Third Party Administration Services
Request for Proposal

Deschutes County

Presented by Davidson Benefits Planning, LLC

Introduction

Following is a request for proposal (RFP) for third party administrative services on behalf of Deschutes County. Deschutes County encompasses 3,055 square miles located in the central portion of Oregon. Currently, there are more than 1000 benefit eligible individuals employed by the County operating in facilities throughout the County. In addition, Central Oregon Intergovernmental Council (COIC) employees also participate in the Deschutes County health benefit program. COIC currently has 125 benefit eligible employees.

- Proposals are due by Wednesday, February 15, 2017. Please forward one (1) electronic and two (2) paper copies of your proposal to:

  Paper Copy:

  Erica Muller
  Davidson Benefits Planning, LLC
  7632 S.W. Durham Rd.; Suite #115
  Tigard, OR 97224

  Electronic Copy:
  ericam@jjdavidson.com

  whitneys@jjdavidson.com

  Please send emails to both Erica and Whitney with any questions. Under no circumstances is the client to be contacted regarding this RFP.

- The plan is to be effective August 1, 2017.

- Please provide your proposal net of commissions.

- Please contact us if your intent is to provide a stop-loss quote.

- Included as part of this RFP are the following:
  - Questionnaire
  - Claims Experience
  - Current Plan Design Summaries
  - Census

Summary of Requested Services for Deschutes County

This request for proposal is all inclusive for the following services requested. Please respond to those sections that apply to the coverages within your scope of services.

- Medical, prescription drug, vision and dental administrative services
- Monthly eligibility reconciliation
- Data reporting and predictive modeling
- Plan document preparation
- Monthly and annual claims accounting reconciliation
- TPA Coordination with other vendors providing administrative and insurance services
- Centralized billing services
- COBRA Administration
- Mental Health and Chemical Dependency Administration and Management
- Preferred provider network access and management
- Nurse advice line/Telephonic Services
- Medical and case management services
- Disease management services
- Consumerism/self-service programs
- HR self-service utilities (online eligibility, etc…)
- Wellness/Preventive Care Programs/Administration

Client Background

Deschutes County is headquartered in Bend, Oregon with locations all over Deschutes County. The types of employees consist of departments providing public services that include health & human services, public safety & emergency services, planning & zoning, community justice, public works and solid wastes. They also have internal and support services such as finance, information technology, risk management and legal services. The workforce is comprised of both non-represented and represented members from 6 unions. The County provides health coverage for County employees, eligible retired employees and their eligible dependents. The County also provides a wellness program, on-site clinic and onsite pharmacy.

Deschutes County currently offers a self-funded plan with stop loss coverage that includes two PPO medical plans, a vision plan and a dental plan administered through EBMS. They have been working with EBMS for 10+ years. The intent of this marketing effort is to determine the best long term TPA partner for Deschutes County.

Results of the RFP will be reviewed by the Employee Benefits Advisory Committee (EBAC), consisting of representatives of labor and management, makes recommendations to the Board of County Commissioners regarding the County's benefit program.

Deschutes County Current Partners for Medical/Dental/Vision/Rx:

Medical/Dental/Vision TPA	EBMS
Dental Network	None
Vision Network	None
PBM	Northwest Pharmacy Services
Stop Loss	Sunlife
Onsite Clinic	Medcor
Onsite Pharmacy	Premise Health

Estimated Schedule of RFP Events:

RFP Sent Out	January 30, 2017
Proposal Due	February 15, 2017
Selection of Finalists to be Interviewed	March 1, 2017
Interviews	Week of March 15th
Notice of Intent to Award	April 1, 2017
Contract Finalized	April 15, 2017
Implementation	April 15 – July 1, 2017
Open Enrollment	July 1 – July 31, 2017
Effective Date	August 1, 2017

- *Dates are approximate and subject to change.*

Questionnaire

A. Background

1. Please describe your company's ownership (public or private).
2. Provide a list of all organizations owned by your company. In what year was your company founded?
3. Provide a reference list of three (3) active public sector (preferably county) clients and three (3) recently terminated clients.
4. Describe any mergers and/or acquisitions that have occurred in the past 36 months or are expected to occur in the next 12 months.
5. Please provide a copy of your company's annual financial report for the most recent fiscal year.
6. Has any party brought legal action against your organization during the past two years? What was the result?
7. Provide the location and hours of operation for the claims and customer service center proposed for Deschutes County:
   a) Claims center
   b) Customer service center
8. How long have claims and customer services been in operation in this location?
9. What services do you offer that make your company unique among your peers?
10. How many employees do you currently have?
11. How many clients and members do you currently have?
12. How many clients do you have in Deschutes County? And how many clients do you have that are a County (in any area)?

