual
1. Average speed to live voice (Indicate your administrative standard for the time it should take for a member to reach a Member Services representative)	_____ seconds	_____ seconds
2. Initial call resolution (Indicate the percentage of callers who had their problem resolved during the initial call)	_____ %	_____ %
3. Abandonment rate (Indicate the percentage of callers who hang up AFTER being placed on hold by Member Services)	_____ %	_____ %

Disease Management Program Criteria

Hamilton County Government is interested in understanding the efforts undertaken by managed care organizations to improve the health and health outcomes of enrollees. Therefore, we are requesting information on the health promotion and disease management programs operational in your health plan. Since disease management means different things to different parties, we have defined the following (6) criteria as necessary to be considered a disease management program for the purposes of this document. Please apply these criteria when determining your response to the following questions:

- Mechanism to identify enrollees who are “at risk” and likely to benefit from early intervention and education
- Written clinical guidelines, reviewed at least annually by plan (preferably with a high degree of provider input/acceptance)
- Coordinated program to assess and meet enrollee/family/provider learning needs and enrollee self-care needs
- Ongoing monitoring mechanism to evaluate program success and improvement opportunities over time
- Calling the “high risk” enrollee by a qualified nurse to educate and motivate compliance to guidelines
- Calling the provider as needed to coordinate enrollee compliance

With Hamilton County’s plan to implement Health Risk Assessments and a disease management program similar to the Asheville project, please describe how these programs can be integrated in the disease management process to achieve a higher treatment and prevention compliance. What data can your organization share in order to achieve a high level of integration?

1. For disease management programs that meet the above criteria and are currently operational in your Plan, please provide the date of implementation.

Disease or Condition	Date Began	Disease or Condition	Date Began
Asthma		Hypertension	
COPD		CAD/Hyperlipidemia	
Depression		ASA Therapy Post MI	
Low Back Pain		Congestive Heart Failure	
Diabetes		Other Coronary Program	
Diabetes HGB AC1 Monitoring		Stroke Prevention	
GERD		Atrial Fib/Anticoagulant Use	
PUD/H. Pylori		Beta Blocker Post MI	
HIV/AIDS		Elderly Prevention / Falls	
Pregnancy/Childbirth		HIP Fracture Management	
Low Birth Weight Infants		Other(s)	
Breast Cancer			
Prostate Cancer			
Immunosuppression			

2. For any Disease Management programs that the plan out-sources, please complete the following.

Program Name	Vendor / Date Vendor Began	Oversight Monitoring Mechanism	Frequency Program is to be Reviewed	Date of Last Documented Review

3. For your health plan's top five disease management efforts, please complete the following grid.

Disease State or Conditions	1. _____ _____ _____	2. _____ _____ _____	3. _____ _____ _____	4. _____ _____ _____	5. _____ _____ _____
Define how members are targeted. Please define the criteria used to identify the "at risk" population (age, gender, familial history, HRA questions, pharmaceutical use, etc).					
# of Current Enrollees Eligible for Program					
# of Current Enrollees in the Program					
How does the HMO identify potential enrollees to physicians? How often does this occur?					
How does the HMO factor physician participation in its disease management programs into physician performance measures and incentives?					
Please indicate the objectives or performance measures the HMO has or will use to evaluate the success of this program: ___ Enrolling a designated % of eligible members ___ Number of members completing program ___ Reducing utilization of other services ___ Reducing risk factors ___ Returning member to work early ___ Patient satisfaction ___ External review evaluation ___ Patient functionality ___ Cost effectiveness					

Disease State or Conditions	1. _____ _____ _____	2. _____ _____ _____	3. _____ _____ _____	4. _____ _____ _____	5. _____ _____ _____
How frequently does a nurse call high-risk enrollees?					

4. In **Attachment V 2**, include the following information for the top five Disease Management programs described above:
- A. A copy of the clinical practice guideline(s) supporting the program.
 - B. Sample reports showing statistics covering physician compliance with the program.
 - C. Sample reports provided to physicians listing patients who are enrolled in program or should be enrolled.
 - D. Samples of the targeted member outreach communication material.
 - E. Member education material related to the disease and integrated into the program.
 - F. Physician education materials related to the guidelines and the program.
 - G. Tools used to evaluate effectiveness of program and opportunities for improvement.
 - H. Return on investment (ROI) calculations for each disease from the plan's experience.

