

Attachment 6

Appendix L—Cost Proposal Requirements

NOTE: Bidder must sign and date each page of this Cost Proposal in the spaces provided at the bottom of the page.

Complete each of the sections 1 through 6 below using the following assumptions and instructions.

General Assumptions

In completing this Cost Proposal, use the following assumptions:

- The respective Third Party Administration and Customer Service PMPM and PEPM fee quotes and the In-State Indemnity Physician Network Access fee quotes are to be valid from the implementation of program support through June 30, 2005(December 31, 2005 for BORHP). Thereafter, Third Party Administration and Customer Service fees will be prospectively adjusted based upon CPI-U for the preceding twelve (12) month time period (for example, fees for July 1, 2005, through June 30, 2006, will be adjusted based upon CPI-U for July 1, 2004, through June 30, 2005). Assume CPI-U of 5 percent in responding to this Cost Proposal.
- The state agrees to renegotiate the PMPM/PEPM if membership volume declines more than 10 percent over a consecutive six-month period of time. If this were to occur, DCH would allow for a renegotiation of the PMPM/PEPM fixed fee to be effective during the next fiscal year.
- Assume an average Medicaid population of 980,000 members throughout life of contract.
- Assume an average PeachCare for Kids population of 120,000 members throughout life of contract.
- Assume an average SHBP population of 570,000 members including both active and retired individuals. Of these, 398,000 total members (203,000 employees) are enrolled in PPO, CCO, and indemnity options. For the purposes of pricing access to the in-state indemnity physician network, assume that there are 24,500 employees in the indemnity option for SHBP. The remaining 172,000 SHBP members are enrolled in HMOs. For these members, the prime contractor would not provide TPA and customer services, but would provide open enrollment support. Assume these figures throughout the life of the contract.
- Assume an average BORHP population of 75,000 total members (36,000 employees) in PPO, CCO, and indemnity options throughout the life of the contract. For the purposes of pricing access to the in-state indemnity physician network, assume that there are 7,500 employees in the indemnity option for BOR. The remaining 9,000 BORHP members are enrolled in HMOs.

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- For the purposes of this Appendix, Year 1 is considered to run from the contract start date (on or about June 15, 2001) through June 30, 2002. Subsequent Years run from July 1 of a given year through June 30 of the following year. Please note that the Operational Fees proposed for the Board of Regents Health Plan represent the period January 1, 2004 through December 31, 2004 for Year 3. Subsequent years for BOR run from January 1 of a given year through December 31 of the same year.

Third Party Administration and Customer Service Fees

Third Party Administration and Customer Service fees are subject to re-negotiation should membership volumes decline by more than 20 percent from those assumed in this Appendix.

The Third Party Administration and Customer Service Fees will not cover the following expenses, which will be reimbursed separately:

- The medical costs associated with SHBP, BORHP, Medicaid, and PeachCare for Kids;
- Postage costs

The Third Party Administration and Customer Service fee will cover all other costs associated with the delivery of third party administration services included in the scope of this RFP. In estimating costs, bidders' consideration should therefore include, but not be limited to the following:

- Continuous Technology Refresh (per RFP Section 1.1.5.5), including:
 - Improving delivery of services to DCH clients via both technology and service delivery upgrades;
 - Keeping systems current with industry standards and future information technology developments;
 - Providing an annual technology assessment report and recommendations for improvement;
 - Presenting new developments in healthcare information processing technology to DCH, including cost justifications for any additional costs associated with these upgrades;
 - Assuring “backward compatibility” for any technology refresh, including development and support for any interfaces needed to assure that new technology is fully compatible with existing technology in use by the state.

Note: DCH specifically wishes to avoid having to authorize additional cost change orders for maintaining and making improvements to systems and processes covered by this contract. DCH believes that many information technology initiatives will be cost justified based on reductions in personnel costs (e.g., implementation of web and IVR communications technologies) and rework costs (e.g., elimination of data keying errors via the use of EDI). Requests for additional cost change orders may be considered by DCH, but should be based on changes in the scope of

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services required under the contract, not the manner of providing existing services under the contract.