B. System / Contract

1. Will Deschutes County have a dedicated, group specific toll-free customer service number? Is account specific call tracking and monitoring possible?
2. How does your company store client data (e.g. paper; imaging; etc.)?
3. What hardware and software does your company use for claims administration? How long has it been in place? Is the software updated internally or externally?
4. Are there any major changes in hardware or software expected in the next 2 years?
5. Does your system detect those dependents that are close to becoming over the age limit? Do you automatically notify by letter six months and 3 months prior to the date? If so, please provide a sample letter.
6. Thoroughly detail any of Deschutes County's plan design elements which you would not be able to auto adjudicate on your current claims adjudication system. Will any aspects of the Client's proposed plan design require "manual" claim intervention?
7. What percentage of total claims processed are "manual"?
8. What percentage of medical plan claims are received electronically from providers?
9. Does your company currently have an automated voice response phone system? If yes, provide the hours available and scripting menu.
10. Define the call tracking system.
11. Confirm that client specific tracking of call data and claim processing data will be available and reported to the client on at least an annual basis.
12. Describe your services available for hearing impaired, visually impaired and non-English speaking customers.
13. Please provide a sample of your standard member education/communication materials including a member ID card, enrollment documents and an E.O.B. statement.
14. Describe in detail your back-up and disaster recovery system.
15. Please provide an implementation plan and timetable.
16. Provide a sample contract.
17. Confirm that you will provide at least 120 days advance notice of renewal rate change.

18. When was the system most recently upgraded and when do you anticipate the next change?
19. What accumulators are loaded into your claims system?
20. Does the system edit for appropriateness of charges?

C. Team

1. Provide the background of the proposed account service team. Please include: a) name, title and location; b) experience (department and company); c) key responsibilities
2. What is the ratio of members to claims processors or CSRs for the location the client is to be assigned to?
   a) Claims center
   b) Customer service center
3. What was the turnover percentage over the past 12 months at the location the client is to be assigned to?
   a) Claims center
   b) Customer service center
4. Will you assign a dedicated team to Deschutes County for:
   a) Claims processing
   b) Customer service
5. Are you willing to provide a representative to an annual health fair?
6. Will there be an implementation manager assigned to Deschutes County or will the account manager serve this role?
7. Please describe the composition of your claims department.
8. Do your customer service representatives have the ability to make changes to the claims system when assisting member?

D. Eligibility

1. Describe your eligibility and enrollment process.
2. Are you able to accept electronic eligibility? Is there a cost or set-up fee?
3. Are your systems for eligibility administration, claims administration and client reporting fully integrated as one system, or are they multiple stand-alone systems?

E. Online Services

1. Provide your company's web site address.
2. Describe all your company's internet self-service capabilities for:
   a) Account manager
   b) Plan members
3. Please explain in detail any current and upcoming web-based enrollment capabilities which will provide Deschutes County and their employees the ability to enroll 24/7 into your system and provide one consolidated billing format for all their vendors.
4. Provide a login and password for the member website.

F. Reporting / Outcomes / Performance Guarantees

1. Please provide a sample of all available monthly, quarterly and annual reports. Indicate whether there are any additional fees for these reports.
2. Are reports available online? Explain.
3. Do you provide any predictive modeling tools for the client or consultant's use? Explain in detail.
4. Are data mining tools available for the client to create custom reports?
5. Is your system able to create cost and utilization benchmarks alongside the client's data? If so, what categories can the data be split out by (i.e. national, regional, industry, etc.)? What source are the benchmarks based on?