VI. PRICING INFORMATION

Provide pricing information for fully insured rates and self-funded rates. Self-funded rates should be broken down by component, e.g., reinsurance, network, etc., and expressed in per employee terminology. Should Hamilton County request additional provider specific discounts or actual claims re-pricing, will you comply? Please explain.

Benefit plan summaries are provided in Appendix A
 Census data information is provided in Appendix B
 Claims data information is provided in Appendix C

Identify the pricing information as **Attachment VI 3**.

The County would like proposals for both specific stop loss and aggregate stop loss in the event we decide to self fund our plan. Please quote specific stop loss coverage at \$100,000, \$125,000 and \$150,000. Each of these should be quoted on a 12/12 and 12/15 contract basis. Aggregate coverage should be at 125% of expected claims.

In addition to the proposals, please answer the following questions:

1. Number of years your corporation has been actively engaged in Stop Loss Insurance?
2. Please provide brief profiles of the individuals who would be assigned to service our account, including their years of direct experience with medical Stop Loss.
3. What are your Best's and Standard & Poor's ratings?
4. Please provide details of your experience level with self funded plans over 2000 lives. What is your company's average size group? What is your average specific deductible size?
5. If you are working in partnership with an ASO vendor, please provide details of the relationship:
 - How long have you done business with the ASO provider?

- Approximate number of cases and block size?
 - Are any special value added features involved?
6. Regarding your historical renewal rating, please provide the following:
 - Last 24 months average rate increase
 - Last 24 months: largest rate increase provided to a Tennessee policyholder
 7. Do you offer a renewal on every case? Or do you reserve the right to unilaterally terminate a group for poor experience? If so, can this be done only on the renewal date?
 8. Do you laser individual participants on renewals, if so when? If you do not laser on renewals, is it available upon the group's request?
 9. What is required to finalize terms on a new group and issue the contract?
 10. Do you have an actively-at-work provision? What are the requirements for waiving it? Do you reapply actively-at-work provisions on renewals?
 11. What are your standard requirements to finalize terms on a renewal and issue the contract? Do you require disclosure statements on renewals? If so, please provide a sample.
 12. What information do you require to process a specific stop loss claim and an aggregate stop loss claim?
 13. What is your turnaround time for claims reimbursement?
 14. What documentation is required of the policyholder for claims reimbursement?

VII. COST/REIMBURSEMENT INFORMATION

1) For each network by location, provide the inpatient hospital reimbursement information requested below. This information must reflect your current negotiated reimbursement arrangements (for all types of admissions combined) for 2007. Please provide the 2007 Average Daily Billed Charge, regardless of how hospitals are reimbursed, unless you do not receive billed charges from providers, or do not have it available in your files. Also, please provide the 2007 Average Daily Allowed Charge, regardless of how hospitals are reimbursed (per diem, DRG, fee-for-service, etc.) by dividing total reimbursements by number of days.

Location	2007 Average Daily Billed Charge (undiscounted)	2007 Average Daily Allowed Charge (after discounts & before cost sharing)	Total Number of Inpatient Days for 2007
Chattanooga			
Cleveland			
Nashville			
North Georgia			

2) Provide the total dollars for each location for all outpatient services in 2007.

Location	Total Billed Charges (undiscounted)	Total Allowed Charges (after discounts & before cost sharing)	Number of Services
Chattanooga			
Cleveland			
Nashville			
North Georgia			

3) Are the discounts and/or fee schedules associated with all networks(s) you are proposing loaded in your claims system or must claims be submitted elsewhere for re-pricing?

4) Under a self-funded arrangement, will all provider discounts be passed on to the employer? If not, define how they are affected by self-insuring.

5) Indicate your average in-network discount for each key location in the following format, including all non-pharmacy claims.

Location	Inpatient	Outpatient	Other Health	Physician
Chattanooga				
Cleveland				
Nashville				
North Georgia				

6) For each location, give the average anesthesiologist's charge and your average anesthesiologist reimbursement.