- Staff salaries and fringe benefits;
- Rent, utilities, and facilities maintenance;
- Telecommunications service charges;
- Insurance;
- Costs associated with the production and distribution of forms, handbooks, notices, monthly mailing inserts and brochures, checks, EOBs, and remittance advices;
- Costs associated with open enrollment support for SHBP and BORHP;
- Bank and checking account fees;
- Software rental and maintenance fees;
- Performing Provider Training and Provider Workshops;
- Training for DCH staff if required;
- Consumable supplies;
- Maintenance of all computer equipment and routine software maintenance;
- Archival record storage and retrieval fees; and
- Purchase or replacement of all computer and administration equipment subsequent to implementation to support new staff or other program needs.

Fees for Managing Subcontractors

The Prime Contractor must include their fee for managing all subcontractors included in their proposal. This fee does not include management of existing vendors such as MEDSTAT, Express Scripts, UniCare, Magellan, or the to-be-named Third Party Liability Recovery vendor. The Prime Contractor should assume that in the fiscal year commencing July 1, 2004, (January 1, 2005 for BOR) the services currently provided by UniCare for SHBP will need to be provided by the Prime contractor and his subcontractors. **The prime contractor bidder should adjust these fees over time to recognize the additional work required as contractors are added to the scope of services.** More specifically assume the following:

- Responsibility for the utilization management vendor for SHBP and BORHP as of July 1, 2004.
- Responsibility for the behavioral health management vendor for SHBP as of July 1, 2003 and January 1, 2004 for BORHP.

Please note that in future years, the DCH may request that services considered out of scope for this procurement be included. The DCH will negotiate costs associated with the new services at that time.

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Fees for System Maintenance

The Prime Contractor must include their fee for maintaining the system proposed in their bid. System maintenance fees would include:

- Software support and error correction
- Updates and enhancements
- Support for third party systems
- Problem resolution

Payment

The method for contractor payment will be:

Implementation Costs will be paid for each project phase as specified in Appendix H.

Operational Costs will be paid on a monthly basis as follows:

- Annual bid fee for Managing Contractors divided by twelve (12) plus PMPM bid times number of Medicaid/PeachCare for Kids members from current month

Plus

- Annual bid fee for System Maintenance divided by twelve (12)

Plus

- PEPM bid times number of Fixed fee based on July 1 enrollment figures for SHBP/BORHP employees from current month (= PEPM times enrollment figures)

Plus

- Bid In-State Indemnity Physician Network Access fee times number of employees enrolled in the indemnity program for SHBP/BOR from current month.

Fees for a given month may be retroactively adjusted if subsequent eligibility updates show that actual enrollment deviated from the original figures by more than one-half of one percent (0.5%).

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1. Cost Grid: Medicaid and PeachCare for Kids

Section	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
IMPLEMENTATION COSTS						
Phase I System Changes: Medicaid and PeachCare for Kids						
System Equipment: Medicaid and PeachCare for Kids						
Admin. Equipment: Medicaid and PeachCare for Kids						
Startup Cost: Medicaid and PeachCare for Kids						
<i>Medicaid and PeachCare for Kids Total Implementation Costs</i>						
OPERATIONAL COSTS						
Fee for Managing Contractors: Medicaid and PeachCare for Kids 10/1/02 through 6/30/06						
Claims Administration and Customer Service: Medicaid and PeachCare for Kids 10/1/02 through 6/30/06						
<i>Medicaid and PeachCare for Kids Total Operational Costs</i>						
SYSTEM MAINTENANCE COSTS						
Fee for system maintenance for Medicaid and PeachCare for Kids						
<i>Medicaid and PeachCare for Kids Total System Maintenance Costs</i>						
Medicaid and PeachCare for Kids Grand Total Costs						

Year 1 = June 2001 – June 30, 2002
 Year 2 = July 1, 2002 – June 30, 2003
 Year 3 = July 1, 2003 – June 30, 2004
 Year 4 = July 1, 2004 – June 30, 2005
 Year 5 = July 1, 2005 – June 30, 2006

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Note for Year 2 – The Prime Contractor will have both Implementation and Operational costs.

