



REQUEST FOR QUALIFIED SERVICES (RFQS)

PO817

REQUEST FOR APPROACH

For

STATE HEALTH BENEFIT PLAN (SHBP)

CONSOLIDATED HEALTHCARE STRATEGY

For all questions about this RFQS contact:

**Tiffiney Ward
2 Peachtree Street
35th Floor
Atlanta, GA 30303
tiward@dch.ga.gov**

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1.0. INTRODUCTION

1.1. PURPOSE OF PROCUREMENT

1.1.1. OVERVIEW

The Georgia Department of Community Health (hereinafter referred to as DCH) is seeking Approach proposals from qualified Offerors to provide an integrated solution for the administration of a self-funded Health Reimbursement Arrangement (HRA), High Deductible Health Plan (HDHP), Health Maintenance Organization (HMO), and a Preferred Provider Organization (PPO). These four plans are provided to all Members, both active and retired. Coordination of benefits (COB) with Medicare is on a 100% COB basis. In addition to these four plans, the Offeror is required to provide a fully-insured Medicare Advantage Private Fee-for-Service (PFFS) plan that will be optional to eligible Members. All products will be inclusive of pharmacy services. The five products must be available on a statewide and national basis effective January 1, 2009. The integrated solution should be both of the highest quality and cost-effective.

The DCH is interested in receiving Approaches from potential Offerors who are using the most innovative and state-of-the-art services and technology available in the industry today, ultimately seeking to assemble the above suite of program offerings that offer "Best in Class" services and can provide a value based health benefits program for its Members.

Integrated services will include:

- Claims Administration (including HRA Administration)
- Pharmacy Benefit Management
- Statewide and national provider networks (hospital, physician, lab, pharmacy, etc.) for the HRA, HDHP, HMO and PPO plans. DCH prefers the same provider network be used for the HRA, HDHP, HMO and PPO plans. DCH requests a Medicare Advantage PFFS model. For the HMO option, DCH prefers an open-access model.
- Utilization management services including utilization review (UR), prior approval, case management, demand management (nurse line), behavioral health, consumer engagement, and disease management.
- Wellness programs and administration of incentives.
- Centers of Excellence for transplants and other high risk, high cost procedures.
- Online consumerism tools and information.

The DCH will select two health plan Contractors with statewide and national coverage and each Contractor must provide all five products listed above. All Members will be given the options of HRA, HDHP, HMO and PPO plans. Members who are Medicare eligible retirees will also be given the fifth option of a Medicare Advantage PFFS plan from the same two Contractors.

The current number of Members (employees, both active and retired, and dependents) for the SHBP is as follows:

PLAN TYPE	MEMBERSHIP	
	Pre-65	Post-65
HMO	376,016	6,220
HRA	23,297	1,249
HDHP	1,764	92
PPO	217,369	53,025
Medicare Advantage	102	1,027
Indemnity (not open to new members)	5,695	1,895

1.2. **SCHEDULE OF EVENTS**

Schedule of Events	
Dates	Events
January 8, 2008	Release of RFA
January 21, 2008	Deadline for written questions
January 28, 2008	Answers to written questions posted on the DCH website
February 25, 2008	RFA Due
April 30, 2008	Notice of Contract Award (on or about)
June 2, 2008	Contractors begin work (on or about)
January 1, 2009	Effective Date

1.3. **RESTRICTIONS ON COMMUNICATIONS WITH STAFF**

From the date of this RFA until a Contractor is selected and the selection is formally announced by the DCH, Offerors are not allowed to communicate for any reason with any State staff except through the Issuing Officer named herein, or as provided by existing work agreement(s). The State reserves the right to reject the proposal of any Offeror violating this provision. All questions concerning this RFA must be submitted in writing (fax or email may be used) to the Issuing Officer. No questions other than written will be accepted after the issuance of the RFA. No response other than written will be binding upon the State.

1.4. **BASIC GUIDELINES FOR THIS REQUEST FOR APPROACH**

All questions about this RFA must be submitted in the following format:

Company Name

1. Question
Citation of relevant section of the RFA
2. Question
Citation of relevant section of the RFA

Questions must be directed in writing to the Issuing Officer:

Tiffiney Ward
Georgia Department of Community Health
2 Peachtree St., 35th Floor
Atlanta, Georgia 30303
tiward@dch.ga.gov

1.5. **DEFINITION OF TERMS**

Agency - office, agency, department, board, bureau, commission, institution, authority, or other political subdivision of the State of Georgia

AWP - Average Wholesale Price

BTE - Bridges to Excellence

CDHP - Consumer Driven Health Plan

Claims - Original submissions only using the standard CMS-1500 or UB04 format

CM - Case Management

CMS - Centers for Medicare and Medicaid Services

COB - Coordination of Benefits

Contract Administration - The management of all actions that must be taken to assure compliance with the terms of the Contract after award.

CY - Calendar Year

Department of Community Health (DCH) - An agency of the State of Georgia ("State") governed by the Board of the DCH ("Board").

DM - Demand Management

DRG - Diagnosis Related Group

DSM - Disease State Management

DSS - Decision Support System

Employee - The employee, teacher, or retiree who is the primary contract holder. When used in the context of a *per employee per month* to be paid for the services sought through this RFA, "employee" means only the number of employees and retirees eligible for and enrolled in coverage under the SHBP.

Evaluation - The in-depth review and analysis of Offeror's proposals. It involves the application of judgment to the Offeror's proposed price and Approach using the express evaluation factors and criteria in the solicitation and the procedures outlined herein.

HDHP - High Deductible Health Plan

HIE - Health Information Exchange

HRA - Health Reimbursement Arrangement

HMO - Health Maintenance Organization

HAS - Health Savings Account

MAC - Maximum Allowable Cost is the maximum reimbursement limits for certain multiple source covered drugs, including generic drugs, as determined by the Offeror from time to time from the most current information provided to the Offeror by drug pricing services such as First Data Bank and other recognized sources.

Medicare Eligible Members - Those Members eligible for coverage under Medicare Part A, B, or D. Medicare Eligible Members will be included in computing any per employee administrative fees.

Member or Enrollee - Any person enrolled for coverage under the SHBP.

MEMS - Membership Enrollment Management System

MMR - Monthly Membership Report

MOR - Model Output Report

MSP - Medicare Secondary Payer

MSR - Member Service Representative

O.C.G.A. - Official Code of Georgia Annotated (State Statute)

Offeror/Contractor - Respondent to this RFA

PDE - Prescription Drug Event

PDL - Preferred Drug List

P&T Committee - Pharmacy and Therapeutics Committee

PFFS - Private Fee-for-Service Medicare Advantage Plan.

PHA - Personal Health Assessment

Plan - The State Health Benefit Plan

POS - Point of sale

RAPS - Risk Adjustment Processing System

Request for Approach (RFA) - A request to prospective Contractors soliciting a proposal. Contains, or incorporates by reference, the specifications or statement of work and all contractual terms and conditions.

ROI - Return on Investment

SPD - Summary Plan Description

State Health Benefit Plan (SHBP) - The health benefit plan administered by the DCH covering State employees, public school teachers, public school employees, retirees, and their dependents and other contracted groups.

Statutes - Laws passed by Congress or a State legislature and signed by the President or the Governor of a State, respectively, that are codified in volumes called "codes" according to subject matter.

Subscriber - An employee, member of the general assembly, retiree or any COBRA participant enrolled for coverage in the SHBP.

UM - Utilization Management

1.6. **CONTRACT TERM AND NOTICE OF AWARD**

The initial contract term is from the date of contract execution through December 31, 2009 with four (4) additional one (1) year options to renew which shall be exercised at the sole discretion of the DCH. Renewal periods will be based on the Calendar Year period beginning January 1 and ending December 31. Renewal will depend upon funding and Offeror's performance. Contract Award will be by the issuance of a Notice of Award document.

1.7. **BACKGROUND**

I. Department of Community Health

The Georgia Department of Community Health (DCH) was created in 1999 by the Governor and the Georgia General Assembly. The Department is responsible for insuring nearly 2 million people, maximizing the State's healthcare purchasing power, planning coverage for uninsured Georgians, and coordinating health planning for State agencies. The Board of Community Health sets general policy and direction for the DCH.

The DCH is organized in the following manner:

- **Commissioner's Office** – provides strategic and operational guidance to all functions of the DCH. Includes media relations as well as legislative and external affairs.
- **Financial Division** – led by the Chief Financial Officer, this division is responsible for guiding and implementing the financial responsibilities of the DCH.
- **Medical Assistance Division** – directed by the Chief, Medical Assistance, this division manages and enforces the policies and regulations of the State Medicaid program.
- **Information Technology Division** – managed by the Chief Information Officer, this division manages and directs the information technology needs and requirements for the DCH. This responsibility includes oversight for the Medicaid claims payment system.
- **Operations Division** – under the direction of the Chief Operating Officer, this division manages agency administrative responsibilities including procurement, human resources, contract administration, and vendor management.

- **General Counsel** – this division provides the Commissioner and the DCH’s leadership with legal assistance and advice on all matters. This division manages the Division of Health Planning which is responsible for regulating the development and offering of health care facilities throughout the state.
- **Public Employee Health Benefits Division** – under the direction of the Chief, State Health Benefit Plan, this division is responsible for administering the health insurance benefits for State employees, school personnel, retirees, general assembly, and other contracted groups.
- **Managed Care and Quality Division** – lead by the Chief of Managed Care, this division is responsible for establishing and directing the managed care efforts of the DCH for Medicaid members who are not Aged, Blind or Disabled (ABD).

There are also two (2) administratively attached agencies;

- **Composite State Board of Medical Examiners** – licenses and regulates physicians, physician’s assistants, resident physicians, respiratory care professionals, perfusionists, acupuncturists and auricular (ear) detoxification specialists.
- **Georgia Board for Physician Workforce** – develops medical education programs to help ensure that communities have enough physicians.

II. Division of Public Employee Health Benefits

This Division administers the SHBP, which provides health insurance coverage for State employees, school system employees, the general assembly, contracted groups, retirees, and their dependents.

The SHBP spends more than \$2.7 billion annually for healthcare services for more than 680,000 State employees, teachers, school personnel, their dependents, retirees, and active contracted groups and members of the general assembly. The SHBP provides healthcare coverage to beneficiaries residing in virtually every county in the State, plus approximately 14,335 members living outside the State.

There are over 700 employing entities that are authorized, under law, to participate in the SHBP including State agencies, school systems, and other contracted entities. Each employing entity has the responsibility to offer enrollment in the SHBP to each eligible employee or eligible retiree and provide each with the appropriate information and enrollment materials upon employment and retirement. The employing entity is responsible for sending the enrollment information to the SHBP. The SHBP maintains the information and provides the enrollment to each of its Contractors through monthly full file updates and nightly feeds for changes. The SHBP utilizes a proprietary file at this time; however, the SHBP does not maintain other insurance information on its Members and relies on the claims payer to maintain Member insurance information for coordination of benefit purposes.

In 2008, the SHBP offers to its Members the following options: HRA, HDHP, HMO, Indemnity, PPO and a Medicare Advantage plan. The SHBP also offers a Consumer Choice option for the HRA, HDHP, HMO, and PPO products. These options offer Members the same benefits as the standard HRA, HDHP, HMO, and PPO options, except Members may nominate healthcare providers to the network as preferred in-network providers.

Current SHBP Healthcare Plans include:

- United Healthcare – HDHP, Indemnity, and PPO
- BlueChoice – HMO
- Kaiser Permanente – HMO and Medicare Advantage
- United Healthcare Choice - HMO
- Definity – HRA
- Lumenos – HRA

Third party vendor:

- MedStat- The SHBP Decision Support System (DSS) and data warehouse

2.0. INSTRUCTIONS TO OFFERORS

This procurement will be conducted by the gathering of technical, cost, business, and other information from Offerors who submit Approaches to assess their responsiveness and responsibility and to determine next steps. Offerors must complete a confidentiality/non-disclosure statement prior to receiving Member claims information.

2.1. PROCESS FOR SUBMITTING APPROACH

Each RFA should be prepared simply and economically, avoiding the use of elaborate promotional materials beyond those sufficient to provide a complete presentation. If supplemental materials are a necessary part of the Technical Approach, the Offeror should reference these materials in the Technical Approach, identifying the document(s) and citing the appropriate section and page(s) to be reviewed.

Each Technical Approach answer must reference the corresponding section number in the RFA.

Approaches must be submitted to:

Tiffiney Ward
Department of Community Health
2 Peachtree St. SW, 35th Floor
Atlanta, GA 30303
Tiward@dch.ga.gov

February 25, 2008, by 1:00 p.m. Eastern Standard Time (EST)

Any Approach received after the due date and time is ineligible for consideration and will be not be evaluated.

The RFAs will be reviewed by the Issuing Officer for the following administrative requirements:

1. Submitted by deadline.
2. Separately sealed Technical Approach and Financial Approach.
3. All required documents have been submitted.
4. The Technical Approach must not include any information from the Financial Approach.
5. All documents requiring an original signature have been signed and are included in package.

2.1.1. PACKAGING OF APPROACH

The Offeror's Approach in response to this RFA must be divided into two (2) separately sealed packages properly identified.

The contents of each package must include the following documents which must be completed and signed, where applicable, in Offeror's Approach:

- A. A Technical Approach detailing the proposed Approach to performing all of the services requested under Section 3.0;
- B. A statement that Offeror has read the Contract and agrees to abide by the Contract unless the State chooses to open negotiations over specific Contract provisions, which is included as "Exhibit 2" – Sample Contract and Performance Guarantees" (Exceptions Noted or No Exceptions);
- C. A completed Financial Approach, which is included as "Worksheet 1- Administrative Fees". **DO NOT INCLUDE COST INFORMATION IN THE TECHNICAL APPROACH;**
- D. Appendix A: "Approach Certification".
- E. Appendix B: "Sales and Use Tax Registration".
- F. Appendix C: "Off Shoring Requirement Form".
- G. Mark the outside of shipping package as follows:

Name of Company
Phone Number and Point of Contact for Company
RFA # P0817
Due no later than February 25, 2008, 1:00 P.M. Eastern Standard Time

2.1.2. NUMBER OF APPROACH COPIES

- A. Technical Approach
 - 1. An original Technical Approach (marked "Original") and two (2) exact and complete hard copies; and
 - 2. twelve (12) CD-ROMs (in Microsoft Office version 2003 format and Windows 2000 or 2003 versions).
- B. Financial Approach
 - 1. An original Financial Approach (marked "Original") and two (2) exact and complete hard copies; and
 - 2. three (3) CD-ROMs (in Microsoft Office version 2003 format and Windows 2000 or 2003 versions).

Note: Technical Approach and Financial Approach CD-ROMs must be labeled and packaged separately.

Note: If there is a discrepancy between a hard copy submission and the companion CD submission, the CD will have precedence.

2.2. EVALUATION PROCESS

The evaluation of Approaches received on or before the due date and time will be conducted in the following phases:

- evaluation of the Offerors network access,
- evaluation and scoring of Technical Approaches,
- DCH may choose to make site visits to Offeror locations or other locations where the Offeror provides fiscal agent or other claims processing services., and
- enter into negotiations with the top two (2) scoring Offerors.

2.2.1. **EVALUATION OF TECHNICAL APPROACH**

Technical Approaches will be evaluated and scored in categories and may receive a maximum of 1000 total points.

The following are the maximum possible total points for each category:

Table 1 - Scoring Methodology

Category	Maximum Points
Company Overview, Experience, Financial Stability, and Business Litigation	20
Reporting and Billing and Account Management	30
Claims Administration, Claim Systems, Fraud and Abuse	75
Eligibility, Member Services, and Member Communications and Web Tools	50
Pharmacy Services	75
Provider Network	40
Network Access and GeoAccess Report	350
Utilization Management and Wellness	300
Medicare Advantage Private Fee-for-Service Plan	50
Sample Reports and Documents	10
Total Points	1000

DCH reserves the right to conduct Site Visits/Oral Presentations with Offerors after the completion of the Technical Evaluation. An Offeror may be required to demonstrate its system and processes during the presentation as referenced in its response to the RFA. **An Offeror cannot present anything that is not in its written response to the RFA.** An Offeror will be notified by DCH when a Site Visit/Oral Presentations will be conducted. If a site visit is selected the Offeror may not discuss the Financial Approach during the Site Visit/Oral Presentation.

2.2.1.1 Site Visits and Oral Presentations

The State reserves the right to conduct site visits or to invite Offerors to present their technical solution to the Technical Evaluation Team. Site visits and oral presentations are extensions of the Technical Review and points will not be added but points may be deducted. The Financial Proposal must not be discussed during the oral presentation. If during a site visit the Technical Evaluation Team discover deficiencies at the Offeror's site, points may be deducted from the Offeror's original technical score.