7) For each location, indicate the total annual inpatient facility use per 1,000 members for the following:

Type of Admission	Days per 1,000	Discharges per 1,000
Medical/Surgical		
Maternity		
Mental Health/Substance Abuse		

8) Indicate the trend rate used or being used for determining renewal rates for 2007, 2008, and 2009.

Type of Expense	2007 Renewals	2008 Renewals	2009 Renewals
In-Network-Expenses			
Out-of-Network Expenses			
Total (average)			

9) What was your 2006 average cost per hospital day (general acute care as defined by HEDIS)?

10) Compared to Medicare reimbursement for physicians, what would be your health plan's fee schedule (e.g. 140% of Medicare)? Please indicate for each location.

11) The Chattanooga-Hamilton County Health Department - a department of Hamilton County Government - would like to administer influenza, pneumonia, and tetanus vaccines to its employees. Insurance companies desiring to provide medical insurance coverage for Hamilton County Government must be willing to contract with the Chattanooga-Hamilton County Health Department in the administration of these vaccines. Remuneration for these services shall be set at the usual and customary rate. The insurance company shall not make any demands on the

Chattanooga-Hamilton County Health Department to provide other services beyond the scope of vaccinations stated here.

VIII. PHARMACY BENEFIT MANAGEMENT PRICING INFORMATION

1. Is the PBM outsourced: ___ Yes ___ NO

2. If yes, who do you use: _____

3. The following items must be provided for each of these categories:

	RETAIL		MAIL ORDER	
	Brand	Generic	Brand	Generic
Ingredient cost (undiscounted)				
Dispensing fee				
Admin fee				
Discounts off AWP				

- Generic discounts including: (Note: Generic discounts might require AWP equivalent)
 - % of generics adjudicated at MAC: Retail _____ Mail _____
 - MAC discount: Retail _____ Mail _____
 - Non-MAC discount: Retail _____ Mail _____
- Net rebate amount per Rx (or the sum of annual rebates):

- Total annual utilization management savings (net of any sharing):

- Do you currently utilize a formulary? ___ Yes ___ No
- Does pricing vary based on plan design? If so, explain _____

IX. GEOGRAPHICAL ANALYSIS BY EMPLOYEE RESIDENCE

- A. Provide a geographical analysis of Hamilton County Government employees by residential zip codes (see Appendix B). Identify the analysis as **Attachment IX 4.**
- B. Explain out-of-network and out-of-area restrictions or penalties.

- C. What provision is made for out-of-area emergency care?
- D. Explain any other provider restrictions or penalties.
- E. How are provider directories distributed?
- F. How frequently are provider directories updated?
- G. What geographical coverage is your plan capable of (Tennessee, Southeast, United States)? Please provide details.
- H. Describe your process for recruiting providers.

X. HEALTH RISK ASSESSMENTS

Does your company have a Health Risk Assessment (HRA) tool? Is the process outsourced? Please specify if the answers to the following questions pertain to your company or a vendor. Please also provide separate pricing for this service.

General Information

1. How long has the company been in business?
2. How long has the company been providing health risk assessment services?
3. Please provide two current and two former client references that have used your health risk assessment services.
4. Describe the corporate client that you feel you can best serve.

Services Provided

1. Create a flowchart detailing how your company provides health risk assessments and related ancillary services. Please differentiate core services from optional services. Also include approximate elapsed times between each of the service steps where applicable. Provide this flowchart as **Attachment X 5**.

Health Risk Assessment Questionnaire

1. How is the health risk assessment questionnaire administered? Web-based, paper-based, or other?
2. Please list any evidence-based guidelines that were used in the development of the questionnaire.
3. What assistance does your company provide to those completing the questionnaire? If assistance is provided, please explain how.
4. How quickly are results provided?
5. What languages is the assessment available in?

Biometric Screenings

1. Does your company integrate biometric screenings into its health risk assessment? If yes, please list all the biometric screenings that you currently integrate. Please explain the process.
2. Please list any evidence-based guidelines that were used in the integration of biometric screenings with the questionnaire.
3. If your company facilitates the biometric screenings, what level of staffing do you use (phlebotomist, nurse, other) and indicate if you use staff, contract workers, or a combination of both?
4. Indicate if the biometric screenings can be purchased a la carte or must be purchased as a suite of screenings.
5. How quickly are results provided?
6. Do you require participants who are having blood drawn to be fasting? Why or why not?