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2. Cost Grid: SHBP and BORHP

Section	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
IMPLEMENTATION COSTS						
Phase I Changes: MEMS replacement						
Phase II Changes: SHBP and BORHP						
System Equipment: SHBP and BORHP						
Admin. Equipment: SHBP and BORHP						
Startup Cost: SHBP and BORHP						
<i>SHBP and BORHP Total Implementation Costs</i>						
OPERATIONAL COSTS						
Fee for Managing Contractors: SHBP and BORHP 7/1/03 through 6/30/06						
Claims Administration and Customer Service: SHBP 7/1/03 through 6/30/06						
In-State Indemnity Physician Network Access: SHBP 7/1/03 through 6/30/06						
Claims Administration and Customer Service: BORHP 1/1/04 through 6/30/06						
In-State Indemnity Physician Network Access: BORHP 1/1/04 through 6/30/06						
<i>SHBP and BORHP Total Operational Costs</i>						

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SYSTEM MAINTENANCE COSTS						
Fee for system maintenance for SHBP and BORHP						
SHBP and BORHP Total System Maintenance Costs						
SHBP and BORHP Grand Total Costs						

SHBP (Note – BOR operates on a calendar year basis.)

Year 1 = June 2001 – June 30, 2002

Year 2 = July 1, 2002 – June 30, 2003

Year 3 = July 1, 2003 – June 30, 2004

Year 4 = July 1, 2004 – June 30, 2005

Year 5 = July 1, 2005 – June 30, 2006

3. Cost Grid: Shared Resources

Section	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
IMPLEMENTATION COSTS						
System Equipment: Shared						
Admin. Equipment: Shared						
Shared Implementation Grand Total Costs						

4. Cost Grid: Overall Totals (Grand Totals from previous Cost Grids)

Section	Year 1	Year 2	Year 3	Year 4	Year 5	Totals
Medicaid and PeachCare for Kids Grand Total Costs (from Cost Grid 1.)						
SHBP and BORHP Grand Total Costs (from Cost Grid 2.)						
Shared Implementation Grand Total Costs (from Cost Grid 3.)						
Overall Grand Total Costs for Medicaid, PeachCare for Kids, SHBP, and BORHP						

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5. Third Party Administration and Customer Service Fee

The bidder must supply two Third Party Administration and Customer Service fee quotes, one for the administration of Medicaid and PeachCare for Kids, and the other for the administration of SHBP and BORHP. The Third Party Administration and Customer Service fee quotes should use the following pricing bases:

- PMPM (Per Member Per Month) basis for Medicaid and PeachCare for Kids fee:
\$ _____
- PEPM (Per Employee Per Month) basis for SHBP and BORHP fee:
\$ _____
- *Note the PEPM fee for BOR runs on a Calendar year basis.*
- Paper claim per transaction fee for Medicaid and PeachCare Claims Run Out
\$ _____
- Electronic claim per transaction fee for Medicaid and PeachCare Claims Run Out
\$ _____
- Paper claim per transaction fee for SHBP and BORHP Claims Run Out
\$ _____
- Electronic claim per transaction fee for SHBP and BORHP Claims Run Out
\$ _____

6. In-State Indemnity Physician Network Access Fee

The bidder must supply an In-State Indemnity Physician Network Access Fee applicable both to SHBP and BORHP members who select the indemnity plan option.