2.2.2. EVALUATION OF FINANCIAL APPROACH

2.2.2.1. Offeror will use only the Financial Approach Forms provided with the RFA (Section 7).

2.2.3. NEGOTIATIONS

After the Evaluation Committee has scored the Offeror's Approach, the DCH may choose to negotiate agreements with Offerors susceptible to being selected for Contract award, if it is deemed to be in the best interest of the State. Any such Offeror is thereby susceptible to being selected for the award. Such Offerors will be contacted by the DCH and scheduled for negotiations. During the negotiation process, Offerors will have the opportunity to discuss Approach and submit a final revised Financial Approach and Contractual Agreement after negotiations have concluded.

Offerors are urged to submit its best Technical and Financial Approaches with its Approach submissions and should not assume that it will be afforded an opportunity to negotiate. The State reserves the right to award Contracts without further discussions after the receipt of the Final Revised Approach. The Award will be made to the Offeror who provides the best value solution.

2.2.4. SELECTION AND AWARD

The DCH Evaluation Committee will review the Offerors' responses. The selection of the successful Offerors will be made from the negotiations as determined by the DCH. The primary intent of the DCH is to award a Contract to the two (2) Offerors who propose the best solution in the State's best interest.

2.3. REJECTION OF APPROACH/CANCELLATION OF RFA

The DCH reserves the right to reject any or all Approaches, to waive any irregularity or informality in an Approach, and to accept or reject any item or combination of items, when to do so would be to the advantage of the State. It is also within the right of DCH to reject Approaches **that do not contain all elements and information requested in this document**. The DCH reserves the right to cancel this RFA at any time. The DCH will not be liable for any cost/losses incurred by the Offeror throughout this process.

2.4. RELEASE OF CLAIM

By submitting an Approach, the Offeror releases DCH from any and all claims, losses, and liabilities that may arise from DCH's inadvertent failure to provide the Offeror with information that may have been relevant to Offeror in developing its response.

3.0. TECHNICAL APPROACH AND QUESTIONNAIRE

Please be advised that unless otherwise noted, the questions in this section apply to all five products: HRA, HDHP, HMO, PPO and Medicare Advantage PFFS. All products with the exception of the Medicare Advantage program will be administered as self-funded plans.

3.1. COMPANY OVERVIEW

3.1.1. Provide the following information about your organization:

Company Name	
Address	
Telephone Number	
Fax Number	
Web Site Address	
Year Founded	
Number of Employees	
Federal Tax Identification Number	
Number and Names of Locations	

3.1.2. Provide the following information for a single point-of-contact to represent your organization throughout the RFA process:

Name	
Title	
Address	
Telephone Number	
Fax Number	
Mobile Phone Number	
Email	

3.1.3. Provide the following information for the person(s) authorized to negotiate and execute contracts:

Name	
Title	
Address	
Telephone Number	
Fax Number	
Mobile Phone Number	
Email	

3.1.4. Provide the location of the Offeror's office(s) that would be responsible for managing the DCH Contract.

3.1.5. Provide a brief description of your firm's background and history and include the following information. Limit response to two pages.

- A. Legal name, trade name, or any other name under which your firm does business or has done business in the past;
- B. The legal form of your business organization;
- C. The state in which incorporated (if a corporation);
- D. Types of business ventures in which the organization is involved; and
- E. The names and addresses of any owner that has at least five per (5%) financial interest in your company and the type of financial interest.

3.1.6. Describe the legal form of your business organization and provide a chart of the organization structure, which illustrates relationships with any parent company, subsidiaries, sister companies and reporting lines, as they relate to this RFA.

3.1.7. Offeror shall comply with all State and federal laws effective during the term of the Contract and bear any and all expenses that would be reasonably associated with or considered "cost of doing business" ensuring Offeror's compliance with the terms and conditions related to Offeror's performance under the Contract. Confirm your firm's ability to meet this requirement.

3.2. EXPERIENCE

3.2.1. Provide the overall membership of your firm nationally.

Please separate by type of product: HRA, HDHP, HMO, PPO, and Medicare Advantage.

3.2.2. List the five (5) largest accounts serviced by your organization and provide the number of members for each of these accounts. Separate by HRA, HDHP, HMO, PPO, and Medicare Advantage products.

3.2.3. For reference check purposes, please provide a list of three current Government/Public Sector and/or commercial accounts (with at least 20,000 employees) for whom you have provided self-funded HRA, HDHP, HMO, PPO or fully insured Medicare Advantage products similar to those detailed in this RFA for the past three years. This reference may be from any combination of these products but must include an HRA client. At least one reference should be from government/public sector clients.

The reference list must include:

- A. Company name
- B. Name, title, telephone number and e-mail address of a knowledgeable contact person
- C. Date your firm began providing services to this company
- D. Number of members
- E. Type of products offered

Please disclose any services or product offerings terminated by these client(s), the date of termination, and the reason for termination.

3.2.4. Provide the names of all subcontractors along with type of services they will provide, the number of years your firm has utilized the subcontractor, and the contractual relationship between subcontractor and your company. This question applies to services such as provider networks, mental health and substance abuse services, utilization management, pharmacy management, disease state management, HRA administration, transplant services, wellness, and any other services your firm will be providing to SHBP Members. Please use the table provided below. In addition, are you willing and able to submit a copy of subcontractor's contract? If so, please submit copy and, if not, explain why?

Name	Type of Service(s)	Years Utilizing this Contractor	Contractual Relationship

3.2.5. Within the past two (2) years, have there been any significant changes in your firm including but not limited to, changes in ownership, merger/acquisition, personnel re-organization, change in business emphasis, etc.? If so, describe.

3.2.6. Do you anticipate any changes in your firm's basic ownership structure or any other significant changes in your firm within the next twenty-four (24) months including any anticipated mergers and acquisitions? If so, describe and explain how these actions will impact the DCH.

3.2.7. Provide the name, title, and responsibilities of the Account Director that will be dedicated to the SHBP account after implementation. The DCH reserves the right to accept or decline the Account Director as well as other key staff designated for its program both initially and in future Contract years.

3.2.8. Provide the names, titles and responsibilities of the key implementation staff that will be dedicated 100 percent to the SHBP during implementation.

3.2.9. Describe the implementation process for all five products: HRA, HDHP, HMO, PPO, and Medicare Advantage. Provide a detailed timetable assuming a Notice of Contract Award by April 30, 2008 for a January 1, 2009 implementation. The implementation plan must be submitted to the DCH at least 60 days prior to implementation. The implementation processes should include variations for each product, if applicable. The implementation information should provide details on the key roles of each member of the implementation team. Your firm's implementation plan should assume that the SHBP specific communications to Members and external stakeholders must be completed by September 1, 2008. At a minimum, the implementation plan must provide specific details on the following:

- A. Identification and timing of significant responsibilities and tasks
- B. Names and titles of key implementation staff
- C. Identification and timing of the SHBP's responsibilities
- D. Data requirements (indicate type and format of data required)
- E. Transition requirements with the incumbent health plans
- F. Staff assigned to attend and present (if required) at open enrollment/educational sessions

3.2.10. At least sixty (60) days prior to January 1, 2009 effective date; the DCH will have a readiness review of the pending awardees, including an on-site review of the Offeror's facilities. Offeror shall participate in all readiness review activities conducted by the SHBP staff to ensure the Offeror's operational readiness for all products for all services (e.g. claims, eligibility, Member services, network access, network management, medical management, Offeror's staff education, etc.). The DCH will provide the Offeror with a summary of findings as well as areas requiring corrective action. Describe in detail how your firm will comply with this requirement.

3.2.11. Offeror shall provide a twelve month run-out period for medical and pharmacy claims following termination of Contract. Confirm you will meet this requirement.

3.3. FINANCIAL STABILITY

3.3.1. Offeror shall provide financial information that would allow RFA evaluators to ascertain the financial stability of the company as required in Section 3.18.2.3. Confirm you will meet this requirement.

3.3.2. If a public company, provide your most recent audited financial report as required in Section 3.18.2.2.

3.3.3. If a private company, provide a copy of your most recent internal financial statement, and a letter from your financial institution, on the financial institution's letterhead, stating your financial stability as required in Section 3.18.2.4.

Financial information at a minimum should include:

- A. Balance Sheet
- B. Income statement
- C. Statement of cash flow
- D. Notes to financial statements

3.4. BUSINESS LITIGATION

3.4.1. Disclose any involvement by your organization or that of any officer or principal in any and all material business litigation within the last five (5) years. The disclosure should include an explanation, as well as the current status and/or disposition.

3.4.2. Provide a detailed summary of any past or pending investigations, citations, and/or sanctions within the last five (5) years from any state or federal regulatory agency experienced by your firm, including any subsidiaries. This summary should include an explanation of the issue, current status or disposition of the investigation, levied fines, if applicable, and the action(s) taken by your firm to resolve the issue.

3.4.3. Provide information on any notices of breach that customers have issued to your firm or any subsidiaries within the past five (5) years and how these issues were resolved.

3.5. Reporting and Billing

3.5.1. Offeror shall create and generate reports for all products using the formats, including electronic format data elements, instructions and timetables as specified by the DCH and at no cost to the DCH. Additionally, Offeror shall create and generate ad hoc reports upon request at no cost to the DCH. Changes to the format, frequency or data elements of the reports and/or the production of ad hoc reports may be requested by the DCH at any time, and the Offeror must agree to accommodate these changes. Any changes to the format or frequency of the reports on the part of the Offeror must be approved by the DCH before changes occur. Confirm your ability to meet this requirement.

- A. Weekly reports shall be submitted on the same day of each week, as determined by the DCH/SHBP;
- B. Monthly reports shall be submitted by the fifteenth (15th) of each month;
- C. Quarterly reports shall be submitted by the fifteenth (15th) of the month following the end of the quarter; and
- D. Annual reports shall be submitted within ninety (90) calendar days following the end of the twelfth (12th) month.

3.5.2. Provide a general description of your standard reports for all products. Describe your online reporting capabilities as well as your hard copy reporting capabilities. Describe the frequency of each standard hard copy report. You must provide ad hoc reports as required by the DCH. Confirm your ability to meet this requirement. Also, confirm your willingness to train DCH personnel on your online reporting system, at no cost to the DCH.

3.5.3. Offeror shall provide monthly data files consisting of all medical and pharmacy claims to the DCH data warehouse contractor within ten (10) calendar days following the end of each month. Elements in the data feed will be agreed upon by the staff at the DCH. Confirm your ability to meet this requirement.

3.5.4. Offeror shall provide monthly provider files to the DCH data warehouse contractor within ten (10) calendar days following the end of each month. The data file layout shall be determined by the DCH. Confirm your ability to meet this requirement.

3.5.5. For each product, describe how your firm will handle the following transaction categories:

- A. Administrative billing process
- B. Adjustments
- C. Recoveries
- D. Run-Out of claims
- E. Reconciliation
- F. Issued but un-cleared checks

3.5.6. For each product, describe the following aspects of your administration fee billing process:

- A. Payment options
- B. Billing frequency
- C. Due dates
- D. Adjustments
- E. Recoveries
- F. Run-Out Claims
- G. Reconciliation

3.5.7. For each product, describe the payment process for medical and prescription claims:

- A. Payment options
- B. Adjustments
- C. Billing frequency
- D. Late payments or interest on late payments
- E. Due dates
- F. Detail check register for paid claims by account type

3.5.8. Offeror shall establish and maintain a bank account used to disburse funds on behalf of the DCH and agree that all claim payments made on behalf of the SHBP will not be combined with those of other clients. An imprest balance will be maintained and the account will be funded as the drafts clear the bank. Describe how you will meet this requirement.

3.5.9. Offeror shall perform due diligence for stale dated checks. Offeror must maintain separate reports or some type of tracking mechanism for these items due to the requirement of the DCH to maintain a liability in the financial records for seven (7) years. Describe how you will meet this requirement.

3.5.10. Describe your firm's standard banking and funding requirements.

3.5.11. Offeror shall support an Automated Clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments for medical and pharmacy services. Confirm your ability to meet this requirement for both medical and pharmacy claims.

3.5.12. Offeror shall provide a SAS70 report to the DCH annually and include corrective action plans for any issues identified in the report. Confirm your ability to meet this requirement.

3.5.13. Do your online and hard copy claims reports include HRA claims and pharmacy claims? Do your utilization reports include HRA claims and pharmacy claims? In addition to integrated reports, DCH requires a separate report providing more detail about HRA claims on a monthly basis summarizing by employee groups the following information. Discuss how you will meet this requirement.

- A. Coverage amount
- B. Expenditures for current month
- C. Year-to-date expenditures
- D. Remaining balance

3.5.14. Offeror shall provide an annual report based on the calendar year the total amount of HRA forfeitures summarized by employee groups. Confirm your ability to meet this requirement.

3.5.15. Offeror shall provide an annual report for each product with estimates of incurred unpaid claims, administrative fees and outstanding check amounts as of the end of the calendar year. Confirm your ability to meet this requirement.

3.6. ACCOUNT MANAGEMENT

3.6.1. Please identify the dedicated account management team you propose to work on the SHBP account and provide an organization chart, including names and titles, of management and key personnel that will be responsible for account management. Indicate whether the person who will fill each position is already employed by your firm or whether he/she will be recruited upon Contract award. If the person(s) are already employed, provide resumes and length of time with your firm. At a minimum, the positions below should be included.

- A. Account Director – Responsible for overall account relationship including strategic planning in relation to plan performance, consultative services, recommendations for benefit design and cost containment opportunities, overseeing contractual services under the contract with the DCH, and managing all other Offeror's staff working on this account.
- B. Account Manager – Responsible for day-to-day operations management and all services provided by Offeror which supports those operations.
- C. Operations Manager – Responsible for all claims operations and reporting.
- D. Clinical Program Director/Clinical Program Manager – Responsible for all UM, Case Management, DSM, DM programs and other clinical support.
- E. Wellness Director – Responsible for overseeing the Offeror's Wellness Programs, including, but not limited to, educating Members/client regarding on-line Personal Health Assessments (PHAs), wellness programs and web tools. Also must participate on the DCH Wellness Committee to formalize a communications strategy and coordinate Wellness Fairs (including worksite wellness) as requested by the DCH.
- F. Pharmacy Director/Pharmacy Manager – Responsible for all pharmacy services including but not limited to strategic planning in relation to plan performance and clinical programs, analysis of plan performance and presentations/support.

G. Member Services Manager - Responsible for all customer service functions and reporting.

3.6.2. The Account Director/Manager and account team must be available during regular business hours and during emergencies including being available for frequent telephone and on-site consultation with the DCH in Atlanta, GA. Confirm the Account Director's and Account Manager's availability for frequent telephone and onsite consultation with the DCH in Atlanta, GA.

3.6.3. If your firm must hire key personnel upon Contract award, the Offeror must provide a detailed recruitment plan for such personnel that confirms the Offeror's ability to meet the Contract implementation date.

3.6.4. Offeror shall provide at a minimum one (1) fulltime on-site staff for the DCH offices dedicated to problem resolution, customer service, etc. Confirm your ability to meet this requirement.

3.6.5. Offeror shall have account management personnel located within the metropolitan Atlanta area throughout the life of the contract. Confirm your ability to meet this requirement.

3.6.6. Describe how your team will be responsive, creative, and innovative in developing solutions and recommendations to reduce healthcare cost, improve quality of healthcare and access, and increase Member satisfaction.

3.6.7. All registered nurses, care managers, physician reviewers, and allied health team members must be appropriately licensed in the state in which they are employed. Confirm your ability to meet this requirement.

3.6.8. Offeror shall respond to all DCH inquiries within one (1) business day. Offeror must effectively advance the interest of the DCH through the corporate structure to facilitate resolution of issues. Describe your firm's process to escalate problems or concerns through the corporate structure to facilitate resolution of issues. Discuss how your firm will report your findings to the DCH.

3.6.9. Offeror shall report the SHBP-specific utilization data in an electronic format approved by the DCH, on a monthly basis and conduct monthly and/or quarterly meetings to review and analyze such data with the SHBP representatives. Confirm your ability to meet this requirement.

3.7. **CLAIMS ADMINISTRATION**

Note: if you have a separate claims administration unit for your Medicare PFFS plan please provide the requested information below separately for each unit.

3.7.1 Offeror shall adjudicate claims by determining if the claimant is a Member of the SHBP on the date of service, calculate benefit liability according to the SHBP approved benefit schedule and medical policy guidelines, and issue payment for the benefit. If additional information is required for accurate adjudication, Offeror must elicit the information and notify the provider and Member of the delay and required information to perfect the claim. Describe how your firm will meet each of these requirements.

3.7.2. Does your firm's claim system have processes and edits in place to identify improper provider billing? This includes, but is not limited to, up-coding, unbundling of services, and duplicate bill submissions including billing across programs (e.g., pharmacy and physician office or pharmacy and DME). Please describe.