6. Will you provide “pended claim reports” on a monthly basis? Please explain in detail what a pended claim is for your company. Can you track all pended claims dates from the first to the last on your report?
7. Do you provide reports on expenses and savings for large case management? If so, provide a sample report.
8. When reinsurance is involved will you give 50% (or earlier if required) specific stop-loss notification to the reinsurance carrier? Explain your system in detail for notification procedures. (Medical TPA Only)
9. Do you routinely survey members regarding their satisfaction of your service providers they utilize? Do you survey your employer groups’ Human Resources Department for satisfaction of your billing/eligibility/claim service? If so, please provide sample survey results for review.
10. Please provide a list of administrative, financial and procedural performance standards, guarantees and penalties your company is willing to agree to. Confirm that the standards will be measured against group specific results.
    A. Can performance guarantees include a subjective account manager satisfaction guarantee?
    B. How do you track member satisfaction? Do you guarantee results?
    C. Do you provide cost trend guarantees? Please explain.
11. Provide a sample of pharmacy reports available to clients. Do you provide these reports to clients as part of your standard reporting package?
12. Please confirm willingness to provide semi-annual data file transfers to our analytics partner. (Illustrate costs to do this, if any)

G. Medical TPA / Process

1. Will your company work on behalf of the client with the following external vendors?
   a) PPO Networks
   b) Mental health / chemical dependency providers/vendors
   c) Pharmacy benefit manager
   d) Stop loss vendor
   e) Medical/case manager
2. Are there any additional charges for interfacing with external vendors?
3. Please indicate the basic performance measurements indicated below for the specific claims office that will be assigned to this client:

	2016
a) Turnaround time	
b) Claim processing accuracy	
c) Financial payment accuracy	
d) Payment incidence accuracy	
e) Average number of claims processed per examiner per day	
f) Telephone response time	
g) Abandonment rate	

4. Do claim processors also have responsibility for member/customer service?
5. How frequent are claim payments sent to providers? Are claims batched for processing?
6. Explain how your company verifies COB information.
7. Will you assume financial liability for claims paid in error by your processors?
8. Describe your procedures for screening and adjudication of provider billing unbundling and/or upcoding.

9. Confirm that you implement the following cost containment procedures:
    a) Review for medical necessity
    b) Level of care
    c) Maximum allowable fees and standards of Medical, Dental and Vision practices
10. Are benefit drafts sent to providers and insureds on employer's check stock or TPA/insurance carrier check stock?
11. Please describe your process for customer service interaction on claim issues.
12. How frequent are benefit payments and EOBs produced and released to members and providers?
13. Do you utilize medical/dental consultants? On Staff? On Site?
14. Credit will need to be given for all deductibles, coinsurance amounts and stop loss limits accumulated January through July February 2017 for their August 1, 2017 effective date. How would you propose to transfer this data if the client chooses you as their new vendor?
15. Will you provide the client with personalized I. D. cards? Will the ID Card's utilize an identifier other than the social security number? Is there any additional cost?
16. Can the I.D. cards include medical and rx information? Will these cards be in paper or plastic?
17. Describe the process for claimants who contact your office to discuss and/or appeal claims, including timeframes for reply.
18. Do you perform subrogation internally or do you subcontract this service? Explain your subrogation process with all fee schedules reflected.
19. Are your claim processors encouraged and/or rewarded for taking the initiative in calling physicians or hospitals, follow-up on pended claims, on ICD-9 coding errors or discrepancies?
20. Describe the training process for your claim processors. How many security clearance levels and dollar amount clearances are in your system?
21. Will you provide consolidated billing services for the client? Please describe in detail.
22. At what percentile, do you pay U&C? How often is it updated? What is U&C based upon?
23. How do your processors interact with physicians when detected abuses are found?

24. Can you describe your ability and experience of integrating with the Deschutes County on-site clinic?

H. Audits / Fraud Control

1. Confirm that a claims office audit is conducted each year. Please provide your most recent copy of the results for the claim office that you propose for this client. The following items should be addressed:
   a) Date the audit was performed
   b) Period covered
   c) Type of audit, i.e. random, targeted or other
   d) Who performed the audit
   e) Results of the audit, including:
      - Number of claims audited
      - Dollar value
      - Payment error rate (incorrect number of claims divided by total number of claims)
      - Monetary error rate (total dollars paid incorrectly divided by total dollars)
      - Total error rate (number of claims with paid or non-paid procedural
      - Errors divided by total claims)
      - Auditor's recommendations
2. Deschutes County may request an outside audit of your claim administration periodically. Does this present a problem?
3. What are your internal standards for accuracy of claims administration and financial payment?
4. Describe your company’s internal audit function of plan/claims administration
5. Describe your internal fraud control procedures.