- PEPM (Per Employee Per Month) basis for SHBP and BORHP fee:
\$ _____

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Attachment 7

Appendix O—Mandatory Minimum Contractor Requirements

The prime contractor and/or its subcontractors must adhere to the following:

- Have been licensed to transact business as a health benefits claims administrator for at least five years; and be licensed in the state of Georgia (to conduct the business of paying health claims on behalf of a self-insured health benefit plan and Medicaid program).
- The contractor and/or its subcontractors must have experience for at least three years in administering large volumes of Medicaid claims (20 million claims per year or more). **“Administering large volumes of Medicaid claims,” means being responsible for the system and operations processing that is required to process health care claims.**
- The DCH/BOR business must not represent more than a 40 percent increase, on a company-wide basis, in existing health insurance claims volume for the last three years to the contractor(s) responsible for claims administration.
- The DCH/BOR claims must not represent more than a 40 percent increase in the dollar value of existing health insurance claims payment workload for the last three years to the contractor(s) responsible for claims administration.
- The contractor’s financial statements must reflect a sound financial condition. If financial losses have occurred in one of the last two fiscal years, the current ratio of assets to liabilities must be favorable, as determined by DCH/BOR.
- The contractor must agree to establish a dedicated claims processing unit and customer service unit for Medicaid/PeachCare for Kids and for SHBP, and for BORHP, respectively.
- The contractor must have more than one/multiple claims and customer service offices to serve as backup to the primary service location for the DCH/BOR accounts.
- The contractor must establish one or more offices in Georgia to provide the services described in this RFP. At a minimum, the account office must be located in the metropolitan Atlanta area **and an operational processing center for receipt of correspondence and other required documents must be located in the State of Georgia, but the exact location is up to the Contractor’s discretion.**
- **The Prime Contractor must have the required financial qualifications and agree to be responsible for the performance of the entire team. The Prime Contractor may subcontract all or part of claims administration as long as the Prime Contractor assumes responsibility for the management of all subcontractors.**
- The contractor must disclose the names and roles of all subcontractors.
- The contractor and all subcontractors will certify that they do not discriminate in employment practices based on race, color, religion, age, gender, marital status, political affiliation, national origin, or disability.
- The contractor must agree to provide claims processing software that is customized to the requirements of the DCH/BOR accounts.
- **The main components of any proposed key software must have been in operation for at least one year by October 1, 2002; so the system must be in *production* by October 1, 2001—**adjudicating and paying health insurance claims for a current or past client with at least one hundred thousand (100,000) covered employees/two hundred and fifty thousand (250,000) enrollees. DCH/BOR will

entertain proposals consisting of developmental key software, however be advised that proposals containing complete development may be negatively evaluated.

- The claims software program(s) must provide for “online” or “real time” adjudication for claims and claim adjustments.
- The claims software program(s) must have web-enabled capabilities by the implementation dates of each program within DCH/BOR.
- The claims software program(s) must currently administer complex reimbursement methodologies such as diagnostic related groupings (DRG), tertiary hospital/professional global rates, and resource based relative value scale (RBRVS) provider fee schedules.
- The claims software program(s) must currently be able to accept medical inpatient and outpatient preauthorization records from multiple vendors, and track and apply them correctly to claims for editing purposes.
- The contractor must agree to administer/accept the State’s PPO provider network panel and fee schedules, a national PPO provider network panel and fee schedules, and an indemnity fee schedule provided by an external contractor.
- The contractor must have real-time phone monitoring and agree to allow the State to monitor member and provider calls. This monitoring capability must be available remotely if the customer service center is not located in the metropolitan Atlanta area.
- The contractor must offer firm fixed prices for:
 - design, development, and implementation of the Medicaid/PeachCare for Kids information system and associated services to occur by 10/01/2002;
 - design, development, and implementation of the State Health Benefit Plan information system and associated services to occur no later than 07/01/2003;
 - design, development, and implementation of the Board of Regents Health Benefit Plan information system and associated services to occur no later than January 1, 2004;
 - design, development, and implementation of a system to combine all DCH populations into one (or the appearance of one) information system platform on or before 01/01/2004, and all BOR populations on or before 01/01/2004;
 - each of three State Fiscal Year operational periods—beginning with State Fiscal Year 2003 (07/01/2002–06/30/2003). The operational costs must be broken out as required in **Appendix L** of the RFP; and
 - each year starting with State Fiscal Year 2003, provide a yearly fee for managing subcontractors proposed by the prime contractor in response to this RFP.
- The contractor must submit its pricing information in the format described in the pricing exhibits included in **Appendix L**.
- The contractor must agree that if selected, its pricing arrangements will not change during the initial contract year.
- The contractor and all subcontractors must agree that the eligibility and claim records and any records created from the eligibility and claim records are owned by the DCH/BOR and that confidentiality shall be maintained as specified in the specimen contract.
- The contractor must currently accept and process online or batch eligibility updates and that the claim system is currently capable of automatically verifying eligibility during adjudication.
- The contractor must submit its current system architecture for the proposed system(s).