Follow-Up Services

1. Does your company provide any form of employee counseling or other types of follow-up during or after the health risk assessment? Explain. Please clearly define what you mean if you use any industry or proprietary terms in your explanation (e.g. "health coaching", "disease management", etc.).
2. What evidence-based guidelines were used to develop the follow-up programs you listed above?
3. What qualifications and/or credentialing do follow-up related workers have?
4. List the methods follow-up workers use to communicate with employees (in-person sessions, telephonic, mail, email, etc.). Which method(s) are primary?
5. Please provide an example case study of how the programs you listed above have made a positive impact for one of your clients. Methodology for any listed ROI figures must be included.
6. Does your company employ a medical director? If yes, what are his/her responsibilities related to health risk assessment results. What are his/her credentials?

Reporting and Data

1. What type of reporting packages do you provide to:
 - a. Employees?
 - b. The employer?
2. How are the reports provided (paper-based, web-based, monthly, quarterly, etc.)?
3. Are there buy-up reporting options for the employer? Explain.
4. Are you willing to run ad-hoc reports?
5. Provide examples of each of these types of reports as **Attachment X 6**. Please label each example report as for employee, employer and/or if it is a buy-up option.
6. Are you able to provide data transfers to a client's health plan? If so, what formats?
7. Are you able to provide data transfers to a data warehouse vendor? If yes, have you done it before and in what type of data format(s)?

Incentive Programs

1. Does your company have any incentive program(s) to assist employees to either participate in a health risk assessment or to encourage at risk employees to modify their risk factors? Please explain.

Compliance

1. How does your company assure HIPAA compliance?

Pricing Structure

1. If you mentioned a service and/or product in this RFI, please indicate how you bill for those service(s) and/or product(s) (capitation, fee for service, other).

Miscellaneous

1. Do you require a minimum number of participating employees for your services? If yes, what is the minimum number?
2. Can you administer your services for multi-site organizations?
3. What quality assurance/control processes do you have in place for maintaining the efficiency and effectiveness of your questionnaire and the other ancillary services such as health coaching or other services? Explain.
4. Do you provide copies of the patient release forms?
5. What information about your company do you wish to share that has not been asked? (Limit answer to one (1) page).

XI. ENCLOSE A PROVIDER DIRECTORY FOR THE CHATTANOOGA, CLEVELAND NASHVILLE, AND NORTH GEORGIA AREAS

Identify the Directory of Providers at **Attachment XI 7**. Finalists will be asked to prepare a network disruption analysis.

XII. PROVIDER CPT CODE SURVEY

Please give your plan's reimbursement. See Appendix D. Provide as **Attachment XII 8**.

XIII. HOSPITAL QUALITY PROFILES

Medical Error Prevention/Patient Safety

Hamilton County Government expects Plans to foster an approach to patient safety (e.g., error reduction) that emphasizes root cause identification rather than individual performance and blame. The Plan will work with the delivery system to improve systems and processes that impact safety.

The Plan will work with their contracted hospitals to implement patient safety standards in the following key areas that have been documented to be effective at reducing medical errors and/or improving patient outcomes:

- 1) Computer Physician Order Entry (CPOE) for non-rural (e.g., within a SMSA) network hospitals.
- 2) An ICU Physician Staffing (IPS) standard for non-rural network hospitals.
- 3) An Evidence-based Hospital Referral (EHR) standard for non-rural, elective hospitalizations.
- 4) High Safe Practices scores based on the 27 Leapfrog Safe Practices.

In addition, Plans will develop and disseminate information about the importance of patient safety to all of their members. At a minimum, plans need to describe the value of these hospital safety features in language that is easily understandable and empowers the member to become involved in ensuring safety.

Purchasers expect plans to encourage their contracted hospitals to self-warrant the information on Computer Physician Order Entry, ICU Physician Staffing, Evidence-Based Hospital Referral, and Safe Practices on the Leapfrog website (leapfroggroup.org) before January 1, 2004.

Please list all of the plan's contracted Chattanooga, Cleveland, Nashville, and North Georgia hospitals in the table below. List the name and city of each urban (i.e., within a SMSA) hospital and indicate the medical error prevention/patient safety information, as applicable, that has been warranted on the Leapfrog website.