6. Describe your computer security procedures. What procedures do you take if there is a security breach? What is your timing to notify your clients? Do you have a notification system and processes in case of a security breach?
7. Is your system SAS 70 certified? Provide a copy of the last SAS 70 report conducted for your firm.
8. What percent of claims are subject to internal claims audit?
9. At what level do you automatically pend hospital bills for audit?
10. Describe your billing process.

I. Networks

1. Can you work with First Choice Network and First Health Network?
2. Can you offer global discount packaged hospital/physician fees (Centers of Excellence) on specific conditions; i.e., heart, kidney, cancer, pre-natal, Transplants, etc? If so, please provide discounted percentage fees or set package fee documentation.
3. For terminally ill patients (Aids, Cancer, etc.), do you have contracted hospice care (including inpatient care, home care, and respite care) as an alternative to inpatient hospitalization for terminally ill patients?
4. Does your company have the ability to reprice all PPO network claims internally?
5. What PPO networks are available to you in Bend, Oregon? Are they regional or national? Are they compatible with your claim system and loaded into your system or are they repriced by the TPA?
6. How many PPO networks can your system handle? What PPO benefit options would you recommend for Deschutes County?
7. Please provide the average discount for each of Deschutes County's MSA and by provider type (PCP, specialty, hospital, other).
8. Please provide a network access report for your network(s).

J. COBRA Administration

1. Please explain in detail all COBRA administrative and compliance services from your company. If provided, are these services contracted out to another vendor?

K. Compliance

1. What are your processes for complying with HIPAA, including privacy and security requirements, and EDI?
2. How does your company stay up to date with new compliance and regulations?
3. Will you provide the needed information to Deschutes County to complete their annual IRS 5500 filing?

L. Claims Management

1. Describe in detail your utilization review procedures for the following procedures.
   a) Inpatient/Outpatient precertification
   b) Second Surgical Opinion
   c) Skilled nursing facility review
   d) Home Health Care review
   e) Hospice review
   f) High risk maternity - prenatal screening review
   g) Large case management review
   h) Mental/Nervous/Alcohol/Drug
2. How is medical management integrated in the claims payment system? What are your limitations? How will you integrate the UR services? Do you provide a nationwide toll-free telephone number? Provide sample brochures used in explaining programs to insureds.
3. Describe your large claim or catastrophic claim management. Do you wait until the claim reaches a certain dollar amount before it is considered a "large or catastrophic claim" or do you base it on diagnosis? Does your claim paying system have early detection devices to alert a large claim case management firm of a potential claim in excess of $15,000 and/or any level set by client with 48 hour notice? Explain in detail step-by-step procedures.
4. Do you provide high risk maternity education, monitoring and services? Describe detection and monitoring procedures and communication material. How often does your program report to the client? If this service is carved out, is there a credit offered?
5. Do you have an internal "hospital audit" unit for review of inpatient hospital claims for Diagnosis Related Groups (DRG) validation (correct coding of diagnosis and procedures), all bills for selected diagnosis and DRGs, and review of claims for medical necessity of admission and/or length of stay? Can you supply reports as to your success?

6. Do you have an internal "physician audit" unit for review of physician claims for unbundling of claims, correct coding of diagnosis and procedures, and review of claims for medical necessity? Can you supply reports as to your success?
7. In your pre-authorization review, have you established guidelines to control the use of various medical procedures which may have had an impact on the cost of care while providing questionable benefits, including tests and procedures now believed to be outmoded, redundant, or of unproven value?
8. In your precertification review, do you include a package of services to eliminate Friday/Saturday admissions, unnecessary care and to channel needed care to the most cost effective and appropriate setting? Are you capable of providing a precertification package with cost effective provider referrals and directing of hospice care, skilled nursing facilities, and home health care?
9. Please describe your approach for concurrent review and discharge planning. Who performs the review? When is the review initiated? Where is the review performed?
10. How do you integrate the patient's family into case management?
11. How do you handle situations where a physician disagrees with recommendations from case management?
12. Please explain the use of non-medical personnel, nurses and physicians in the utilization review process.
13. Discuss the criteria upon which "medical necessity" is established.
14. Can you measure under-utilization, re-admission rates and post-surgery complications for physicians in your network?
15. Can you monitor provider referral patterns?
16. Describe in detail all of your available disease management programs.