3.7.3. Offeror shall pay in accordance with State law, all provider claims that are clean and payable. A clean claim is defined as not missing any information necessary to process said claim, is not under appeal or does not involve coordination of benefits (COB), third party liability or subrogation. Discuss any limitations your firm may have in meeting this requirement.

3.7.4. Offeror must encourage its providers, as an alternative to the filing of paper-based claims, to submit and receive claims information through electronic data interchange (EDI), i.e. electronic claims. As part of this Electronic Claims Management (ECM) function, the Offeror shall also provide on-line and phone-based capabilities to obtain claims processing status information. Describe the capabilities your firm has available to meet this requirement.

3.7.5. Offeror must generate Explanation of Benefits (EOB) and Remittance Advices in accordance with State standards for formatting, content and timeliness. Describe content of EOB and provide a sample copy as requested in Section 3.18.5.

3.7.6. Describe your capabilities to provide Members with a periodic Health Statement summarizing all claims activity. How frequently is the Health Statement provided? Provide a sample copy as requested in Section 3.18.5.

3.7.7. Describe the Member's ability to look up claims activity online. Offeror shall provide a temporary username and password for the DCH to review your member website.

3.7.8. You must assume all costs associated with claims processing including the interest charges assessed per O.C.G.A. § 33-24-59.5, the cost of reprocessing and resubmission costs due to processing errors caused by the Offeror or to the design of systems within the Offeror's span of control. Confirm your understanding and ability to meet this requirement. Discuss any limitations.

3.7.9. Describe your system's capability regarding the following:

- A. Electronic claim payments
- B. Multiple fee schedules
- C. Interface with utilization management system
- D. Interface with Member service system
- E. Rebundling software
- F. System edits
- G. Ability to pend and bundle claims from the same EOB
- H. In and out-of-network claims paid on same system
- I. Prevention of payment of duplicate claims

3.7.10. What percentage of hospital and physician claims is submitted electronically? What percentage are auto adjudicated? Describe the process for non-auto adjudicated claims. Describe the process for helping the DCH to improve its auto-adjudicated claim rate.

3.7.11. Are all network hospital and physician discounts and payment methods loaded directly into your claims system and accessed automatically during claims adjudication?

3.7.12. In what instances do you have to manually calculate benefits for contracted and non-contracted providers? What is the time frame to manually calculate these claims?

3.7.13. Provide the following information regarding internal claims audit(s):

- A. What are current standards for internal claim audits?
- B. How often are claim processors audited?
- C. When errors are found, what is the time frame for correction of the claim?
- D. Is there a collective report indicating the audit results of all claim processors?
- E. Are reports quarterly, semi-annual, etc.?

- F. What claims do you consider for high dollar audits?
- G. Are high dollar audit claims handled internally?
- H. How are criteria determined for internal audit?
- I. Are standards equivalent to claim industry?
- J. What percent of claims are audited internally?

3.7.14. Describe how Offeror will conduct a quality review of claims such as prior approval determinations to ensure compliance with clinical guidelines and plan-specific benefits. What is the frequency of claim quality reviews?

3.7.15. What types of training are provided for the claim processors? Confirm if your training includes any of the following:

- A. Formal classroom training - If yes, how many weeks of formal classroom?
- B. Training for new claims processors
- C. Training on customer service system
- D. Monitoring of learning (e.g., tests, homework, etc.)
- E. Conflict resolution training
- F. Initial auditing of work (If yes, also specify the number of weeks that auditing of work continues)

3.7.16. What are the average years of experience for your firm's claims processing staff?

3.7.17. What was your average claims processing staff turnover rate for 2006 and 2007? What initiatives has Offeror implemented to reduce staff turnover?

3.7.18. Provide targets and actual results for the following performance activity/measurements.

	2006 Standard	2006 Actual	2007 Standard	2007 Actual
Average Claim Processing Turnaround Time (% in # days)				
% Financial Accuracy (% of dollars paid accurately)				
% Procedural Accuracy				
% Payment Accuracy (% of claims paid correctly)				

3.7.19. Does your claim system have the following capabilities?

- A. Capture dollar amount (e.g., total charges, covered charges, discount adjustments)
- B. Identify providers by Tax ID#
- C. Track deductibles, co-payments and out-of-pocket maximums
- D. Adjudicate claims based on per diems or DRGs
- E. Produce reports by DRGs or other acuity measure
- F. Track annual limitations for services such as chiropractic, psychotherapy, etc.
- G. Apply penalties such as failure to pre-certify, non-participating physician, etc.
- H. Identify Temporomandibular Joint Syndrome (TMJ)
- I. Track lifetime limitations
- J. Track pre-existing limitations with a first dollar per condition limit payment (e.g. pay first \$1000 and then investigate for pre-existing on an individual basis), including receipt and input of creditable coverage from prior carrier
- K. Track lifetime maximums across products
- L. Identify providers by National Provider Identifier (NPI)

3.7.20. How many medical claims did your firm adjudicate nationwide during the 2007 calendar year for US-based employees? *Claims are defined as original submissions only (do not include voids or adjustments) and should only include claims submitted using the standard CMS-1500 or UB04 format.*

3.7.21. Which claim office would adjudicate the SHBP's medical claims? How many medical claims did this claim office adjudicate during the 2007 calendar year? *Claims are defined as original submissions only (do not include voids or adjustments) and should only include claims submitted using the standard CMS-1500 or UB04 format.*

3.7.22. How are your medical claims criteria developed and applied in processing claims? Include your current process for reviewing "experimental and investigational" procedures and describe sources of information used in rendering the review determination.

3.7.23. Describe your process for handling transplant claims to comply with the SHBP maximum limitations, review of bills for negotiated prices by the transplant center as well as non-contracting centers, and evaluation as to whether the claim is a result of the transplant. How many staff will be dedicated to specialized processing for transplant claims for the SHBP? What are the qualifications of the staff who are assigned to this task?

3.7.24. Describe your process for reviewing requests and claims for skilled nursing visits, DME, and types of home care for determining if the services meet medical necessity. What are the qualifications of the dedicated staff that will conduct the SHBP reviews and evaluate claims for these purposes?

3.7.25. The PPO plan has a pre-existing limitation as described in Section 3.7.19 (J). Please describe your process for reviewing and administering this plan provision. Also include the process for requesting and updating creditable coverage information from a Member's prior insurance to waive pre-existing as prescribed under federal law.

3.7.26. Describe how claims incurred outside the United States are reviewed and adjudicated.

3.7.27. Explain how your system currently:

- A. Identifies existence of other insurance (e.g., from another employer, workers compensation or motor vehicle insurance)
- B. Questions/tracks COB
- C. Handles COB conflicts
- D. Communicates with Members and providers
- E. Interfaces with other group carriers/Medicare regarding COB.

3.7.28. Can your system accommodate Medicare Crossover Claims for age, disability and End Stage Renal Disease (ESRD)? Describe any limitations.

3.7.29. The DCH will provide Medicare information on post-65 retirees in the eligibility file. Explain how, when and where Medicare Part A, Part B, and Part D information is stored on your claims administration system.

3.7.30. When ESRD claims are received and the date of when Medicare becomes the primary payer has not been updated on the patient's Medicare record, explain how these claims are processed. Also, explain how the information about the Member's Medicare eligibility is gathered.

3.7.31. Describe your firm's review process to identify claims incorrectly paid by the DCH as primary that should have been paid as secondary with regard to regular COB and Medicare payments.

3.7.32. Explain your current process for recovering overpayments on claims. Can your company set up an auto-deduct feature from future claims for the requested overpayments/refunds? If yes, describe the process.

3.7.33. Explain your current process for investigating provider refunds that were not requested.

3.7.34. Federal law requires health plans to reimburse Medicare for claims that Medicare paid, in error, as primary (called Medicare Secondary Payer Program, or MSP). Does your firm currently have a data-match file in accordance with the Medicare Voluntary Data-Match Agreement? If not, does your firm have any plans to obtain one? If yes, describe the process and if not explain why.

3.7.35. You must process Medicare demand letters, per MSP, within the timeframes specified in the letters to avoid interest charges. In addition, you must handle all telephone calls in relation to Medicare demand payments, from Subscribers, employing entities, and collection agencies. Confirm your ability to meet this requirement. Describe any limitations.

3.7.36. Describe your process for handling Medicare Secondary Payer Claims.

3.7.37. Effective January 1, 2008, federal law requires employer health plans to reimburse TRICARE for any claims paid by the TRICARE program, instead of the employer health plan, as primary (called TRICARE Secondary Payer program). You must handle any data-match requirement in accordance with any federally-provided TRICARE Voluntary Data-Match agreement. Confirm your ability to meet this requirement. If you cannot, do you have any plans to obtain such an agreement?

3.7.38. Describe the process for handling TRICARE Secondary Payer Claims.

3.7.39. Offeror shall receive and process TRICARE demand letters within the timeframes specified in the letters to avoid interest charges. Confirm your ability to meet this requirement. Discuss any limitations with meeting this requirement.

3.7.40. Offeror shall notify employing entities and the SHBP of TRICARE payments in relation to the demand letters. Confirm your ability to meet this requirement. Describe the notification process.

3.7.41. Offeror shall handle all telephone calls in relation to TRICARE demand payments, from Subscribers, employing entities, and collection agencies. Confirm your ability to meet this requirement and describe any limitations.

3.7.42. Offeror shall have procedures and processes in place for cost avoidance to the plan to include the following:

- A. Identify other insurance coverage.
- B. Identify Members with Medicare and coordinating coverage through cross-over with Medicare, interfacing with the DCH eligibility to inform the DCH of those Members with Medicare.
- C. Provide services, or interface with external contractors, for high dollar bill audits, provider credit balance audits, subrogation, COB information, and other cost avoidance and cost recovery services

Describe your process for meeting the requirements delineated in A, B, and C above.

3.7.43. Offeror must track and report all refunds for the SHBP, identifying trends and assisting in activities that will avoid incorrect payment of the SHBP funds. You must provide reports on a monthly, quarterly and annual basis. Reports should include the following. Confirm you can meet this requirement. Discuss any limitations in meeting the reporting requirements delineated in the list below.

- A. Beginning backlog/status
- B. Number of closed cases
- C. Number of new cases added to backlog
- D. Number of cases with recoveries
- E. Dollar amount of total payout for each case
- F. Dollar amount of recovery for each case
- G. Month ending backlog
- H. Trending by month and year
- I. Ratio of recovery by month
- J. Comment area that may be needed to explain elements on report by month and year.

3.7.44. You must report COB savings to the SHBP. You should calculate the COB savings percentage by using the following formula:

$$\frac{Lpl - Ps}{Pt}$$

Lpl = the amount of the SHBP as primary liability
 Ps = the actual payment of the SHBP as secondary liability
 Pt = total benefit payments

The amount of COB spending is to be reported to the SHBP separately for the savings amount for medical and pharmacy. Do the reports include the following?

- A. Billed amount
- B. Paid amount
- C. Network savings
- D. Non-Medicare COB savings
- E. Medicare COB savings
- F. Negotiated savings

Describe your firm's ability to meet this requirement.

3.7.45. Does your firm have the capability to audit spousal responses to COB when they answer "no" that they are not eligible for coverage with their employer? Discuss any limitations you may have.

3.7.46. There will be times when the DCH may require a system enhancement to the claim administration system that will enable claims to be more accurately and efficiently processed. Explain how this request will be implemented and the average time requirement associated with the system enhancements.

3.8. CLAIM ADMINISTRATION SYSTEM

3.8.1. Will your firm be adjudicating all five products on the same claim administration system? If not explain which products are paid on which claim system and fill out the following table for each system. Also, explain if there are separate claims administration systems for different components of a plan, e.g. HRA, pharmacy, etc. Complete the following table for each separate system.

Name of System	
Date of last upgrade	
Date of next upgrade	
Is the system maintained internally or externally?	
How often is the system backed up?	

Are there back-up systems in place?	
How long has your organization been using this system?	
How frequently is routine regular maintenance performed and when is it done?	
System availability to teleworkers?	
Percentage of 2007 system downtime	

3.8.2. Describe your claims administration system as it relates to the following HRA requirements:

- A. The pro-ration of the HRA for mid-year hires
- B. The ability to handle different family tier structures (e.g., two tier, three tier, four tier)
- C. The ability to administer a cap on rollovers
- D. The ability to administer health promotion incentive contributions to the HRA
- E. The ability to handle individual deductibles when there is family coverage (e.g. does entire family deductible have to be satisfied before benefits are paid or can individual deductible be satisfied when family coverage exists?)
- F. The end of the year rollover amounts if a Member decides to change options

3.8.3. Can your firm administer the current plan designs for the HRA, HDHP, HMO and PPO? Please review the current plan designs provided as EXHIBIT 1 (Section 6.0) for the HRA, HDHP, HMO and PPO and list any provisions you cannot administer on an automated basis by your claims administration system.

3.8.4. Describe how your firm will maintain documented, state-of-the-art software to accurately process transactions submitted on behalf of SHBP Members.

3.8.5. Describe how your firm will maintain a claims management system that can identify date of receipt (the date the Offeror receives the claim as indicated by the date-stamp), real-time-accurate history of actions taken on each provider claim (e.g., paid, denied, suspended, appealed, etc.), and date of payment (the date of the check or other form of payment).

3.8.6. Confirm you will agree to obtain DCH approval for any release of data regarding claim and membership information not specifically authorized by the DCH.

3.8.7. Confirm you have or will implement a firewall to secure information about utilization, pricing information or other information that is useful to Offeror in marketing or expanding non-State business relationships. Discuss any limitations in meeting this requirement.

3.8.8. Confirm you will provide all requirements for electronic transfers of data to and from the DCH and make provisions for other DCH contractors to test and use electronic transfers of data for interfaces as required.

3.8.9. Describe your firm's ability to process paper claims "on-line" or process claims "real time" for manually keyed initial claims and adjustments. Your claim process must include imaging, scanning, or other EDI media, an appropriate balance of on-line and batch processing applications is required.

3.8.10. Describe your firm's use of on-line help screens and user manuals to increase the number of questions/problems that can be resolved without reference to paper manuals.

3.8.11. Describe your firm's enterprise data warehouse (EDW) component for ease in generating user-defined reports and ad hoc reports for the SHBP. Describe the process of transferring data to the warehouse and ensuring the SHBP data will be HIPAA compliant and subject to confidentiality and

data security policies of the DCH. Describe whether software used is capable of analyzing and producing reports for the physician and hospital profiling. In addition, describe if the EDW is capable of producing utilization and pricing information in various categories.

3.8.12. Confirm you will absorb all costs related to the change in systems or due to changes in state or federal law, rules, and/or regulations.

3.8.13. Describe how your claims system integrates with Member service and utilization management systems.

3.8.14. Please provide the following information regarding system upgrades.

- A. Is the system accessible at the time of upgrades?
- B. What is standard timeframe for upgrades?
- C. Do you pre-notify the client?
- D. What is timeframe of notification?
- E. How will the SHBP be affected (time, cost, service, etc.) by upgrades?
- F. Give a description of the organization's success, since using this system
- G. How many upgrades have been performed since the initial usage?
- H. How long was your system down in CY2007 for routine maintenance/upgrades?
- I. How many hours was your system down in CY2007 for unscheduled downtime?

3.8.15. Describe your firm's disaster backup and recovery plan, including off-site location for backup information in the event of a disaster. The description should include the procedure for notifying the SHBP when the disaster plan is invoked.

3.8.16. In the event of a disaster at the SHBP, confirm that the Offeror shall agree to handle additional member and benefit coordinator phone volume and eligibility updates to support the SHBP business continuity.

3.8.17. Describe how you will meet the SHBP's requirements to retain data and documents stored and maintained in your claims system on-line for twenty-four (24) months and off-line for no less than 5 years.

3.8.18. Describe how your firm will employ a function that manages access to information contained in your system while restricting access based on various hierarchical levels of system functionality and information and blocking system access after repeated failed access attempts.

3.8.19. Offeror shall agree to authorize the DCH and the State Department of Audits personnel to have access to detailed EDP system documentation and all subsystems relevant to services provided for the DCH at the Offeror's facilities. Access must be granted within two (2) weeks of the request. Provide a detailed explanation if you cannot meet this requirement. Documentation must include, but not be limited to:

- A. File structures
- B. Program libraries
- C. Program logic
- D. Program edits
- E. Establishment of fee schedules
- F. Interface programs or subsystems

3.8.20. Will your firm accommodate the SHBP's requirement to allow remote access to a test region for the claims adjudication system? If not, why? Describe any limitations associated with this requirement.

3.8.21. Will you allow view access of claims records within the claims system to identified SHBP staff? If not, why? Describe any limitations associated with this requirement.

3.8.22. Is your firm willing and able to customize the software used (if needed) in your system to meet the SHBP's business needs? If not, why?

3.8.23. Offeror must have the ability to submit data and work with the DCH data warehouse contractor. Any data exchanged must be in a layout, medium, and frequency defined and approved by the DCH. Any costs associated with the development and exchange of data interfaces is the financial responsibility of the Offeror. Confirm your ability to meet this requirement.