Hospital Name	Location		Information Warranted on Leapfrog Website For:		
	City	State	CPOE	ICU Staffing	Evidence-Based Hospital Referral
			[] Yes [] No	[] Yes [] No	[] Yes [] No
			[] Yes [] No	[] Yes [] No	[] Yes [] No
			[] Yes [] No	[] Yes [] No	[] Yes [] No
			[] Yes [] No	[] Yes [] No	[] Yes [] No

What percentage of the plan's hospital admissions fulfilled all four components of the Standard?

Please provide a description of the plan's hospital contract language that addresses the quality of the facility. For example, does your hospital contract require JACHO accreditation?

XIV. PERFORMANCE AND FINANCIAL GUARANTEES

Indicate if the health plan will (yes), will not (no) agree to each of the following standards.

PERFORMANCE STANDARDS 2006

	YES	NO
* Meet minimum reporting requirements as outlined by HC21 for: <ul style="list-style-type: none"> • Claims Reports • Financial Reports • Utilization Reports • Data Co-operative (Appendix E)* 		
* Claims payment standards <ul style="list-style-type: none"> • Payment accuracy rate 97% • Financial accuracy rate 99% 		
* Provider turnover less than 5%		
* Quarterly update to provider directory Participants notified of changes within 45 days		
* Satisfactory phone response time – 90% in 45 seconds between memo selection and human voice		
* Satisfactory abandon call rate less than 5%		
* Turnaround of claims processing time – 85% within 10 working days/14 calendar days		
* Rate guarantee period up to 24 months for ASO clients		
* Fees at risk based on actual plan savings with self-insured clients		
* Pharmaceutical rebate sharing with self-insured clients		
* All negotiated discounts for all services passed on to self-insured clients		
* Timeliness of ID Card distribution – 100% before appropriate date		
* Restrictions and limitations on distribution of money at risk		
* Demand Management Programs – offer 24 hours a day, 7 days a week nurse line		
* Disease Management programs – offers diabetes disease management		
* Generic drug as a percentage of total prescription drugs – between 45-50%		

Please state the Plan's financial guarantee for these performance standards _____

*The County shall be the owner of all claims data, and the successful proposer(s) shall, at the County's direction, make any or all claims data available electronically (or in report form if requested) to vendors with which the County has executed Business Associate Agreements (BAA) under HIPPA. The successful proposer(s) shall not charge more for providing such data than the proposer's actual cost. Proposer(s) shall not use claims data for any purpose except administration of the County's medical insurance program without the written consent of the County. The current claims data fields are found in Attachment E.

XV. SIGNATURE PAGE

The information contained in this document is true and correct, containing **NO** misrepresentations. The information is **NOT** tainted by any collusion.

Print Name and Title

Print Company Name You Are Representing

Signature (Officer of the Company)

Date

APPENDIX A: BENEFIT PLAN SUMMARIES

The following documents are attached:

- Co – Pay PPO Plan Summary
- Co – Insurance PPO Plan Summary

APPENDIX B: CENSUS DATA

The census data is available in an Excel format and can be obtained by emailing Donna Garrison with your request at donnag@.hamiltontn.gov. If you need a hard copy, please call Donna Garrison at 423-209-6136.

APPENDIX C: CLAIMS DATA

Claims data will be available June 26, 2007 and will be faxed upon written request. Email your request to Donna Garrison at donnag@.hamiltontn.gov or fax your request to 209-6121. **Please provide your fax number when submitting your request.**

APPENDIX D: PROVIDER CPT CODE SURVEY

Please give the plan's reimbursement for each CPT code. If multiple products are included, e.g., HMO, PPO, POS, provide all that are relevant to this proposal.