- The contractor must agree to develop and maintain the interface system for the electronic transfer of data and other contractual information to DCH's/BOR's other third party vendors in a format determined by DCH and/or BOR.
- The contractor must pay all claims in accordance with the applicable DCH/BOR pricing and benefit schedules. The contractor must maintain all necessary pricing, demographic, benefit, and other information necessary for the proper payment of all claims. The required data and financial information must be supplied in formats approved by DCH/BOR. All costs associated with supplying the required data and financial information, including the cost of any electronic interface, shall be the responsibility of the Contractor.
- The contractor must agree to execute, within thirty (30) days of receipt, the Contract, in substantially the form as set forth in **Appendix N**, for the compensation stated in the proposal, if it is determined to be an apparent winning proposal.
- The contractor must certify to the state that a drug-free workplace will be provided for the prime contractor's employees during the performance of the contract as required by the "Drug-Free Workplace Act" (O.C.G.A. 50-24-1).
- The contractor must provide turnover/run out services for no less than six (6) months, as described in the RFP, including but not limited to: claims administration and customer services support for any claims for services rendered up to the contract termination date.

Attachment 8

Appendix S—Membership Enrollment Management System

The Membership Enrollment Management System (MEMS) was developed in 1981 to replace the Old State Health Insurance System. The main objectives of this system are to process, maintain and report membership in the State Health Benefit Plan (SHBP) and Health Maintenance Organizations (HMOs) that do business with the State of Georgia. The Georgia Merit System originally administered MEMS. In July of 1999, the Department of Community Health (DCH) assumed ownership of MEMS. Also, the FACS accounting system was replaced by Phoenix in July 1999. Specifically MEMS supports:

- The Maintenance of members enrolled in the SHBP and HMOs, which have been established in Georgia.
- The accounting functions related to processing and maintaining accurate financial records for payroll location deductions and contributions, direct payment from persons no longer eligible for payroll deductions, and refunds due to and from members.
- Generation of data used to update the Phoenix system.
- Generation of updates to be sent to the claims administrator, Blue Cross/Blue Shield (BC/BS), and to the various HMOs.
- On-line displays of all significant data base information.
- Providing payroll locations with monthly statements and transaction listings, in order to assist with the collections and maintain the location payroll systems in balance with MEMS.
- Preparing monthly statements to assist with the collecting and recording of direct payments.
- Maintaining accurate and timely accounts receivable data for tracking claims refunds owed to the State.
- Printing transaction reports and maintaining history files to provide complete audit trails.

MEMS consists of the following six subsystems:

1. System Maintenance
2. Membership Maintenance
3. Common Accounting
4. Direct Payments Accounting
5. Payroll Location Accounting
6. Refund Accounting

Each subsystem performs tasks unique to the function it supports and also interfaces with some or all of the other subsystems.