3.8.24. Describe your test region. Does it mirror or substantially mirror the production region? Describe how the test and production regions are kept synchronized.

3.9 FRAUD AND ABUSE

3.9.1. Offeror shall have a written Program Integrity process, including a mandatory compliance plan designed to guard against fraud and abuse. This Program Integrity Policies and Procedures must include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of fraud and abuse in the administration and delivery of services under the Contract. Provide a copy of your current Program Integrity policy and procedures as required in Section 3.18.4.2

3.9.2. Offeror shall designate a Compliance Officer who is accountable to the Offeror's senior management and is responsible for ensuring that policies to establish effective lines of communication between the Compliance Officer and the Offeror's staff, and between the Compliance Officer and the DCH staff, are followed. Describe in detail how you will meet this requirement.

3.9.3. What provisions do you have for internal monitoring and auditing of reported fraud and abuse violations, including specific methodologies for such monitoring and auditing?

3.9.4. Describe your firm's policies and procedures to ensure that all officers, directors, managers and employees know and understand the provisions of the Offeror's fraud and abuse compliance plan.

3.9.5. Describe your firm's policies and procedures to establish a compliance committee that periodically meets and reviews fraud and abuse compliance issues.

3.9.6. Provide your firm's written standards for organizational conduct. Describe effective training and education for the Compliance Officer and the organization's employees, management, board members, and subcontractors relative to fraud and abuse.

3.9.7. Describe information about fraud and abuse identification and reporting given in provider and Member materials.

3.9.8. Describe for any suspected fraud and abuse reports provisions for investigation of the report, any corrective action, and follow-up.

3.9.9. Describe your system's edits or triggers for identifying discrepancies and fraud in the following areas:

- A. Aberrant billing
- B. Abuse
- C. Up-coding
- D. Misrepresentation
- E. Experimental/investigational procedures

- F. Cosmetic procedures
- G. Chiropractic care
- H. Pharmacy

Please include any other areas of investigation not mentioned above.

3.9.10. How many claims administration staff will be assigned to detect, fraud, abuse, and over-utilization of services for the SHBP account? What processes are used to detect, fraud, abuse, and over-utilization? Describe the process used in researching to determine if fraud and/or abuse has occurred and pursuit of monies if requested. Describe two (2) examples of focused fraud and abuse audits conducted by your firm over the past twelve (12) months, including details on the results and communication to providers, if applicable.

3.9.11. Member Services Representatives (MSRs) and other staff have access to highly confidential and protected information under the guidelines of HIPAA. What types of background checks are performed during the hiring process for new employees?

3.9.12. Describe your Fraud and Abuse audit process for pharmacy claims submissions including both electronic point-of-sale claims as well as paper claims.

3.9.13. Does your firm have a Fraud and Abuse audit process for high dollar claims? Describe in detail.

3.9.14 Describe your firm's procedures for the detection of fraud and abuse that includes, at a minimum, the following:

- A. Claims edit
- B. Post-processing review of claims
- C. Provider profiling and credentialing
- D. Quality control
- E. Utilization management

3.9.15. Offeror shall cooperate and assist any State or Federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud and abuse cases, including permitting access to your place of business during normal business hours, providing requested information, permitting access to personnel, financial and medical records (at no charge to DCH), and providing internal reports of investigative corrective and legal actions taken relative to the suspected case of fraud and abuse. Describe how your firm will meet this requirement.

3.9.16. Offeror shall work closely with the DCH's Office of Inspector General (OIG) program integrity staff to ensure that the activities of one entity do not interfere with an ongoing investigation being conducted by the other entity. Describe how your firm will meet this requirement.

3.9.17. Offeror shall report known or suspected fraud and abuse cases to the OIG unit and the SHBP staff. You must not investigate or resolve the suspicion without making the DCH aware of, and if appropriate involved in, the investigation, as determined by the OIG. Describe how your firm will meet this requirement.

3.9.18. Offeror shall submit a fraud and abuse report to the OIG on a monthly, quarterly and annual basis of suspected, reported, and investigated fraud and abuse cases. Confirm you will meet this requirement.

3.10. ELIGIBILITY

The SHBP currently uses the Membership Enrollment Management System (MEMS) to create and maintain membership eligibility information. MEMS core functions, besides the maintenance of eligibility records, includes billing and accounting functions. The SHBP produces a proprietary eligibility file from MEMS that is described in the file layout in EXHIBIT 2. The SHBP sends a full eligibility file of enrollment once a month to the current contractors. The SHBP produces a nightly change file, in the same file layout, that has only the additions, deletions, and changes to the membership records.

3.10.1. Offeror (or if using subcontractor) must agree to accept and process the eligibility updates from the DCH for both health and pharmacy eligibility. You must accept and process nightly eligibility change files from the SHBP, as well as receive and process full files for monthly comparisons with appropriate reporting on discrepancies. The files will be in a layout and medium designated by the SHBP and you must accept eligibility file layout changes and the costs of any systems development and testing necessary. Your system must currently be capable of automatically verifying eligibility during adjudication. Confirm your ability to meet this requirement and describe any limitations.

3.10.2. The SHBP file includes up to six segment lines of eligibility for employees and dependents. Confirm your firm can accept a minimum of six segment lines of eligibility sent by the SHBP, including retro-termination dates, future termination dates, and future coverage segments.

3.10.3. The SHBP file includes the actual termination date of an employee or dependent. Can your firm accept the true termination dates sent by SHBP, including retro-termination dates, instead of automatically terminating coverage if the record is absent from the file (term by absence)? Confirm that you will accept true termination dates and create an error report for records missing from the file.

3.10.4. Confirm that you have Connect: Direct and secure File Transfer Protocol (FTP) and that you can accommodate the file format provided in this RFA. All costs incurred by you for programming changes and testing in acceptance of the current eligibility file and access to Connect: Direct will be paid by the Offeror.

3.10.5. Describe your organization's process for acceptance of full file eligibility feeds. Include the steps taken to validate the file upload/update and the notification, if any, to SHBP that the file was successfully updated.

3.10.6. Explain Offeror's process of working error reports generated from the file loads.

3.10.7. DCH expects you to stop an eligibility upload in the event that established error thresholds are exceeded. Please confirm you can comply with this requirement. Describe how you propose to notify SHBP in the event an eligibility upload is aborted. Will the previous file be reinstated?

3.10.8. Does Offeror accept and process eligibility loads each calendar day of the year unless otherwise specified by the DCH?

3.10.9. SHBP requires view only on-line access to the SHBP's eligibility on your system. Confirm your willingness and ability to accommodate this request with training for the on-line tool and on-going support for the SHBP staff.

3.10.10. Describe Offeror's flexibility to accommodate an alternate Member identification (ID) number that contains nine characters with a combination of alpha and numeric numbers (e.g. A999W999). Confirm your firm's ability to accommodate an alternate Member ID used by the SHBP on all correspondence and ID cards. If not, explain why.

3.10.11. Medicare eligibility for Parts A, B, and D are included in the SHBP eligibility file. Confirm you are capable of updating and storing all three parts of Medicare in your system to be used for COB.

3.10.12. Can your staff perform manual updates between standard file uploads when authorized to do so by SHBP? Are you willing and able to provide the SHBP with a staff person to provide real time emergency eligibility updates for a same day turnaround for medical and pharmacy? If different please explain.

3.10.13. SHBP covers a disabled dependent age 19 and older if the dependent was disabled as a covered SHBP Member before age 19. Please describe the process for determining whether a dependent is disabled, including a description of the clinical guidelines used, the credentials of the staff making the determination, the appeals process, and the frequency of review for continued disability and process for notifying SHBP.

3.10.14. SHBP covers dependents age 19 and older if enrolled full-time and under the age of 26. Describe your firm's process for determining eligibility for these dependents including the frequency enrollment are verified and the process to update the SHBP of the dependent's eligibility status. Do you use the national student clearing house?

3.10.15. Please explain the process for mail that is returned to your office as a result of a wrong address or marked as 'no forwarding' address.

3.11. MEMBER SERVICES

Note: If you have a separate Member services group for your Medicare PFFS plan or your HRA plan please provide the requested information below for each Member services group.

3.11.1. Confirm that you will operate a dedicated unit for all products with a toll-free dedicated Member services telephone line to answer questions from Members between the hours of 8:00 a.m. and 6:00 p.m. Eastern Standard Time (EST), Monday through Friday, excluding holidays specified by the DCH. If the Offeror does not have a dedicated provider services line, confirm that the Member services telephone line will be able to handle provider questions.

3.11.2. What are the average years of experience for your firm's Member services staff? What was your average Member services staff turnover rate for 2006 and 2007? Describe any initiatives your firm has implemented to reduce Member services staff turnover.

3.11.3. Describe the information screens that are available on-line to the MSRs (e.g., claims data, provider information, etc.). Confirm that you have a tracking system that tracks Member inquiries and written correspondence. Does your current process require MSRs to log calls? Explain or describe the following:

- A. The process that your current system uses to track calls/correspondence.
- B. What type of "tickler file" is in place that the MSR has for follow-up to a Member's/provider's inquiry?
- C. What type of monitoring or quality checks are in place to assure a resolution for the customer?

3.11.4. Confirm that you will submit telephone policies and procedures on managing calls and correspondence from Members and providers to the DCH staff for review and approval within sixty (60) calendar days of Contract Award.

3.11.5. Confirm that you have special telephone features for the hearing impaired.

3.11.6. Indicate the availability of special services to address non-English speaking callers (e.g. French, Hispanic, Italian) through a translation service. Confirm that you will have, at a minimum, one (1) Spanish speaking person on site in your Member services unit at all times.

3.11.7. Describe the investments that your firm has made in call center technology over the past three (3) years that have enhanced customer service and Member satisfaction.

3.11.8. Describe your firm's process for providing training to Member services staff in all areas, including, but not limited to, covered services, the provider network, and any prior approval or pre-certification requirement related to SHBP. Confirm that you will allow the DCH to review your training program/materials, etc and attend/monitor the training classes on an on-going basis? Describe your ideas for partnering with the DCH in the training process.

3.11.9. Confirm that you will have a dedicated retiree line with a Member services staff trained to assist the retired population with coordination of benefits related to Medicare Parts A, B and D.

3.11.10. Confirm that you will record all calls and keep recording for 24 months. Discuss any limitations with meeting this request.

3.11.11. Confirm if you are willing and able to allow the DCH staff to have call monitoring capability for live and/or recorded calls remotely and onsite. If recorded calls, allow SHBP to select a sampling on a weekly basis. Please describe if your firm's system is capable of allowing the SHBP staff to hear a specific call made to your call center if the SHBP staff person can provide the date, time and MSR involved.

3.11.12. Complete the table below indicating the access the SHBP, Members, and providers will have

	Geographic Location	Hours of Operation	Is this function outsourced?	If outsourced, provide name of the outsourcer
Member Service Center				
Claims Administration Office				
Account Management Office				
Utilization Management Office				
Case Management				
Disease Management				
Behavioral Health				
Pharmacy Benefit Manager				
Medicare Advantage				

to your firm or subcontractor that will be serving the SHBP.

3.11.13. Confirm that you will report Member services call stats on a weekly, monthly and quarterly basis.

3.11.14. Confirm that you will conduct quarterly and annual Member satisfaction surveys for each product.

3.11.15. Affirm your firm's compliance with the HIPAA Privacy and Security Rule. You must attach a copy of your firm's HIPAA compliance procedures and protocols that meet the HIPAA Privacy Rule and the HIPAA Security rule. In your response, specifically address how you safeguard for individually identifying information in your Member services department. You must accept responsibility for any fines assessed to the SHBP due to non-compliance with current guidelines for HIPAA due to no fault of the SHBP.

3.11.16. Can the MSRs transfer a call (without a Member having to terminate the call and then call back) to a different number for calls related to:

- A. Claims (both medical and pharmacy)
- B. Medical Management
- C. Grievance Department
- D. Behavioral health/substance abuse
- E. Pharmacy
- F. SHBP call center
- G. Other (specify)

3.11.17. Please complete the table below. Are MSRs responsible for:

	Yes	No
A. Phone coverage for Member inquiries		
B. Phone coverage for provider inquiries		
C. Online claim re-adjudication		
D. Act as back log claim adjusters		
E. Telephonic correspondence with Members		
F. Written correspondence with Members		
G. Other (specify)		

3.11.18. Describe your firm's process for handling Member claim appeals. Include the different levels of appeals, timeframes for filing and response time to Member.

3.11.19. Confirm that you will offer a voluntary external independent review in the event a Member has exhausted all levels of appeals for denied claims.

3.11.20. Offeror must provide monthly, quarterly and annual appeals reports to the DCH. Do you have the capability of tracking the number of appeals and grievances received, overturned and upheld. In addition, is your firm able to track the types of appeals, (e.g., types of plan exclusion, balance billing issues)?

3.11.21. What is your process for handling grievances? Provide the response time to a Member if a grievance is filed.

3.11.22. Explain the procedure for tracking Members and providers involved in fraud and abuse cases, including the steps taken when these cases are identified.

Subscriber Identification (ID) Card

3.11.23. Confirm that you will mail, via surface mail, a Subscriber ID card to all Subscribers ten (10) business days before the beginning of each year based on the information provided by the DCH as a result of open enrollment. Confirm that you will mail ID cards to newly enrolled Subscribers within five (5) business days of receiving notice of enrollment from the DCH. If the Subscriber enrolls his/her spouse, confirm that you will send a minimum of two (2) ID cards to the Subscriber and any additional cards as requested by the Subscriber. Confirm that you will re-issue the Subscriber ID card within ten (10) business days of notice if a Subscriber or spouse reports a lost card or for any reason that results in a change to the information disclosed on the Subscriber ID card.

3.11.24. Confirm your ability to provide a Subscriber ID card that at a minimum includes the information required under State law as indicated in the following:

- A. The Subscriber's name and date of birth;
- B. The names of all dependents covered and their dates of birth;

- C. The Subscriber's random identification number; and
- D. Offeror's twenty-four (24) hour, seven (7) day week toll-free eligibility and pre-certification services telephone number and applicable co-payments and deductibles for services. List any elements not currently included.

3.11.25. Confirm you will submit a front and back sample Member ID card to the DCH for review and approval within sixty (60) calendar days of Contract Award.

3.11.26. Confirm that your firm will produce weekly and monthly reports on the number of ID cards produced and the number of ID cards rejected during the abstraction process.

3.11.27. Does Offeror require a separate ID card for pharmacy services?

3.12. MEMBER COMMUNICATIONS AND WEB TOOLS

A. Summary Plan Description (SPD) Requirements

3.12.1. Confirm that you will provide each employing entity copies of the Summary Plan Description (SPD) as needed for Open Enrollment and newly hired employees and mail, upon request, the SPD to retired employees and make SPD available via electronic means to the SHBP membership.

3.12.2. Confirm that you will submit to the DCH for review and approval the SPD within ninety (90) calendar days of Contract Award. Further, you must agree that the SPD will be provided to the DCH for review and approval within ninety (90) calendar days prior to publication and distribution each calendar year. Please confirm your ability to meet this requirement.

B. Provider Directory Requirements

3.12.3. Offeror must mail or ship Georgia provider directories to all employing entities an amount equivalent to 10% of the employee population of that entity (the membership information to be provided by the SHBP). Confirm you will mail provider directories upon request to Subscribers within ten (10) business days of receiving the request for the directory. Describe any limitations with this request.

3.12.4. How often are paper-based provider directories updated?

3.12.5. Confirm that your firm is able to provide the following minimum data elements for the provider directories:

- A. Provider or Facility Name
- B. Provider Address and telephone number
- C. Medical Group
- D. Practicing Specialty(ies)
- E. Specialties Board Certified
- F. Providers that are not accepting new patients
- G. Age/gender limitations
- H. Languages Spoken

C. Web Tools

3.12.6. Describe your Member website capabilities including whether your member website includes the following:

- A. Provider directory and provider search (physician, hospital, pharmacy, and ancillary providers)
- B. Map Quest directions to provider's office
- C. Ability to make a doctor's appointment online
- D. Ability to review claims payment status online
- E. Ability to review a history of claims payments (medical and pharmacy), including deductible status, out-of-pocket maximum status and HRA status
- F. Ability to review or print out a Health Statement with a history of claims payments
- G. Ability to see a summary of the SHBP plan design and review the SHBP SPD
- H. Ability to print ID cards
- I. Ability to take an online personal health assessment (PHA) and receive a summary report of findings
- J. Ability to contact Member Services online
- K. Ability to review the SHBP appeals process and file an appeal online
- L. Ability to review the fraud and abuse notification process
- M. Physician and hospital quality and/or outcomes data
- N. Physician and hospital ranking or premium designation
- O. Physician and hospital pricing data by procedure by provider
- P. Pharmacy pricing data, including pricing of all drugs within a therapeutic class and pricing by pharmacy
- Q. Preferred Drug List
- R. Information about diseases and conditions
- S. Treatment cost estimator
- T. List of covered dependents

3.12.7. Offeror shall maintain a Member website that allows Members to access a searchable provider directory that will be updated, at a minimum, weekly. Confirm your ability to meet this requirement.