CPT	CPT Description	2006 Reimbursement
99213	OFFICE/OUTPATIENT VISIT, EST	
99214	OFFICE/OUTPATIENT VISIT, EST	
J0256	ALPHA 1 PROTEINASE INHIBITOR	
J1745	INFLIXIMAB INJECTION	
97110	THERAPEUTIC EXERCISES	
90999	DIALYSIS PROCEDURE	
88305	TISSUE EXAM BY PATHOLOGIST	
70553	MRI BRAIN W/O & W/ DYE	
98941	CHIROPRACTIC MANIPULATION	
95811	POLYSOMNOGRAPHY W/CPAP	
99284	EMERGENCY DEPT VISIT	
99283	EMERGENCY DEPT VISIT	
47562	LAPAROSCOPIC CHOLECYSTECTOMY	
95810	POLYSOMNOGRAPHY, 4 OR MORE	
93510	LEFT HEART CATHETERIZATION	
99396	PREV VISIT, EST, AGE 40-64	
J2505	INJECTION, PEGFILGRASTIM 6MG	
45380	COLONOSCOPY AND BIOPSY	
99215	OFFICE/OUTPATIENT VISIT, EST	
43239	UPPER GI ENDOSCOPY, BIOPSY	
99203	OFFICE/OUTPATIENT VISIT, NEW	
78465	HEART IMAGE (3D), MULTIPLE	
45378	DIAGNOSTIC COLONOSCOPY	
99244	OFFICE CONSULTATION	
72148	MRI LUMBAR SPINE W/O DYE	
99212	OFFICE/OUTPATIENT VISIT, EST	
90806	PSYTX, OFF, 45-50 MIN	
810	ANES-LOW INTEST ENDO-DIST TO DUOD	
76092	MAMMOGRAM, SCREENING	
59400	OBSTETRICAL CARE	
J9310	RITUXIMAB CANCER TREATMENT	
50590	FRAGMENTING OF KIDNEY STONE	
97140	MANUAL THERAPY	
92014	EYE EXAM & TREATMENT	
99294	PED CRITICAL CARE, SUBSEQ	
99285	EMERGENCY DEPT VISIT	
73721	MRI JNT OF LWR EXTRE W/O DYE	
74170	CT ABDOMEN W/O &W /DYE	
66984	CATARACT SURG W/IOL, 1 STAGE	

E0601	CONTINUOUS AIRWAY PRESSURE DEVICE	
99204	OFFICE/OUTPATIENT VISIT, NEW	
J1640	INJECTION, HEPARIN SODIUM, 30 ML	
1967	NEURAX LABR ANLG/ANES-PLAN VAG DEL	
45385	LESION REMOVAL COLONOSCOPY	
A0427	ALS1-EMERGENCY	
J9045	CARBOPLATIN INJECTION	
72193	CT PELVIS W/DYE	
78815		
80061	LIPID PANEL	
99218	OBSERVATION CARE	
J9263	OXALIPLATIN	
59510	CESAREAN DELIVERY	
99232	SUBSEQUENT HOSPITAL CARE	
63030	LOW BACK DISK SURGERY	
99282	EMERGENCY DEPT VISIT	
J0881		
99243	OFFICE CONSULTATION	
740	ANES-UGI ENDOSCOPY-INTRO PROX DUOD	
92980	INSERT INTRACORONARY STENT	
D7240	IMPACT TOOTH REMOV COMP BONY	
99395	PREV VISIT, EST, AGE 18-39	
93307	ECHO EXAM OF HEART	
790	ANES-INTRAPER UP ABD W/LAP;NOS	
J0885		
840	ANES-INTRAPER W/LAPARSCPY; NOS	
77418	RADIATION TX DELIVERY, IMRT	
71020	CHEST X-RAY	
71260	CT THORAX W/DYE	
47563	LAPARO CHOLECYSTECTOMY/GRAPH	
97014	ELECTRIC STIMULATION THERAPY	
J9170	DOCETAXEL	
74150	CT ABDOMEN W/O DYE	
90378	RSV IG, IM, 50MG	
70450	CT HEAD/BRAIN W/O DYE	
11042	DEBRIDE SKIN/TISSUE	
99296	NEONATE CRITICAL CARE SUBSEQ	
58552	LAPARO-VAG HYST INCL T/O	
58550	LAPARO-ASST VAG HYSTERECTOMY	
62311	INJECT SPINE L/S (CD)	
85025	COMPLETE CBC W/AUTO DIFF WBC	
99202	OFFICE/OUTPATIENT VISIT, NEW	
E1390	O2 CONC 1 PORT 85%/> O2 @PRSC RATE	
80050	GENERAL HEALTH PANEL	
92004	EYE EXAM, NEW PATIENT	
C1874	STENT COATED/COVR W/DELIVERY SYSTEM	