M. Pharmacy Management

1. Describe the available options and your recommendation for transitioning mail order prescriptions.
2. Discuss your available pharmaceutical based disease management programs.
3. Discuss your available programs to ensure pharmaceutical compliance.
4. Discuss your available specialty/biotech programs.

5. Provide a copy of each of your standard formularies.
6. Does your company develop the formulary you utilize or is it created by another PBM? If it's not of your own development, who develops and updates it?
7. Describe all methods available to encourage generic utilization.
8. Does your system have the ability to electronically and automatically review a patient's claim history to determine whether they fulfill the requirements to receive a prior authorized drug?
9. Are you willing to send *targeted* letters to members adversely affected due to a change in the formulary?
10. Are all multi-source brand name drugs on the third tier for 3-tier plans?
11. Which major chains do not participate in your broadest network?
12. Are you willing to provide members discounts on non-covered drugs (100 percent copay)? Confirm that the pricing will be the same financial arrangement (discount and dispensing fees) as is provided in this RFP for covered drugs.
13. What is the source of AWP (average wholesale price) used for this proposal?
14. What is the average discount (weighted by dollars) for drugs on the MAC list?
15. What percent of GCNs are on your MAC list? What percent of generic AWP will be MAC'd?
16. Is mail order pricing is based upon the actual dispensed package size or based on fixed package size of 100s or pints?
17. Are you willing to amend the agreement to allow the client the right to cancel the agreement at any time after one year for any reason with 30 days advance notice?
18. Upon termination, do you charge for providing the succeeding PBM transition information on open mail order claims? If so, what do you charge?
19. Provide a network geo-access report for your broadest network based on the included census.

N. Dental Administration

1. What are your U&C levels based on? Are they flexible according to the client's needs?
2. Do you offer a dental network? If so:
   a) Provide a network match up based on the census provided.
   b) What are the average PPO discounts based on type of service?
   c) Is the network able to be offered without a differential in non-network plan design?
   d) What are the criteria for allowing dentists into the network?

O. Vision Administration

1. Do you offer a vision network? If so:
   a) Provide a network match up based on the census provided.
   b) What are the average discounts based on type of service (exam. Lenses, frames, contacts)?
   c) Is the network able to be offered without a differential in non-network plan design?
   d) What are the criteria for allowing providers into the network?
2. Do you offer discounts on non-covered services (e.g. polarizing lenses, scratch proofing, etc…)?
3. Do you offer discounts on Lasik surgery?
4. Provide a list of all non-discrimination services you standardly provide.

P. FSA Administration

1. Provide a list of services included as part of your standard FSA services and services available at an additional cost. (including debit cards)
2. How long has your company provided FSA services?
3. What is your average reimbursement turnaround time? And is it auto deposit?
4. Can your system automatically link to claims to provide an FSA reimbursement without filing a FSA form?

(Auto- Adjudication)

5. Provide a list of all non-discrimination services you standardly provide.

Q. Financial Proposal

1. Please provide ***any and all*** fees your company will charge (preferably on a per employee per month basis). Provide the guarantee period for each fee. Note that the fees for 2017 will assume no run-in processing (i.e. immature). 2018 fees are to reflect a mature plan. (Note: Extended fee guarantees will be looked upon very favorably.)
2. Provide pharmacy reimbursement rates, dispensing fees, administrative fees, clinical fees, disease management fees and rebates.
3. Disclose how changes in enrollment may affect administrative fees.
4. Do you have capabilities to provide daily, weekly, bi-weekly, or monthly claim benefit drafts? Are your transfers through an automated clearinghouse or through wire transfer? Explain in detail your drafting, banking, and account reconciliation services and procedures. Full disclosure is required.
5. May the client select their own bank and/or branch, or do you require that they use a specific bank?
6. Is an initial deposit required to set up banking arrangements? If so, how much is required for daily, weekly, or monthly transfer arrangements? How is the amount calculated?
7. Provide any implementation credit or allowance.