3.12.8. Do you have the capability for Members to submit questions and receive responses through your Member website? If yes, describe the process and tools used by the Member. Responses should be made within twenty-four to forty-eight (24–48) hours. Please describe any limitations regarding this requirement.

3.12.9. If you have a physician and/or hospital ranking system please describe your process for ranking providers. How much of the ranking is based on cost and how much on quality? How is quality information used to form the ranking?

3.12.10. Confirm your ability to submit monthly Member website activity reports to the SHBP. Reports should include at a minimum the following categories:

- A. PHA activity (include member's name, SSN, and date of assessment)
- B. Health information
- C. Claims inquiry
- D. Request for EOB
- E. Provider search
- F. Provider price look-up
- G. Provider quality look-up
- H. Other

3.12.11. Can your Member website link to the DCH website for plan specific information? Can you provide single sign on?

3.12.12. Can your firm provide a monthly report of PHA utilization including the Member's name, SSN, and the date of completion of the PHA?

3.12.13. Can your firm administer incentives in the HRAs, such as money added to account for compliance with annual physicals and other age/sex recommended clinical guidelines? Provide examples of what you are administering for other clients.

3.12.14. Do you have an online plan selector tool to help eligible employees determine their plan election during the open enrollment period and for new hires? Can your plan selector tool include health plans from other contractors? Can claims information (medical and pharmacy) be downloaded into the tool?

3.12.15. Are you able to message Members on more cost effective treatment options? For example, if a Member is taking a specific cholesterol lowering agent will you message the Member with the amount he/she could save if he/she changed to generic or split pills, or purchased via a 90 day retail program?

3.12.16. Is Member messaging available electronically, telephonically, and/or through the mail? What types of messages do you send Members?

3.12.17. What steps have your firm taken toward improving Health Information Technology (HIT)? Describe your progress, state of development, and future commitment in terms of education, communication, awareness, and integration with utilization management.

3.12.18. Has your firm taken steps toward development of Personal Health Records (PHR)? Please describe your firm's PHR capabilities. Do you automatically load information in the PHR from your claims system? Do you load information into the PHR from your PHA? What percentage of your Members has a PHR? How many of those are actively using the PHR, (e.g. adding additional information, providing the PHR to a provider, etc.)?

D. Open Enrollment

3.12.20. Offeror shall participate, as determined by the DCH, in open enrollment meetings, retiree meetings, and benefit fairs held each plan year (on average 50 - 60 meetings) at no cost to the DCH. What support will you provide the DCH during open enrollment? This requirement includes, but is not limited to posters, brochures, Internet websites, and any materials that contain statements regarding the benefit package and provider network-related materials. Neither the Offeror nor its subcontractors shall distribute any marketing materials without prior, written approval from the DCH.

3.12.21. Confirm that you will share in the expense of the open enrollment Health Plan Decision Guides. The Contractor's share will be calculated in two parts using the following formula:

$$\begin{aligned} & (\text{Total cost} \times 25\%) \div (\text{Number of health plan Contractors}) \\ & \quad \text{Plus} \\ & (\text{Total cost} \times 25\%) \times (\text{Percentage of Subscribers enrolled in each health plan option}) \end{aligned}$$

3.12.22. Discuss how your firm will promote programs to enhance the general health and well-being of Members. You must provide all health promotion materials available to Members, advice on any wellness clinics or community-sponsored health fairs, and any education materials provided to Members and healthcare providers. You will be expected to participate in any DCH sponsored health events. Please confirm that you can accommodate this request.

3.13. PHARMACY SERVICES

3.13.1. The DCH requires a comprehensive retail pharmacy network to include 24-hour pharmacies. Give a detailed description of your pharmacy network. Your response should be related to retail pharmacies only and not institutional pharmacies. As part of your response, specifically address Geo-Access, network adequacy, provider credentialing, contracting requirements, provider disciplinary processes, as well as, provider relations resources/communication/ and approach.

3.13.2. Does your firm (or your pharmacy benefit manager (PBM) subcontractor) own a retail, mail order, or specialty pharmacy? If so, what firewalls are in place to ensure provider compliance with network requirements and to ensure no preferential treatment is given to such an entity?

3.13.3. Give a brief overview of your pharmacy claims adjudication platform/system. At a minimum, speak to the capacity and scalability of the current system, NCPDP standards utilized for claims processing, historical downtime in the past twelve (12) months, redundancy, methodology for and frequency of system enhancements and modifications, as well as your organization's strategic plans to keep the system current with new claims processing and industry standards.

3.13.4. Describe your pharmacy benefit management disaster preparedness and recovery plan. Include the frequency at which such a plan is tested and the results of the last test.

3.13.5. How does your organization define "electronic prescribing"? Does this include the transmission/receipt of prescriptions via fax server as well as through the NCPDP Script Standard?

3.13.6. Do you have current business relationships with any of the business partners involved in the e-prescribing effort? If so, describe those relationships and the value this will bring to the SHBP.

3.13.7. Do you have a mechanism that would allow incentives to be paid to pharmacy providers who accept electronic prescriptions? If so, is this based upon a per electronic prescription received basis or is this a blanket incentive payment if the pharmacy accepts any electronic prescriptions? Please describe.

3.13.8. Do you have a mechanism that would allow incentives to be paid to prescribers who issue electronic prescriptions? If so, is this based on a per electronic prescription transmitted basis or is this a blanket incentive payment if the prescriber utilizes any electronic prescribing technology? Please describe.

3.13.9. Describe the efforts your firm would undertake to support an e-prescription effort for the SHBP and identify which components would be included in your base offering. **(Do not include pricing in your response).**

3.13.10. Describe your pharmacy claims adjudication system's flexibility as it relates to editing for:

- Quantity limits by:
 - A. Prescription
 - B. Day
 - C. Month
 - D. Year
 - F. Lifetime
 - G. Drug grouping (e.g. drug grouping, maximum of 18 units of oral triptan products per 30 days across all such products – Imitrex, Frova, Axert, Amerge, Zomig, etc.)
- Processing of multi-ingredient compound claims as allowed by NCPDP v5.1
- Maximum Days supply
- Refill-too-soon

- Therapeutic duplication
- Age limits
- Gender limitations
- Drug-Disease contraindications
- Pregnancy edits
- Step therapy edits
- Percentage co-pay with minimum and/or maximum
- Fixed dollar co-payments with minimum and/or maximum
- Individual and family deductibles
- Monthly, quarterly, annual drug benefit cap
- Split or cusp claims (partial plan responsibility and partial patient responsibility once patient reaches cap)
- Lower of usual and customary charge vs. contract rate vs. co-pay at retail
- Fixed dollar or zero dollar co-payments and percentage co-insurance as determined by drug in the same benefit
- Stop losses-individual and family
- Drug Disease edits
- High/Low Dose
- Maximum Duration edits

3.13.11. If there were Member maximum lifetime benefits associated for the combined medical and pharmacy expenditures, how would your system support the management of that lifetime maximum? Likewise, how does your system prevent duplicate payment for drugs covered separately under the medical and pharmacy programs?

3.13.12. Describe the capabilities and responsiveness of the pharmacy technical call center designated to assist pharmacy providers with inquiries regarding claims adjudication issues.

3.13.13. Describe Offeror's ability to apply on-line electronic step therapy edits and how the system will support allowing a claim for a specific drug to adjudicate without intervention if claims history includes prior treatment with a specified drug or group of drugs. Are there other pertinent data elements your step therapy adjudication logic considers (e.g., diagnosis, CPT codes, pre-scriber specialty code, etc.)?

3.13.14. Describe Offeror's pharmacy claims processing system's ability to accept ICD-9 codes on the pharmacy point-of-sale system and incorporate that information into automated stepped therapy or processing of claims with prior authorization requirements. Likewise, what is the Offeror's reporting ability using point-of-sale submitted ICD-9 information.

3.13.15. Describe Offeror's ability to provide customized messages back to pharmacies to further clarify the reason for a claim disposition or to provide additional information to the provider. Specify any size limitations (number of bytes) that your organization places on such fields. Additionally, can these messages be posted to paid as well as denied claims? Can this field be used to communicate preferred drug alternatives to providers when they fill a prescription for a non-preferred medication? To what extent will SHBP be able to customize these messages? Please list any limitations surrounding this functionality.

3.13.16. Describe Offeror's approach to the development of prior authorization criteria; deployment of such criteria; and timely modification of the criteria based upon new clinical evidence/standards of practice/etc.

3.13.17. What is your average turnaround time for pharmacy prior authorization requests? What is your average turnaround time for pharmacy appeal requests?

- 3.13.18. What training and educational background is required of the individuals conducting pharmacy prior authorization reviews? Are pharmacists available to handle escalated clinical calls/questions?
- 3.13.19. What resources (pharmacists, physicians, specialists, etc.) are available to conduct reviews of prior authorization denial request appeals?
- 3.13.20. What are the hours of operation of the pharmacy prior authorization desk?
- 3.13.21. Describe in detail your firm's paper claims tracking/processing/adjudication system and processes for Member and provider submitted claims. Include how claims are handled when the submission form is incomplete or not in the standard format.
- 3.13.22. What is your average turnaround time for the payment of a paper claim from the date of receipt to payment?
- 3.13.23. Describe the criteria used to screen claims for possible duplicates.
- 3.13.24. What is included in reports provided to a client listing paper claims activity?
- 3.13.25. Are there any point-of-sale (POS) benefit plan edits which are not routinely applied to paper claims? If so, provide detail on those edits. Also provide a description of your ability and/or limitations to apply the full POS benefit design edits to the SHBP paper claims, if requested.
- 3.13.26. Offeror must provide COB functionality in your claims adjudication system, including at the POS non-Medicare and Medicare COB, as appropriate. Describe your organization's ability to automate COB adjudication process at POS for "secondary payer" claims (e.g., balance of claim after the primary payment has been applied).
- 3.13.27. Describe Offeror's ability to provide information related to the Member's COB (plan name/other payer information or phone number) in the free text field with any claim that is denied due to the presence of COB for the Member.
- 3.13.28. DCH currently utilizes a "wrap around" option for its retirees enrolled in a Medicare D plan. Please confirm your ability to coordinate benefits using the wrap around feature and that secondary payer data is routed to the TrOOP contractor for Centers for Medicare and Medicaid Services (CMS).
- 3.13.29. Does your firm contract directly with the pharmacy network or is it subcontracted? If subcontracted, with whom? Provide details of agreement.
- 3.13.30. Describe your firm's process for notifying SHBP of terminations or suspensions of pharmacies from the network.
- 3.13.31. Does your Member website offer a pharmacy locator link that can be placed on the SHBP website?
- 3.13.32. Briefly describe the programs Offeror has in place to audit pharmacies for abuse patterns, discover over and under prescribing, and/or discover potential fraud and abuse. Are these services provided by your organization or sub-contracted to an outside contractor? Please affirm your understanding and commitment to adhere to the Georgia Pharmacist Bill of Rights. (Response limited to two pages).
- 3.13.33. Briefly describe tools (specify those available electronically versus hardcopy) available to Offeror's MSRs to respond to inquiries from Members and providers regarding specific plan designs (including covered drugs, prior authorizations and suggested substitutions).

- 3.13.34. Describe in detail the availability of a pharmacist for Member and provider (physician, prescriber, and pharmacist) inquiries. Specifically address whether those pharmacists are first line to answer any calls or are involved only under special conditions. What hours are the pharmacists available?
- 3.13.35. How do you proactively notify and/or advise clients of drugs “in the pipeline” and their potential cost, benefit, and drug coverage implications? Include methods utilized by your firm’s clinical staff to learn of these new products.
- 3.13.36. Describe how Offeror will promote generic substitution. What is your generic substitution rate?
- 3.13.37. Briefly describe how Offeror evaluates the effectiveness of programs to monitor, measure, and influence physician-prescribing habits.
- 3.13.38. Describe the Offeror’s Preferred Drug List (PDL) proposed for the SHBP. Is this preferred drug list open, managed, or closed?
- 3.13.39. What is the composition of your firm’s national Pharmacy and Therapeutics (P&T) Committee, including the number of physicians and their specialties? Please outline their responsibilities and how often the P&T Committee meet. Describe your process to address new drug products (both brands and generics) that arrive on the market prior to a PDL update.
- 3.13.40. Give a detailed description of your firm’s process to determine drug status on the PDL.
- 3.13.41. How is the PDL communicated to physicians, pharmacists, Members and other plan stakeholders? How often are changes made to the PDL? How are changes communicated to clients, Members, pharmacy providers, physicians and other stakeholders? What is the timing for the notification?
- 3.13.42. Provide a general description of your firm’s rebating process.
- 3.13.43. Offeror must agree to pass-through 100% of pharmacy rebates to be paid across all claims: generic, brand, and specialty. Rebates will be paid no less frequently than quarterly. Confirm your ability to meet this requirement.
- 3.13.44. Offeror shall agree to pass-through 100% of its negotiated pharmacy provider discounts, MAC rates and dispensing fees. Offeror will not retain margin or “spread” on any of its pharmacy reimbursement contracts. Confirm your ability to meet this requirement.
- 3.13.45. Offeror shall agree to offer a guaranteed minimum brand and specialty drug discount based on the required full network pass-through arrangement. Confirm your ability to meet this requirement.
- 3.13.46. Offeror shall offer guaranteed overall effective generic discount, inclusive of the Offeror’s MAC list reimbursement rates. Confirm your ability to meet this requirement.
- 3.13.47. How flexible is your firm’s system at creating new pharmacy benefit designs? Identify down to what level new benefits can be designed (e.g., account, group number level, plan level)
- 3.13.48. What is the process for clients to request benefit design changes and the general timeframe necessary to implement benefit design changes.

- 3.13.49. Currently SHBP Members enrolled in a HMO can obtain a ninety (90) day supply of medications for two (2) co-payments at the retail pharmacy. Confirm that you are willing and able to support this type of benefit design on all products with co-pays.
- 3.13.50. Describe the issue resolution process including turn-around time and liability for benefit design errors that may occur.
- 3.13.51. Describe Offeror's approach for producing clinical, financial, and benefit design analytical reports and models.
- 3.13.52. Offeror shall agree to allow the DCH, if deemed necessary, to audit all financial terms including discounts, fees and rebates. Confirm your ability to meet this requirement.
- 3.13.53. What is Offeror's source for average wholesale price (AWP)? Offeror shall agree the AWP used to price the claim will be the one associated with the actual NDC-11 submitted by the pharmacy and used to fill the prescription. Confirm your ability to meet this requirement.
- 3.13.54. Offeror shall agree in the event there are changes in the marketplace to the baseline measure used for the ingredient costs of drugs (i.e., AWP); the terms will be adjusted accordingly to provide an equivalent price. The Offeror has to provide notice to the DCH and provide a means for the DCH to evaluate whether the revised terms proposed are acceptable. Confirm your ability to meet this requirement.
- 3.13.55. Offeror shall adjudicate all retail claims at the lesser of a) the contracted network discount+dispensing fee, b) MAC+dispensing fee, c) the provider's usual and customary (U&C) price, or d) the submitted ingredient cost plus submitted dispensing fee. Confirm your ability to meet this requirement.
- 3.13.56. Offeror shall comply with all requests by the DCH to communicate with network pharmacies to ensure appropriate notification and education of pharmacies. Confirm your ability to meet this requirement.
- 3.13.57. Offeror will NOT assess a dispensing fee for claims priced at U&C. Confirm your ability to meet this requirement.
- 3.13.58. Offeror agrees to cooperate in transitioning the DCH at the contract's end to another Contractor. No additional charges will be assessed to the DCH to support transitioning to a new Offeror for run-out services other than those already included in administrative fees, including but not limited to, open prior authorization files, drug coverage documentation, custom formulary files, claims extract, etc. Confirm your ability to meet this requirement.
- 3.13.59. Offeror agrees there are no other programs and/or services for which the DCH will be charged fees that are not disclosed in the Financial Proposal. Confirm your ability to meet this requirement.
- 3.13.60. Offeror may NOT include claims that were priced using the U&C price (submitted price, etc.) or savings associated with any drug utilization review program, which includes but is not limited to switching from brands to generics, etc., when calculating guarantees. Note: Zero balance claims pricing logic is not allowed; thus it may not be used in the calculation of guarantees. Confirm your ability to meet this requirement.
- 3.13.61. Offeror shall agree the guaranteed discount off AWP will not exclude any products from the calculations (e.g. generics during their exclusivity period, "specialty" drugs, etc). Confirm your ability to meet this requirement.