76075	DEXA, AXIAL SKELETON STUDY	
99233	SUBSEQUENT HOSPITAL CARE	
72141	MRI NECK SPINE W/O DYE	
C1721	CARDIOVERT-DEFIBRILLATOR DUAL CHAMB	
90937	HEMODIALYSIS, REPEATED EVAL	
80053	COMPREHEN METABOLIC PANEL	
98943	CHIROPRACTIC MANIPULATION	
72192	CT PELVIS W/O DYE	
58662	LAPAROSCOPY, EXCISE LESIONS	
27447	TOTAL KNEE ARTHROPLASTY	
88175	CYTOPATH C/V AUTO FLUID REDO	
74160	CT ABDOMEN W/DYE	
41899	DENTAL SURGERY PROCEDURE	
J0886		
G0121	COLON CA SCRN NOT HI RSK IND	

APPENDIX E

We would expect our endorsed plans to support our HC21 Data Co-operative by agreeing to provide the following data fields for participating members contracting with them, including provider and cost information, and deliver this data without charge on a quarterly basis within 31 days following the end of the quarter for which the data derives.

Please check the fields where you agree to provide this information for self funded members.

REQUIRED FIELDS:

Claims Extract Fields:

- Patient ID—Can be up to 32 characters. This field should uniquely identify the patient. Family or Subscriber codes are not sufficient without a dependent code.
- Relationship to subscriber
- Employer ID (entity, subgroups, and any related fields)
- Eligibility category—Active FT, Active PT, Retiree, COBRA,
- Product—Medical/Surgical, Dental, Vision, etc.
- Plan Type—HMO, PPO, POS, EAP, etc
- Sex—Only values of F and M are permitted by the ETG grouper.
- Patient Age or Date of Birth
- From Date—Date of service for outpatient claims and admission/from date for inpatient claims.
- Thru Date—Date of service for outpatient claims and discharge/ “to” date for inpatient claims.
- Date Paid—Include dates claim is adjudicated and paid.
- Provider ID—Provider code for all claims including pharmacy claims. Include servicing and billing providers if they are different.
- Provider Specialty—Must be filled in on all claims, including pharmacy and hospital.
- PCP Provider ID—If applicable
- PCP Provider Specialty—If applicable
- In/Out of network flags—Include if applicable.
- Diagnosis Codes—Valid ICD-9-CM codes. You can use either 5 or 6 digit formats (with or without the decimal point) but must be consistent. Include all available codes.
- Procedure Code—CPT-4, UB-92 revenue code, or HCPCs Level II code. Home-grown codes should be documented along with other payer-specific codes.
- Procedure Modifier—Standard CPT-4 modifiers. This field is not strictly necessary, but highly recommended.
- DRG Code—Inpatient claims should include DRG code if applicable.
- National Drug Code (NDC)—The 11 digit standard drug code. If your PBM alters these codes, convert them back to standard format.
- Cost Fields—All cost fields – “Paid,” “Allowed,” and “Billed.” Please include a definition for each cost field.
- Place of Service—Include all place of service codes. Include reference table if your place of service codes are not standard.

- Service Type Code(s)—We need to identify claims is for room and board, professional services, or ancillary services. You do not need to create a separate field if this information is available elsewhere on the claim. Please include with definitions.
- Units of Service—For HCFA-1500 and UB-92 claims, we recommend using the units field. For pharmacy claims, use either days supply and/or quantity.
- Claim Type—HCFA 1500, UB 92, PBM, Dental, etc.
- Ordering Provider ID—If present on a claim, this ID will replace the ETG grouper’s clustering method. (Included by most PBMs)

Member Extract Fields:

- Member ID— This field should uniquely identify the patient. Family or Subscriber codes are not sufficient with out a dependent code. The ID number should be consistent with the claim extract.
- Relationship to Subscriber
- Member Date of Birth
- Sex
- PCP Provider ID—If applicable
- Coverage Start Date
- Coverage End Date
- Employer Group—Include entity, subgroups, and related fields
- Product—Medical/Surgical, Dental, Vision, etc.
- Plan Type—HMO, PPO, POS, EAP, etc
- Eligibility category—Active FT, Active PT, Retiree, COBRA,
- Contract Type (e.g., single, 2-party, family, etc.)