SYSTEM MAINTENANCE SUBSYSTEM

System Maintenance allows DCH to maintain reference data and validations tables used by all of the other subsystems. The data is used by the other subsystems to edit transactions, display error messages, expand codes and create Phoenix entries. Some of the files in this subsystem include:

- Rate Table (RTEM)
- Q-Care Pay to Provider File (QCPM & QCPV)
- Provider File (PRVM)
- Descriptor File (DESM)
- Payroll Location File (PALM)
- Group File (GRPM)
- Contractor File (CNTM)
- HIPAA Files (HIPM, HIPV, CCVM)

MEMBERSHIP MAINTENANCE SUBSYSTEM

This subsystem provides the Health Insurance division with the ability to maintain on-line member transactions such as enrollment, coverage changes, terminations, direct pay approvals, dependent maintenance and social security number changes. The major functions of this subsystem include the following:

- Maintaining timely and accurate information for all members of the SHBP and HMOs.
- Providing an automatic interface for membership transactions to the BC/BS system and the HMOs.
- Preparing transaction listings and coverage summary reports for payroll locations.
- Supplying members with ID cards and access to their membership information.
- Supporting enrollment in multiple plans with different types of coverage.

Currently we have 14 groups with 953 Payroll Locations. Membership in the PPO, PPO Choice and High Options exceeds 205,000 members and 209,000 dependents. The various HMOs membership exceeds 65,000 members and 67,000 dependents.

Membership Maintenance interfaces with all of the other subsystems. It provides information for validating members' data in the accounting subsystems. Direct Payments and Payroll location Accounting use data from membership to compute monthly billings.

COMMON ACCOUNTING SUBSYSTEM

Common Accounting allows the DCH Accounting Section to set up and maintain batches of accounting data for the accounting subsystems. The processing functions of common accounting are invoked twice in the processing of data unique to a subsystem. First, batch controls areas are established and monitored by this system. Once batches are balanced they are released through Common Accounting. Secondly, after each subsystem has completed processing of its data, Common Accounting will convert the data into Phoenix usable transactions and reports for the DCH Accounting Section.

DIRECT PAYMENTS ACCOUNTING SUBSYSTEM

Some members do not pay for their health insurance through payroll deductions; instead they send payments directly to DCH. The Direct Payments Accounting Subsystem controls these payments. The DCH Accounting Section uses it:

- Maintain accounts receivable data for members making direct payments.
- Prepare monthly statement for direct payees.
- Process direct payment cash receipts and adjustments.
- Provide displays and reports that assist with the collection effort.

The Direct Pay subsystem interfaces with the Common Accounting subsystem in the establishing of batches and in the reporting data to Phoenix.

PAYROLL LOCATION ACCOUNTING SUBSYSTEM

Most members pay for their health insurance through payroll deductions. Also each member agency must contribute to the SHBP. This subsystem allows the DCH Accounting Section to:

- Prepare monthly deduction and contribution statements for member agencies.
- Maintain accounts receivable information for uncollected deductions and contribution payments and errors.
- Provide a means of balancing deductions against membership enrollment.
- Provide displays and reports that assist in the collection process.

This subsystem also interfaces with the Common Accounting subsystem in the establishing of batches and the reporting of data to Phoenix.

REFUND ACCOUNTING SUBSYSTEM

Refund Accounting allows the DCH Accounting Section to enter and maintain data related to the repayment of claims expense by members and/or providers. The subsystem processes notices of refunds, cash receipts, cash applications, and adjustments. It maintains accounts receivable data and provides displays and reports to assist in the collection effort. This subsystem interfaces with the Common Accounting subsystem in the establishing of batches and the reporting of data to Phoenix.

TECHNICAL OVERVIEW

MEMS is an online system that utilizes a centralized database. This section will summarize the key technical aspects of MEMS.

TECHNICAL SPECIFICATIONS

▪ Database Manager	-	TOTAL
▪ Communications Software	-	CTMS
▪ Source Language	-	COBOL II (Batch) TEBOL (Online)
▪ Library Manager	-	Panvalet
▪ Job Scheduler	-	Control-M
▪ Transmission Platform	-	Connect:Direct via Advantis
▪ Interactive Voice Response (IVR)	-	Periphonics
▪ Address Checking/Mailing Prep	-	CODE1-PLUS & MailStream Plus

On-Line MEMS is up from 7:00 a.m.–9:00 p.m. Monday through Friday, excluding state holidays starting in July 2000, due to State House Bill 670.