- 3.13.62. Offeror shall provide quarterly reconciliation of all guaranteed financial terms including discounts, fees, and rebates. Confirm your ability to meet this requirement.
- 3.13.63. Offeror agrees to use the same MAC list for the DCH and pharmacy providers. Confirm your ability to meet this requirement.
- 3.13.64. Offeror shall offer MAC pricing for all multi-source generics. Confirm your ability to meet this requirement.
- 3.13.65. Offeror agrees to provide pharmacy utilization and cost reports to the DCH at least quarterly. Ad hoc reports will be provided within two weeks at no additional charge. Confirm your ability to meet this requirement.

3.14. PROVIDER NETWORKS (for HRA, HDHP, HMO, and PPO)

- 3.14.1. The DCH would prefer the same provider network for the HRA, HDHP, HMO and PPO plans. Indicate if you will be using the same network for all four plans. If different identify which plan. Please provide the name of your proposed provider network (e.g., Premium, Prime, Preferred Plus, etc.)
- 3.14.2. Provide a Geo Access analysis for both providers and pharmacies in Georgia and outside Georgia as described in WORKSHEET 21, found in Section 7.0 WORKSHEETS. You must have a statewide network of providers and pharmacies in Georgia and a national network of providers and pharmacies (no mail order).
- 3.14.3. Provide three (3) electronic copies of your proposed network(s) of providers. Offeror must use the formatted spreadsheet (with read/write capabilities) to submit the physician name, provider ID, TIN, address, provider type and contract type on the CDs. Label as APPENDIX E.
- 3.14.4. Are all of Offeror's provider networks managed by your firm or do you subcontract any portion of your network from another organization? If you subcontract, please provide information about the subcontracted network. Also provide copy(ies) of these agreements.
- 3.14.5. Provide a copy of Offeror's credentialing and re-credentialing policy and procedures as required in Section 3.18.7.7.
- 3.14.6. Describe the selection process used for your firm's provider network. Include the following:
- A. Procedures for verifying application information
 - B. Physician profiling
 - C. Hospital profiling
 - D. System for maintaining information
 - E. Approval process for credentialing and selection
- 3.14.7. Does Offeror's selection and credentialing process allow you to decline an individual physician of a provider group or organization? What is the average time to credential and add an individual physician? What is the average time to credential and add a medical group?
- 3.14.8. In the event Offeror receives an incomplete application, what is your process to notify the provider?
- 3.14.9. Describe how your firm tracks provider adds, changes, and terminations. Provide a sample report tracking the turnaround time for completing these provider transactions.
- 3.14.10. What will be Offeror's standard process and advance notification timeframe to notify the SHBP and its Members of significant network changes?

3.14.11. How often is each physician and hospital re-credentialed?

3.14.12. Confirm whether the following are verified during physician re-credentiaing? If not, provide a written explanation.

- A. State license
- B. DEA license
- C. Board status
- D. Hospital privileges
- E. Malpractice Insurance
- F. Site visits

3.14.13. Confirm whether the following are verified during hospital re-credentiaing? If not, provide a written explanation.

- A. State license
- B. JCAHO Accreditation
- C. Malpractice Insurance
- E. Site visits
- F. Mortality and Morbidity rates
- H. Readmission rates
- I. Malpractice events or litigation

3.14.14. Complete the following table for providers in Georgia that identifies provider turnover (provide percentage) for the following calendar years. These turnover statistics should apply to the network(s) you are proposing. If you have a separate network based on a specific product (e.g., HMO only, HMO and PPO, etc.), clearly label the network table.

	Provider Termination					
	Voluntary			Involuntary		
	Hospitals	PCPs	Specialists	Hospitals	PCPs	Specialists
2005						
2006						
2007						

3.14.15. Complete the following table for providers in Georgia that identifies provider additions for the following calendar years. If you have a separate network based on a specific product (e.g., HMO only, HMO and PPO, etc.), clearly label the network table.

	Provider Additions (Whole Numbers)		
	Hospitals	PCPs	Specialists
2005			
2006			
2007			

3.14.16. How does your firm monitor, report and address issues regarding physician appointment waiting times? If an issue occurs how do you handle? The SHBP's minimum requirement for routine visits is fourteen (14) days and emergency or urgent care within twenty-four (24) hours. Describe how your organization addresses issues with appointment wait times and corrective actions required of providers.

- 3.14.17. If a network gap or deficiency is identified by your firm or the SHBP, how does your firm address the need for additional providers? Your explanation should include a description of the network analysis, recruitment plan, use of internal staff resources, and the timetable for completion.
- 3.14.18. Offeror shall provide a corrective action plan for any major deficiencies in the network, including geographic areas where the Offeror does not meet the access standard defined by the SHBP. Describe how your firm will meet this requirement.
- 3.14.19. How do Members access the Centers of Excellence and/ or transplant network services? Describe the Centers of Excellence and transplant network services for each product.
- 3.14.20. Is there a separate unit from the Member service unit for providers to call? How are provider calls and provider correspondence handled? Is there a tracking record made for provider inquiries? Is there a website the provider can use for inquiries?
- 3.14.21. Does your firm maintain a written Quality Assurance (QA) policy to monitor network providers? If no, please describe your firm's Quality Assurance protocols/procedures used to monitor network providers; include how quality standards are developed, communicated, reassessed and revised.
- 3.14.22. Can Members nominate providers to your firm's networks? If so, please describe nomination procedures and time required for processing. Describe any differences among the different products.
- 3.14.23. How is provider data stored, tracked and retrieved in your firm's operation and systems?
- 3.14.24 Offeror must commit to supporting the DCH in developing initiatives towards Health Care Transparency (HCT) and Health Information Exchange (HIE) that would encourage the use of electronic health records, make available to Members increased information on cost and quality of care, and offer provider incentives that reward high quality at low cost. Discuss your firm's current efforts towards aligning itself with the DCH initiatives outlined in this requirement.
- 3.14.25. Offeror shall provide a written description regarding network providers currently using electronic patient health records systems, including the percentage of contracted providers using such technology. If your firm does not have network providers using electronic health records systems, Offeror must describe the firm's current or future plans to integrate electronic health records into the organization for use by Members, physicians, hospitals, and other providers.
- 3.14.26. Does Offeror currently offer access to personal digital assistants (PDAs) to contracted physicians? If not, is your firm willing to consider establishing a mechanism for these electronic devices to be purchased by physicians?
- 3.14.27. Does Offeror have decision support systems that can provide clinicians with up-to-the minute information on best practices and treatment options? Please describe current capabilities or future plans to provide this type of technology.
- 3.14.28. Describe your strategy to educate Members on the use of urgent care facilities. What efforts have been made to increase utilization at these facilities and what recruitment efforts are underway to increase the number of these types of facilities in your network?

Provider Contracting

3.14.29. Describe any changes to your firm’s provider contracting strategies that your firm anticipates over the next three (3) years.

3.14.30. Provide three (3) electronic copies of the listing of your Georgia hospital contracts in your current Georgia network. This listing should include hospitals under contract and indicate those with Letters of Intent or Letters of Agreement. The listing of your hospitals should also indicate those contracts that will expire prior to January 1, 2009. Offeror must use the formatted spreadsheet (with read/write capabilities) to submit the hospital name, provider ID, TIN, address, provider type and contract type on the CDs. Label as APPENDIX F.

3.14.31. Indicate what percentage of provider reimbursement is through the following types of payments:

	Primary Care Physician (%)	Specialist Physician (%)	Other Non-Facility (%)
Fee-for-service/billed charges			
Discount from charges			
Fee-for-service with discount			
Fee-for-service with withhold			
RBRVS			
Capitation			
Other (please specify below)			
Totals must equal 100% to be valid	100%	100%	100%

3.14.32. Indicate what percentage of inpatient and out-patient hospital reimbursement is through the following types of payments.

	Inpatient Hospital (%)	Outpatient Hospital (%)
Discount from charges		
Case rate		
Per diem rate (by bed type)		
Per diem rate (global)		
DRG per case		
APG per case (outpatient)		
Shared risk arrangements		
Other (please specify below)		
Total (must equal 100% to be valid)	100%	100%

3.14.33. Have there been any changes to Offeror’s provider or hospital reimbursement methodology within the past eighteen (18) months? If yes, describe the changes and when they occurred. What have been the financial results realized from this change?

3.14.34. Does your firm anticipate any changes to your reimbursement methodology within the next 18 months? If yes, when? What reimbursement changes do you anticipate? What savings does your firm expect to realize from this change?

3.14.35. Please complete the following table:

	Primary Care	Specialist	Hospital
How often is the fee schedule revised?			
Is there a built-in adjustment factor?			
Average adjustment factor in 2006?			
Average adjustment factor in 2007?			

3.14.36. What is the term and duration of physician contracts? Explain your firm's contract renewal provisions and termination provisions.

3.14.37. What is the term of your firm's hospital contracts? Explain contract renewal provisions. Explain termination provisions and obligations for continuation of care of Members hospitalized at the time of termination and for transfer of Members after termination.

3.14.38. How are levels of network hospital charges monitored and compared? How does your firm's inpatient and outpatient network hospital payment levels compare to local, regional and national norms?

3.14.39. Members may select the Consumer Choice Option (CCO) for the HRA, HDHP, HMO, and PPO plans. In the CCO, a participant may request that an out-of-network provider, who is located and licensed in Georgia, be reimbursed as an in-network provider through a nomination process. The Offeror must approve the nominated provider and the provider must accept the nomination, meet the Offeror's requirements, and accept the Offeror's network rate of reimbursement as payment in full. After the provider accepts the nomination, all claims from that provider for that patient only, are paid at the in-network level. The Member is not liable for any amounts above the fee schedule. The providers that may be nominated include behavioral health providers and transplant providers, as well as general physicians.

3.14.40. Offeror shall have a nomination process for patients to nominate a physician, to verify licensing status, to contact the physician, to determine if the physician is willing to accept the Offeror's requirements and reimbursement terms, and inform the Member of acceptance or denial of the provider. The Offeror must have a method to process the claims, for one patient only, as in-network for the nominated physician. Confirm your ability to meet this requirement.

3.14.41. Offeror shall provide a written description of how the CCO process will be administered for SHBP Members. Also, the Offeror must confirm that a written CCO policy and procedure will be submitted, including applicable forms, to the DCH within sixty (60) calendar days of Contract Award. Confirm your ability to meet this requirement.

3.15. CONSUMER DRIVEN HEALTH PLANS

3.15.1. When did your firm first start offering an HRA and a qualified HDHP?

3.15.2. Provide the total number of employers and number of employees covered by both the HRA and HDHP on the following dates: 1/1/05, 1/1/06, 1/1/07, and 1/1/08. Provide a second table with this same information for your largest clients (e.g. over 10,000 CDHP Members).

Total number of employers:

Year	Employers		Enrolled Employees	
	HRA	HDHP	HRA	HDHP
1/1/05				
1/1/06				
1/1/07				
1/1/08				

Large employers:

Year	Employers		Enrolled Employees	
	HRA	HDHP	HRA	HDHP
1/1/05				
1/1/06				
1/1/07				
1/1/08				

3.15.3. Will the same Member services unit handle HRA, HDHP, HMO, and PPO Members? What training have the MSRs received about the HRA product? Discuss if the claims customer service and Member services are split or are they same.

3.15.4. Describe the information that is available to the MSR. Do MSRs have access to the Members' health statements and EOBs? Do MSRs have access to the Members HRA balance? Do MSRs have access to the pharmacy data?

3.15.5. How does your firm handle HRA rollover dollars from a prior carrier?

3.15.6. Can your firm administer a 100% preventive benefit, in accordance with age prescribed national preventive care guidelines? If preventive service is rendered that does not meet the national preventive care guidelines will your firm's claims system process it the same as a traditional medical claim?

3.16. UTILIZATION MANAGEMENT AND WELLNESS

3.16.1. Offeror shall maintain policies and procedures for conducting prior approval/pre-determination review, inpatient/outpatient reviews, pre-certification and/or prior notification for medical necessity and/or benefit review for appropriateness of setting related to inpatient admissions and certain outpatient procedures. Provide a brief description of your policies and procedures for conducting the following utilization management services: prior approval, pre-determinations, pre-certification and/or prior notification of inpatient and outpatient services. What criteria does your firm use for determining length of stay and medical necessity and do these criteria vary by location?

3.16.2. Offeror shall have a process for conducting concurrent reviews and initiating discharge planning to coordinate discharge needs and facilitate transitions to appropriate levels of care. Explain your process for conducting medical concurrent reviews and discharge planning.

3.16.3. Offeror shall perform medical, behavioral health and pharmacy review appeals in accordance with the DCH approval of Offeror's policies and procedures. Describe your process for conducting medical, behavioral health and pharmacy review appeals, include each step of the appeals process, and provide all levels of appeals available to Members (including voluntary external review appeals) and turnaround times for each level of appeal.

3.16.4. Offeror shall allow the DCH "view only access" to the care management and claims systems. Discuss your capability and any limitations in meeting this requirement.

3.16.5. Offeror must have a comprehensive Case Management (CM) Program with services that include, but are not limited to, the review of long-term home health, hospice, high risk pregnancies, high cost durable medical equipment, high cost medical/pharmacy claimants, chronic/terminal medical conditions, catastrophic/complex illnesses and injuries, and transplantation cases. The CM Program shall be integrated with utilization management and offer early proactive CM interventions through a variety of methods, including, but not limited to, predictive modeling, education and assistance to eligible plan Members while helping to contain cost and maximize benefits. Describe your CM Program and indicate how it is integrated with other utilization management programs offered by your organization to help contain cost and maximize benefits. How are candidates for CM identified and what percentage of Members are typically accepted into the program? The Offeror shall attach a copy of the current CM policies and procedures.

3.16.6. Offeror shall provide access to a network of Centers of Expertise for select high-risk and/or complex medical conditions such as spinal cord injuries, burns, cardiac diseases and neonatal care, as well as, a Centers of Excellence for transplant services. Provide a list of Centers of Expertise and Centers of Excellence that are currently included in your network and indicate which transplants are performed at each Center. Are transplant expenses for lodging and travel included in the program? If Emory Hospital (Atlanta, GA) and Children's Healthcare of Atlanta are not currently in your transplant network, please indicate your willingness to contract with these facilities on behalf of the DCH.

3.16.7. Offeror shall provide a twenty-four (24) hour nurse advice line with call tracking capabilities of both incoming and outgoing calls. Discuss your twenty-four (24) hour nurse advice line, including days and hours of operation. Confirm what health educational materials are available and how these materials are dispensed to Members, and describe your call tracking capabilities for both incoming and outgoing calls.

3.16.8. Offeror shall provide an engagement model disease state management program (DSM) (opt-out) that includes, at a minimum, asthma, diabetes for adult and pediatrics, COPD, congestive heart failure, coronary artery disease, oncology, and co-morbid conditions. Your DSM program must include a proven methodology for calculating and reporting a return on investment (ROI). List and discuss all DSM programs currently available. Describe how you will monitor and report compliance and participation on a quantified basis. Describe how long each program has been in effect, whether the program is subcontracted to another firm and the performance results and anticipated ROI for each program.

3.16.9. Offeror shall identify actual and potential DSM program enrollees through information gathered from multiple sources, (e.g., UM reports, medical and pharmacy claims data, predictive modeling, PHAs, personal health records, etc.) Describe how you identify actual and potential disease management enrollees? What is your strategy and approach for increasing DSM enrollment? Describe the sources of data that go into your predictive modeling software.

3.16.10. Offeror shall have a process for determining risk categories for each Member enrolled in the DSM programs. Indicate the risk categories used to identify enrollees of your DSM programs (e.g., high, low, moderate risk, etc.) and describe the frequency of outbound contact for each risk category, including frequency of mailings and any other pertinent details to describe the functionality of the programs.

3.16.11. Offeror shall provide DSM participation incentives (e.g., scales, glucose monitors, blood pressure cuffs, etc.) that are approved by the DCH to encourage Member enrollment in the programs. What types of incentives do you currently offer to encourage Member enrollment?

3.16.12. Describe any programs Offeror has in place to increase physician's compliance with evidence-based guidelines. Provide program results.

3.16.13. Describe the methods Offeror employs to educate providers on effective evidence - based treatment patterns and to penalize/terminate providers for ineffective treatment patterns?

3.16.14. Offeror shall provide wellness and prevention programs and participate on the DCH Wellness Committee to promote statewide health and wellness initiatives to all SHBP Members which would include, but is not limited to, PHAs, tobacco cessation programs, nutritional and weight management education, stress management techniques, worksite wellness, and DCH approved incentives to engage participation. It is the SHBPs expectation that the Offeror provide incentives to both promote participation in the PHAs and to reward members' participating in an appropriate wellness program.