Provider Extract Fields:

We expect health plans to provide “provider” extracts that include provider information nationally for HC21 Data Cooperative members with national presence. Check the boxes of the documentation you agree to provide.

- Provider ID
- Medical License Number
- DEA Number
- Federal Tax ID
- UPIN, Medicare Provider Number, etc. (if available)
- Last Name
- First Name
- Middle Name
- Degree
- Provider Type
- Provider Specialty
- IPA/Network
- Group/Affiliation
- Provider Group Type (single specialty, multi specialty)
- Practice Location Address
- Phone

1. Our data processing vendor will need tables to label codes appearing in the extracts. The tables should include one field for the code and another with the label. Additional attributes may also be included. Reference table should be provided for all payer-specific codes. Examples include:

- . Providers (e.g., Provider/PCP code, name, group affiliation, specialty)
- . Service Types:
- . Benefit Codes
- . Plan Types
- . Line of Business
- . Product Codes
- . Budget Codes
- . Plan Codes:
- . Service Codes
- . Specialty Codes
- . Employer Groups

2. Health plans will be expected to provide the following documentation. Check the boxes of the documentation you agree to provide.

File Layouts—Documentation showing the physical structure of the data extract. Include data types, delimiters, etc.

Control totals (Qrtly)—Include report showing record counts and sum of key cost field for each extract.

Field Definitions—Describe each field included in the extract and whether there are known issues about any of the fields. Please distinguish similar field names, especially financial fields.

Selection Criteria—Describe the criteria used to select records for the initial extract and subsequent updates. Each update should be discrete.

3. Health plans will be expected to deliver data on a quarterly basis (within 31 days from the end of the quarter). Check where you agree. If you do not agree, please explain.

Data should be delivered in a text delimited format on CD, DVD, secure email, or secure File Transfer Protocol (FTP) posting to:

Jeff Townsend, Director of Purchaser Services
HealthCare 21 Business
Coalition, 25 Market Street, Suite 900
Knoxville, TN 37902.

Arrangements to post directly to our data warehouse vendor's FTP site can be negotiated.

Updates should be Full replacement files.

Eligibility files will be full replacement

Provider files will be full replacement

Pharmacy Claims files will be full replacement

Medical Claims files will be full replacement

4. If health plans prefer to deliver quarterly incremental updates, you must insure that the incremental updates can be loaded “as is” without duplicating any claims previously loaded. Check where you agree. If you do not agree, please explain.

- Eligibility files will be incremental
- Provider files will be incremental
- Pharmacy Claims files will be incremental
- Medical Claims files will be incremental

If you transfer incremental update files, please describe how you handled adjustments, voids and reversals.

Please describe how you handle changes in member records by attaching additional sheets to this Attachment. **Provide as Appendix E Attachment 1.**

Please include how this would affect claims previously loaded by attaching additional sheets to this Attachment. **Provide as Appendix E Attachment 2.**

If you plan to encrypt member and patient ID codes, we expect that encryption be consistent over time and across all the extracts.

5. Do you agree to provide all the above data without charge? If not, please explain.
6. Do you agree to provide all the above data on a quarterly basis 31 days following the end of the quarter? If not, please explain.
7. Please include a sample(s) of the “Data use”, Non-Disclosure Agreements, and/or BAA that would need to be in place for you to transfer data on behalf of our members/your clients for inclusion in our Data Co-operative.

APPENDIX F

CERTIFICATE OF COMPLIANCE

For

RFP # 707-1

By indication of the authorized signature below, the Proposer does hereby make certification and assurance of the Proposer's compliance with all provisions of this RFP and the following items:

1. the laws of the State of Tennessee and Hamilton County;
2. Title VI of the Civil Rights Act of 1964;
3. the Equal Employment Opportunity Act and the regulations issued there under by the federal government;
4. the Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government;
5. Hamilton County's Disadvantaged Business Enterprise guidelines;
6. the Drug Free Workplace statement;
7. the condition that the submitted proposal was independently arrived at, without collusion, under penalty of perjury; and,
8. the condition that no amount shall be paid directly or indirectly to an employee or official of Hamilton County as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Proposer in connection with the procurement under this RFP.

Company Name: _____

Authorized signature: _____

Date: _____