DATABASE CONSIDERATIONS

MEMS employs TOTAL to organize and manage the database. MEMS uses standard input and output routines to access and update the database. There are 65 TOTAL files in the MEMS database with over 40,000 tracks of disk storage allocated.

MEMS PROGRAM BREAKOUT

TP Programs	-	130
Batch Programs	-	<u>210</u>
Total		340

Note: Most batch report programs update the SYTM file by turning off the process indicator. They also build a TRLV record. These programs however do no other updating.

Attachment 9

Appendix T—Member Lock-In and Case Management

Based upon utilization management analysis of member activity, patterns of inappropriate uses of medical services may be identified. In those cases, it may be necessary to perform monitoring of those members' services through utilization of lock-in. Lock-in is the restriction of a Medicaid member to a particular provider, as deemed necessary by the State. The member lock-in function encompasses the activities necessary to place a member in a lock-in status and perform service monitoring to determine if aberrant practices have been corrected. Members reviewed for lock-in may be in the fee for service (FFS), pre-admission screening & annual resident review (PASARR) program, managed care program, or other capitated programs. The Prime Contractor is required to bring a best of breed subcontractor to perform the following quality management and improvement (QM&I) functions:

1. Notify the physician, pharmacy, hospital, or other providers about the lock-in for the member;
2. Update the system in the appropriate areas to indicate that the member has been locked-in and instruct the member services subcontractor to update the member database with the selected hospital, pharmacy, and physician;
3. Provide case management services to direct members to needed services (e.g., identify providers with weekend or after hours care facilities if the member mis-utilizes the emergency department);
4. Monitor the member's service utilization to determine if aberrant behaviors have been modified and corrected. Make recommendations for actions and education that may improve the member's behaviors; and
5. Generate reports on lock-in activity on a schedule and format defined by DCH/BOR.

DCH/BOR is responsible for approving all policy related to member lock-in and based on recommendations from QA (Quality Assurance), approving member lock-in.

Operational requirements related to this member lock-in and case management function include:

1. Notify the member of his/her lock-in providers by letter upon acceptance of the lock-in by the providers;
2. Implement the lock-in and update the member database (and/or other applicable databases) with the selected physician, pharmacy, hospital or other provider that the member is locked into;
3. Monitor the member's service utilization to determine whether aberrant activities have been corrected;
4. Develop an action and education plan for members whose service utilization is aberrant and in need of correction; and
5. Maintain a log of members on lock-in and submit monthly and quarterly reports of lock-in activity to DCH/BOR.

Attachment 10

Appendix A—Schedule of Events

Event	Date
Release RFP	02/14/2001
Deadline for Written Questions*	03/06/2001
Optional Bidders' Conference/Two Delegates Maximum**	03/09/2001
Transcript of the Bidders' Conference and a list of conference attendees will be posted on the Internet at www.gagta.com and at www.communityhealth.state.ga.us	03/16/2001
Bidder Q&As will be posted on the Internet at www.gagta.com and at www.communityhealth.state.ga.us	03/19/01
Contract Posting	03/29/2001
Intent to Bid Letter	04/04/2001
Proposals Due***	04/26/2001, 3:00 PM EST
Technical Evaluation	04/26/2001–05/21/2001
Finalist/Oral Presentations	Week of 05/21/2001
Finalist/Vendor Demo Site Visits	Week of 05/28/2001
Cost Evaluation Complete by GTA/Mercer	06/01/2001
Contract Award Date (on/about)	06/06/2001
Phase I Implementation—Medicaid/PeachCare for Kids	10/01/2002
Phase II Implementation—SHBP	07/01/2003
Phase II Implementation—BORHP	01/01/2004

*Please submit questions via e-mail to: bshepard@gagta.com

**Participation in the Bidders' Conference is limited to only two people attending from each Bidder or subcontractor.

***Proposals must be delivered to the following address no later than 3:00 PM EST:

Georgia Technology Authority
100 Peachtree Street, Suite 2300
Atlanta, Georgia 30303-3404