List and briefly discuss all wellness and prevention programs and incentives currently available and your experience with using incentives to promote and support PHA participation in these programs? Describe what has been your process for offering these incentives, what incentives you find most promotes participation, and across your existing book of business what has been your average participation rate. Describe which health promotion programs are included in your administrative fee quote and which programs are available at an additional cost. **DO NOT INCLUDE COST IN YOUR RESPONSE.** Confirm your ability and capability to utilize a PHA chosen by the DCH. Please provide a copy of your PHA questionnaire and a copy of a sample Member report as requested in Section 3.18.1.2.

3.16.15. Who administers your firm's health promotion programs? Who administers your incentives for these programs? What has been your experience in administering program incentives? Please identify any health promotion programs you are offering that will be administered by a subcontractor.

3.16.16. Does your firm provide health coaching as part of your wellness program? If so, please describe the program.

3.16.17. Is Offeror able to administer a financial incentive in the HRA plan, (e.g. an increase in the HRA account of \$100 for completing a PHA)? Please describe your health promotion and DSM incentive administration capabilities. Can your firm administer these incentives separately for the employee and spouse?

3.16.18. Offeror shall track and report in a format approved by the DCH the number of all PHAs completed at the client and Member levels. How does your organization currently track and report all PHAs completed?

3.16.19. Does the Offeror have the ability to provide a return on investment (ROI) for PHA completion rates? If so please describe.

3.16.20. Offeror shall have the ability to integrate your care management services that include, but are not limited to, utilization review or prior notification, case management, disease management, demand management, behavioral health and substance abuse, and wellness. Describe the degree to which your care management programs are integrated within your organization (i.e. electronic systems integration, etc.)?

3.16.21. Offeror shall provide a comprehensive managed behavioral health/substance abuse program (MBH/SA) for Members that include the co-management of mixed protocol cases (which are those cases with both a medical and psychiatric component). Provide a brief overview of your managed behavioral health/substance abuse program (MBH/SA) to address the above, and provide a written process for how mixed protocol cases will be integrated and co-managed within your firm's medical and behavioral health units for the DCH, and explain how mixed protocol claims are processed.

3.16.22. Offeror shall provide MBH/SA review services for inpatient, concurrent review, select outpatient services/procedures, partial hospitalization, intensive outpatient, outpatient therapies, and

substance abuse. List all current MBH/SA review services offered by your firm and provide brief descriptions of each.

3.16.23. Offeror shall provide a comprehensive Quality Management (QM) Program that, at a minimum, addresses the functions of all care management programs and services referenced in this section. Provide a description of your QM Program.

3.16.24. Offeror shall have a strong QM program to assess, monitor, evaluate, report and compare outcomes on all care management functions using appropriate quality indicators and tools, as well as, Corrective Action Plans when errors and/or deficiencies are identified. Additionally, Offeror shall work with the DCH to develop benchmarks to measure performance against nationally/locally recognized industry standards as mutually agreed upon by the DCH. Discuss how your QM Program will assess, monitor, evaluate, report, and compare outcomes on all utilization management functions using appropriate quality indicators, Corrective Action Plans, tools, and benchmarks (national/local) as mutually agreed upon by the DCH. Also discuss your firm's process for identifying and addressing quality of care issues and concerns.

3.16.25. Offeror shall create and generate standard UM/Behavioral Health/Wellness reports, Lifetime Maximum reports, as well as, cost savings reports where applicable, for all UM/Behavioral Health/Wellness programs and services. Discuss which reports are generated for UM/Behavioral Health/Wellness and Lifetime Maximum.

3.16.26. Offeror shall have staff available during the hours of 8:00 a.m. through 6:00 p.m. Eastern Standard Time, Monday through Friday excluding holidays specified by the DCH; and, 6:00 p.m. through 8:00 a.m. including weekends for pre-certifications of all procedures, other than non-urgent procedures, in accordance with the Patient Protection Act of 1996 codified at O.C.G.A. § 33-20A-7.1. Confirm your ability to meet this requirement.

3.16.27. Do you provide physician messaging regarding potential changes in an individual's treatment protocol based on evidence-based treatment guidelines?

3.16.28. Offeror shall participate in the Bridges to Excellence (BTE) program for Diabetes Care, at a minimum. If not a current BTE participant, the Offeror must commit to becoming an active BTE participant within ninety (90) business days of Contract Award at no cost to the DCH. Describe your firm's current BTE participation. Do you participate in any BTE programs other than Diabetes Care?

3.16.29. Offeror shall have the ability to administer a prescription drug co-pay waiver program for specific medications identified by the DCH as an incentive for Member participation in the DSM programs. Although the DCH may restrict the drug co-pay waiver program to certain plan options (e.g. PPO and Indemnity only), the Offeror should have the capability to administer the program for any contracted plan option as requested by the DCH. In addition, the Offeror must have the capability to track and report Member participation in the drug co-pay waiver program at the drug and client level. Please confirm you are willing and able to meet this requirement.

3.16.30. Describe Offeror's ability to provide a ROI for the co-pay waiver program.

3.17. MEDICARE ADVANTAGE

3.17.1. Describe Offeror's current Medicare Advantage PFFS plans available in Georgia. Please list counties in which you do not operate.

3.17.2. Describe Offeror's plan to provide services in the counties you do not currently operate by 2009.

3.17.3. Provide the total number of employers, number of employees and number of non-employer individuals covered by your firm in 2007 in the following Medicare Advantage products:

- Local HMO
- Local PPO
- Regional PPO
- Private Fee-for-Service

3.17.4. Describe Offeror's process to communicate with retirees to ensure they understand the PFFS plan and are informed about the distinctive features of these plans. Include a discussion of website capabilities including ADA accessibility.

3.17.5. Describe Offeror's enrollment process.

3.17.6. Describe Offeror's process for encounter data submission to CMS Risk Adjustment Processing system (RAPS) including, but not limited to, timing, formats, up-front edits, error corrections and resubmission of rejected data.

3.17.7. Describe Offeror's process for reconciliation between plan information, RAPS reports, Model Output Reports (MORs), Monthly Membership Reports (MMRs), and Prescription Drug Event (PDE) return files.

3.17.8. Discuss whether Offeror can provide information specific to SHBP retirees from the following CMS reports to the DCH warehouse Contractor within ten (10) calendar days following the end of each month.

- Monthly Membership Reports – Non Drug and Drug
- Model Output Reports – Non Drug and Drug
- Prescription Drug Event return files

3.17.9. Offeror must be able to accept and submit ICD-9-CM codes to the highest specificity, including fourth and fifth digits. Confirm your ability to meet this requirement.

3.17.10. Describe Offeror's process to remain current on coding guidelines to ensure accurate risk adjustment payments.

3.17.11. Describe Offeror's employee training and policy formation regarding proper documentation and diagnoses coding.

3.17.12. Describe your provider database for the PFFS Medicare Advantage product.

3.17.13. Discuss how Members will be able to locate providers accepting the PFFS program.

3.17.14. Describe Offeror's process to strategically communicate with physicians and facilities to educate them on your PFFS product, including website capabilities. Submit a sample of all communications. Label as APPENDIX G.

3.17.15. Provide any documented or undocumented provider access problems. Describe Offeror's willingness to work with the SHBP to identify high priority providers and analyze acceptance levels.

3.17.16. Describe Offeror's process to proactively communicate with physicians and facilities to improve documentation skills that allow for more specific diagnosis coding.

3.17.17. Describe Offeror's internal audit procedures to ensure data is being reported correctly and that appropriate reimbursement is received.

3.17.18. Describe Offeror's process to communicate with providers regarding inadequate documentation, diagnosis-related collection issues, and adherence to proper methods for appending (late entry lab/radiology results) or correcting inaccurate data entries.

3.17.19. Will the same Member services unit handle PFFS Members as the other products?

3.17.20. What training will the MSRs receive about the PFFS product?

3.17.21. Describe the information that is available to the MSRs. Do MSRs have access to the Members' health statements and EOBs?

3.17.22. MSRs must be able to help locate an accepting provider within 24 hours when a Member reports a provider not accepting the PFFS plan. Confirm your ability to meet this requirement. Describe what happens if your firm is unable to locate a provider.

3.17.23. Describe any additional PFFS programs that focus on wellness, DSM, and care management.

3.17.24. Pricing for the PFFS plan will not be finalized until after the 2009 Rate book is released (approximately April 2008) and final benefit designs have been determined. WORKSHEET 18 is provided for initial projections based on an assumed Rate book increase of 4% over the 2008 Rate book applied uniformly to all counties.

3.18 SAMPLE REPORTS AND DOCUMENTS

Provide a sample copy of the following documents by plan type and program. **Label as APPENDIX H.**

3.18.1. **MEDICAL AND BEHAVIORAL HEALTH UTILIZATION REPORTS**

3.18.1.1. Standard medical and behavioral health reporting packages for the HRA, HDHP, HMO, PPO, and Medicare Advantage products.

3.18.1.2. Standard PHA questionnaire and sample Member report

3.18.2. **FINANCIAL REPORTS**

3.18.2.1. Billing template

3.18.2.2. Most recent audited financial (annual) report

3.18.2.3. Other financial information that would allow proposal evaluators to ascertain financial stability

3.18.2.4. If private company, provide most recent internal financial statement, and a letter from your financial institution, on the financial institution's letterhead, stating your firm's financial stability.

3.18.2.5. HRA report sample

3.18.3. **SAVINGS REPORTS**

3.18.3.1. Non-Medicare and Medicare COB savings, lifetime maximum, and any other cost savings report

3.18.4. **FRAUD AND ABUSE**

3.18.4.1. Program Integrity Policies and Procedures which include at a minimum:

- A. Policies to ensure that any individual who reports SHBP violations of suspected fraud and abuse will not be retaliated against.
- B. Policies of enforcement of standards through well-publicized disciplinary standards.
- C. Provisions for a data system resources and staff to perform the fraud and abuse and other compliance responsibilities.

3.18.4.2. Fraud and Abuse Policies and Procedures

3.18.4.3. Compliance plan

3.18.5. **MEMBER SERVICES**

3.18.5.1 Member services call statistics and Member inquiry tracking reports

3.18.5.2. Provider directories for the HRA, HDHP, HMO, and PPO products

3.18.5.3. Sample of website screenshots and web activity report

3.18.5.4. Provide copies of all marketing materials (written for hand-outs and for

presentations) and any of your subcontractors' materials that are to be distributed to the DCH for review and approval within sixty (60) calendar days of Contract Award.

3.18.5.5. Correspondence to Members regarding:

- A. Sample EOBs for HRA, HDHP, HMO, PPO, and Medicare Advantage
- B. Sample wellness/health promotion newsletter and program description
- C. Sample enrollment kits
- D. Medical and Pharmacy Claims forms
- E. Appeal Letters
- F. Complaint Letters
- G. Approval/Denial Letters
- I. Standard ID card
- J. Sample health statement

3.18.6. **PHARMACY**

3.18.6.1. Provide copies of policies and procedures for pharmacy audits.

3.18.6.2. Provide an example of the educational pharmacy materials and monitoring tools used to evaluate physician-prescribing habits.

3.18.6.3. Provide a copy of your organization's PDL for most commonly used medications; if you offer more than one, a copy of each.

3.18.6.4. Provide examples of communications developed for members, physicians, health plans and Pharmacists regarding PDL and clinical management issues.

3.18.6.5. Standard pharmacy reporting packages for the HRA, HDHP, HMO, PPO, and Medicare Advantage products.

3.18.7. **PROVIDER NETWORK**

3.18.7.1. Current physician application

3.18.7.2. Current hospital application

3.18.7.3. Current physician Contract

3.18.7.4. Current hospital Contract

3.18.7.5. Medical and Pharmacy Remittance Advice

3.18.7.6. Provide a copy of the quality assurance policy used to monitor network providers.

3.18.7.7. Provide a copy of credentialing and re-credentialing policies and procedures.

3.18.7.8. Provide a copy of your grievance and appeals policy for providers.

3.18.8. **CONTRACT EXCEPTIONS**

3.18.8.1. Provide listing of Contract exceptions identifying section and requested alternative language.

4.0 FINANCIALS

4.1 INSTRUCTIONS

Provide the information requested in Section 7.0, WORKSHEETS 1-21. The instructions for completing each worksheet are provided in each individual worksheet tab. Label your responses to each worksheet with the corresponding worksheet number and tab title.

5.0. TERMS AND CONDITIONS

5.1. PARTNERSHIPS

In case the Offeror consists of a partnership or joint venture, the firm submitting the Statement of Qualification and Request for Approach will be considered the Primary Contractor and Offeror. The Offeror shall disclose the planned use of any subcontractor(s) that will perform any activities for the projected services or work effort (in terms of costs) described in the RFA. Offeror or Primary Contractor is solely responsible for all work contemplated and required by the RFA, whether Offeror or Primary Contractor performs the work directly or through a subcontractor.

5.2. RFA AMENDMENTS

The DCH reserves the right to amend this RFA prior to the Approach due date. All amendments and additional information will be posted to the DCH web site, located at: <http://dch.georgia.gov/shbprfqs>. Offerors are encouraged to check this website frequently.

5.3. APPROACH WITHDRAWAL

A submitted Approach may be withdrawn prior to the due date by a written request to the Issuing Officer. A request to withdraw an Approach must be signed by an authorized individual representing the Offeror.

5.4. COST FOR PREPARING APPROACH

The cost for developing the Approach is the sole responsibility of the Offeror. The State will not provide reimbursement for such costs.

5.5. SAMPLE CONTRACT

The Contract, which the Agency intends to use with the successful Offeror, is included in this RFA and identified as Appendix D. Exceptions to the Contract should be identified and submitted with the Offeror's Approach labeled as Appendix H as requested in Section 3.18.8.1.

The DCH reserves the right to modify the Contract to be consistent with the successful Offeror and to negotiate with the successful Offeror other modifications, provided that no such modifications affect the evaluation criteria set forth herein. The Offeror is encouraged to present their best solution and price Approach.

5.6. CONFLICT OF INTEREST

If an Offeror has any existing client relationship that involves the State of Georgia, the Offeror must disclose each relationship.

5.7. ETHICS IN PUBLIC CONTRACTING

Contractor understands, states, and certifies that it made its approach to the RFA without collusion or fraud and that it did not offer or receive any kickbacks or other inducements from any other Contractor, supplier, manufacturer, or subcontractor in connection with its approach to the RFA.

5.8. RECIPROCAL REFERENCE LAW OCGA 50-5-60(B)

For the purposes of evaluation only, Offerors resident in the State of Georgia will be granted the same preference over Offerors resident in another State in the same manner, on the same basis, and to the same extent that preference is granted in awarding contracts for the same goods or services by such other State to Offerors resident therein over Offerors resident in the State of Georgia. NOTE: For the purposes of this law, the definition of a resident Offeror is one who maintains a place of business with at least one employee inside the State of Georgia. A post office box address will not satisfy this requirement.

5.9. OFF -SHORING / OFFEROR AND SUBCONTRACTOR WORK LOCATION

Offeror or Primary Contractor warrants that all staff used to meet the requirements identified in the RFA, including, but not limited to, programming and call center staff, shall not be from an offshore location. Primary Contractor also warrants that such staff shall be located in the contiguous United States. This requirement pertains to services rendered to members and providers. Please complete off-shoring form attached as Appendix C.

5.10. ADA GUIDELINES

The State of Georgia adheres to the guidelines set forth in the Americans with Disabilities Act. Offerors should contact the Issuing Officer at least one day in advance if they require special arrangements when attending the Offeror's Conference. The Georgia Relay Center at 1-800-255-0056 (TDD Only) or 1-800-255-0135 (Voice) will relay messages, in strict confidence, for the speech and hearing impaired.

5.11. SALES AND USE TAX REGISTRATION

In Compliance with O.C.G.A. § 48-8-59, every company or individual doing business within the State of Georgia is required to file an application for a certificate of registration with the State Revenue Commissioner. Prior to award of this Contract, the apparent successful Offeror will be required to complete and submit to the Agency the Sales and Use Tax Registration form attached as Appendix B. If the completed Sales and Use Tax Registration form is not received by the Agency within one week of the issuing of the Notice of Award, the Agency may, at its sole discretion, eliminate the apparent successful Offeror from consideration and award the Contract to another Offeror.

5.12. COMPLIANCE WITH LAWS

The Offeror will comply with all State and Federal laws, rules, and regulations.

5.13. APPEALS

Offerors should familiarize themselves with the appeal process set forth in the SHBP Policy Manual, located at: <http://dch.georgia.gov/shbprfq5>.

5.14. IRREVOCABLE LETTER OF CREDIT

Refer to the Sample Contract in Appendix D.

5.15. PUBLIC RECORDS AND TRADE SECRETS

Records received by the DCH are subject to disclosure under the Georgia Open Records Act, O.C.G.A. § 50-18-70, *et seq.* All proposals, related materials, exhibits, documents, and samples submitted are subject to public inspection and disclosure; however, it should be noted that trade secrets are excluded from disclosure of public records. If an Offeror determines that the submission of any trade secret is required in response to the RFQS, such documents should be labeled plainly as "confidential", "proprietary", or "trade secret" when submitted in response to this RFQS. The use of labels or markings of "confidential", "proprietary" or "trade secret" must be strictly limited to those documents that are "confidential" or "trade secret" under Georgia law. The determination of the applicability of laws is the responsibility of each Offeror. The DCH may not provide legal advice. After the posting of the Notice of Award, public records submitted in proposals will be available upon request. The DCH's receipt, review, evaluation or any other act or omission concerning any such information shall not create an acceptance by the DCH of any obligation or duty to prevent the disclosure of any such information. NOTE: The final decision about which records are "public records" and will be disclosed is made by the state agency that receives a request for inspection or copies of the records.

6.0. EXHIBITS

You must have completed confidentiality agreements before receiving access to Exhibits 3 through 13.

EXHIBIT 1

6.1 2008 BENEFIT SUMMARIES

A. SHBP HMO BENEFIT SUMMARY

Max. Lifetime Benefit	\$2 million
Pre-Existing Condition	None
Annual Deductibles/Co-Payments	
• Deductible – Single	\$200
• Deductible – Family Maximum	\$400
Annual Maximum Out-of-Pocket Limit	
• Individual	\$1,000
• Family	\$2,000
Preventive Care	100% after a per visit co-payment of \$20 for primary care and \$25 for specialty care. No co-payment for immunizations and mammograms.
• Wellness Care/Preventive	
• Annual gynecological exams (these services are not subject to the deductible)	
Allergy Shots	100% for shots and serum after a \$25 per visit co-payment
Emergency Care – Hospital/Facility	100% after a \$100 per visit co-payment; co-payment waived if admitted.
Mental Health/Substance Abuse Inpatient	90% of coverage; not subject to deductible and limited to 30 days combined per Plan year
Mental Health/Abuse Abuse Outpatient Visits	100% after \$25 per visit co-payment; limited to 25 visits combined per Plan Year
Vision (exam) no eyewear	Contact HMO directly for more information
Skilled Nursing Facility	90% of coverage; up to 45 days per Plan Year; subject to deductible
Physical/Occupational/Speech Therapy	100% of coverage after \$25 per visit co-payment; up to 40 visits per Plan Year (for each)
Outpatient Services	90% coverage, subject deductible
Surgery, Laboratory, X-Rays	
Chiropractic Care (Coverage up to a maximum of 20 visits per Plan Year)	100% of coverage after a \$25 co-payment per visit.
Transplant Services	90% of coverage; subject to deductible
Urgent Care	100% after \$25 co-payment
Dental – coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury.	100% after applicable co-payment; if inpatient/outpatient facility; subject to deductible
Temporomandibular Joint Syndrome (TMJ)	100% after applicable co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/outpatient facility, 90% subject to deductible.
Primary Care Physician Office Visit	100% after \$20 office visit co-payment, not subject to deductible, \$25 specialist
Hospital Inpatient Services	90% coverage, subject to deductible

Pharmacy	<ul style="list-style-type: none"> • Tier 1 Co-Payment \$10 • Tier 2 Co-Payment \$25 • Tier 3 Co-Payment \$50 (may receive 90 day supply for maintenance medications for 2 co-pays)
Hospice	100% of coverage; subject to deductible
DME	100% of coverage when medically necessary
Home Health Care	100% of coverage; up to 120 visits per Plan Year

B. SHBP HRA BENEFIT SUMMARY

NOTE: Preventive care benefit in 2007 and 2006 included a \$500 maximum benefit per person in-network only. No coverage for out-of-network.

	Single	Family
Maximum Lifetime Benefit	\$2 million	\$2 million per person
Employer Responsibility	\$500	\$1,000
Spending Account Type	Health Reimbursement Account	
Annual Deductible (combined in/out-of-network)	\$1,000	\$2,000
Annual Maximum Out-of-Pocket (combined in/out-of-network)	\$2,000	\$4,000
	In-Network	Out-of-Network
Preventive Care	100% per person per plan year	Not Covered.
Allergy Shots	90%	60%
Emergency Room	90%	60%
Mental Health/Substance Abuse Inpatient	90% 30 day limit per yr	60% 30 day limit per yr
Mental Health/Substance Abuse Outpatient	90% 30 day limit per yr	60% 30 day limit per yr
Vision (Exam) no eyewear	Not Covered	
Skilled Nursing Facility	90% up to 120 days per yr	Not covered
Physical/Rehab/Speech Therapy	90% 40 visits per yr	60% 40 visits per yr
Outpatient Lab	90%	60%
Chiropractic Care	90% 20 visits per yr	60% 20 visits per yr
Transplant Services	90%	60%
Urgent Care	90%	60%
Dental- coverage for most procedures for prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	90%	60%
Temporomandibular Joint Syndrome (TMJ) Coverage for diagnostic testing and/or non-surgical treatment of TMJ, up to \$1100 per person per lifetime	90% for related surgical procedures	60% for related surgical procedures

maximum benefit.		
Prescription Drugs (30 day supply)	90%	60%
Hospice	90%	60%
DME	90%	60%
Home Health Care	90%	60%

C. SHBP PPO BENEFIT SUMMARY

NOTE: Preventive care benefit in 2007 and 2006 included a \$500 maximum benefit per person in-network only. No coverage for out-of-network.

	Single	Family
	In-Network	Out-of-Network
Maximum Lifetime Benefit	\$2 million	\$2 million per person
Annual Deductible		
• Deductible – Single	\$500	\$600
• Deductible – Family Maximum	\$1,500	\$1,800
Annual Maximum Out- of-Pocket		
• Individual	\$1,100	\$2,200
• Family	\$2,200	\$4,400
Hospital deductible per admission	\$250	\$250
Preventative Care	100% after \$30 co-payment per office visit. Maximum of \$1,000 per person per plan year; not subject to deductible	Not Covered
Allergy Shots	100% for shots and serum; \$30 co-payment per office visit not subject to deductible	60% subject to deductible
Emergency Room	90% after \$100 co-payment; subject to in-network deductible	90% after \$100 co-payment; subject to in-network deductible
Mental Health/Substance Abuse Inpatient	90% 45 day limit per yr (includes out-of-network visits)	60% 45 day limit per yr (includes in-network visits)
Mental Health/Substance Abuse Outpatient	90% 50 visit limit per yr (not to exceed 50 visits combined)	60% 25 visit limit per yr (not to exceed 50 visits combined)
Vision (Exam) no eyewear	90% not subject to deductible; limited to one eye exam every 24 months	Not covered
Skilled Nursing Facility	90% up to 120 days	Not covered

	per yr; subject to hospital deductible	
Physical/Rehab/Speech Therapy	90% with \$20 co-payment; 40 visits per yr combined with any out-of-network visits	60% 40 visits per yr (including any in-network visits)
Outpatient Lab	90%	60%
Chiropractic Care	90% with \$30 co-payment; 20 visits per yr	60% 20 visits per yr
Transplant Services	90% at contracted facility	Not Covered
Urgent Care	90% with \$45 co-payment per visit	60%
Dental- coverage for most procedures for prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	90%	60%
Temporomandibular Joint Syndrome (TMJ) Coverage for diagnostic testing and/or non-surgical treatment of TMJ, up to \$1100 per person per lifetime maximum benefit.	90% for related surgical procedures	60% for related surgical procedures
Primary Care and Specialist Physician Office Visit	100% after \$30 office visit co-payment, not subject to deductible	
Hospital Inpatient Services	90% coverage, subject to \$250 deductible per admission	60% coverage, subject to \$250 deductible per admission
Pharmacy <ul style="list-style-type: none"> • Tier 1 Co-Payment • Tier 2 Co-Payment • Tier 3 Co-Payment (may receive 90 day supply for maintenance medications for 3 co-pays)	\$10 \$30 \$100	\$10 \$30 \$100
Hospice	100%	60%
DME	90%	60%
Home Health Care	90%	60%

D. SHBP HDHP BENEFIT SUMMARY

NOTE: Preventive care benefit in 2007 and 2006 included a \$500 maximum benefit per person in-network only. No coverage for out-of-network.

	Single	Family
	In-Network	Out-of-Network
Maximum Lifetime Benefit	\$2 million	\$2 million per person
Annual Deductible		
• Deductible – Single	\$1,100	\$2,200
• Deductible – Family Maximum	\$2,200	\$4,400
Annual Maximum Out- of-Pocket		
• Individual	\$1,700	\$3,800
• Family	\$2,900	\$7,000
Preventative Care	100% not subject to deductible	Not Covered
Allergy Shots	90%	60%
Emergency Room	90%	90%
Mental Health/Substance Abuse Inpatient	90% 30 day limit per yr (includes out-of-network visits)	60% 30 day limit per yr (includes in-network visits)
Mental Health/Substance Abuse Outpatient	90% 50 visit limit per yr (not to exceed 50 visits combined)	60% 25 visit limit per yr (not to exceed 50 visits combined)
Vision (Exam) no eyewear	90% not subject to deductible; limited to one eye exam every 24 months	Not covered
Skilled Nursing Facility	90% up to 120 days per yr	Not covered
Physical/Rehab/Speech Therapy	90%; 40 visits per yr combined with any out-of-network visits	60% 40 visits per yr (including any in-network visits)
Outpatient Lab	90%	60%
Chiropractic Care	90%	60%
Transplant Services	90% at contracted facility	Not Covered
Urgent Care	90%	60%
Dental- coverage for most procedures for prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury	90%	60%
Temporomandibular Joint Syndrome (TMJ) Coverage for diagnostic testing and/or non-surgical treatment of TMJ, up to \$1100 per person per lifetime maximum benefit.	90% for related surgical procedures	60% for related surgical procedures
Primary Care and Specialist Physician Office Visit	100% coverage not subject to deductible	Not Covered
Hospital Inpatient Services	90%	60%

Prescription Drugs (30 day supply)	80% with \$10 minimum and \$100 maximum	60% with \$10 minimum and \$100 maximum
Hospice	9%	60%
DME	90%	60%
Home Health Care	90%	60%

EXHIBIT 2

6.2 ELIGIBILITY FILE LAYOUT

1. Confirm that you will be able to receive/send an eligibility file using the current layout.

2. Confirm that you can return a draft eligibility file to the SHBP for accounting.

State of Georgia – MEMS – Contractor Interface Notes

Dates:

Most dates in our database are stored as a 7 digit number in the format. CYYMMDD.
C – Century (1 for 1800s, 2 for 1900s, 3 for 2000s)
YY – 2 digit year
MM – 2 digit month
DD – 2 digit day

Coverage segments start with most recent and go backwards. If an end date is the first of the month the segment should be bypassed.

TERM Codes for Interfaces

- 20 - Change Coverage
- 21 - Change Option
- 30 - Transfer Out
- 31 - Discontinue
- 32 - Retired
- 33 - Termination
- 34 - Into Leave without Pay Status
- 35 - Laid Off
- 36 - Direct Pay Termination
- 37 - Deceased
- 38 - Reduced Hours
- 39 - Termination of Insured Contract and Coverage

Relationship Code Conversions for Interfaces

SP – Spouse
 CH – Dependent under age 19
 ST – Student dependent over age 19
 MH – Mentally handicapped dependent over age 19
 PH – Physically handicapped dependent over age

Coverage Type Conversions

Single Coverage Types are converted to 10
 Family Coverage Types are converted to 20

Dependent Status

Numeric status codes are covered for periods within the effective date and cancel date.
 Non-numeric status are NOT covered periods. (Only Numeric status segments will be sent).

Bypass Segments

If the cancel date in the segment is less than or equal to the effective date that segment should be bypassed.

Dependent coverage is first based on member coverage with a family type for the effective date. If a member is not covered, the dependent is not.

All records going to a contractor will be combined – The option number will be included in each occurs segment in both the member and dependent records. We will only send the last 3 characters of the group number – the first 2 characters of the group numbers are always 49. See chart below:

Group Table

Group Description	MEMS Group#
ACTIVE GROUPS	
State Departments, DFACS offices, Local Health Departments	49100
BOEs (certified teachers) and Libraries	49110
BOEs (service personnel)	49130
Contract Administrative Services	49140
County Governments	49150
RETIREE GROUPS	
RFA P0817	64

BOEs (service personnel) Retirees	49139
Contract Administrative Services Retirees	49149
County Governments Retirees	49159
Prior Retired Teachers (prior to 01-01-79)	49179
Retired Teachers (01-01-79 and after)	49189
Retired State Employees	49199
Retired BOE Service Personnel (prior to 01-01-79)	49314

Option Table Description	MEMS Option Code	MEMS Short Description	MEMS Full Description	MEMS Contractor Code
UnitedHealthcare Choice HMO	03	UNIHLTH	UNITED HEALTHCARE HMO	03
BlueChoice HMO	06	BLUECHOICE	BLUECHOICE	06
Kaiser HMO	07	KAISER	KAISER PERMANENTE	07
High Deductible Health Plan	08	HDHP	HIGH DEDUCTIBLE HEALTH PLAN	03
UnitedHealthcare Choice HMO CCO	13	UNICCO	UNITED HEALTHCARE CCO	03
BlueChoice HMO CCO	16	BLUECH CCO	BLUECHOICE CCO	06
Kaiser HMO CCO	17	KAISER CCO	KAISER CCO	07
High Deductible Health Plan CCO	18	HDHP CCO	HIGH DEDUCTIBLE HEALTH PLAN CCO	03
Kaiser Senior Advantage	27	KAISER M+C	KAISER M+C	07
Definity Consumer Driven Health Plan	31	DEF CDHP	DEFINITY CDHP	03
Lumenos Consumer Driven Health Plan	32	LUM CDHP	LUMENOS CDHP	32
Definity Consumer Driven Health Plan CCO	41	DEF CDHP C	DEFINITY CDHP CCO	03
Lumenos Consumer Driven Health Plan CCO	42	LUM CDHP C	LUMENOS CDHP CCO	32
PPO – effective 1/1/2006	58	PPO	PPO	03
PPO CCO – effective 1/1/2006	68	PPO CCO	PPO CCO	03

BCME01

MEMBERSHIP DATA FILE LAYOUT FILE - MEMBER INTRFACE|
ENROLLMENT DATE - 08-03-90 |
MANAGEMENT PAGE - 01 OF 01 |
SYSTEM PRINTED ON (02-27-2004) |

CONTRACTOR MEMBER UPDATE (FILE LAYOUT) |

(LOCATED)	FIELD	#OF#OF	COMMENTS OR
(BYTES)	FIELD DESCRIPTION	NAME	PICTURE BYT POS CODING STRUCTURE
001-001	GROUP CODE	X(01) 1 1	'G'
002-002	PLAN CODE	X(01) 1 1	'1'
003-011	SOC SEC NO	9(09) 9 9	MEMBER SSN
012-036	NAME	X(25) 25 25	MEMBER NAME
037-043	PREEXISTING DATE	9(07) 7 7	CYYMMDD
044-044	SEX	X(01) 1 1	'M' OR 'F'
045-051	DOB	9(07) 7 7	CYYMMDD
052-060	OLD SOC SEC NO	9(09) 9 9	SSN CHANGE ONLY, ELSE ZEROS
061-228	COVERAGE HISTORY		OCCURS 6 TIMES
	EFFECTIVE DATE	9(07) 7 7	CYYMMDD
	CANCEL DATE	9(07) 7 7	CYYMMDD
	PAYROLL LOCATION	9(05) 5 5	STATE DEPT, BOE
	MEMS OPTION CODE	9(02) 2 2	See Option Table
	GROUP	9(03) 3 3	See Group Table
	COVERAGE TYPE	9(02) 2 2	10 - SINGLE 20 - FAMILY
	TERMINATION REASON	X(02) 2 2	CONTRACTOR TERM REASON CODE
229-240	FILLER	X(02) 2 2	OCCURS 6 TIMES
241-246	FILLER	X(06) 6 6	BLANKS
247-248	MEMS CONTRACTOR CODE	X(02) 2 2	See Option Table

CONTRACTOR DEP UPDATE(FILE LAYOUT)

[LOCATED]	FIELD	#OF#OF	COMMENTS OR
(BYTES)	FIELD DESCRIPTION	NAME	PICTURE BYT POS CODING STRUCTURE
001-001	GROUP CODE	X(01) 1 1	'G'
002-002	PLAN CODE	X(01) 1 1	'4'
003-011	SOC SEC NO	9(09) 9 9	MEMBER SSN
012-012	CODE	X(01) 1 1	Z
013-013	TYPE	X(01) 1 1	D
014-038	DEPENDENT'S NAME	X(25) 25 25	DEPENDENT NAME
039-040	SEQUENCE NUMBER	9(02) 2 2	
041-047	DOB	9(07) 7 7	CYYMMDD
048-048	SEX	X(01) 1 1	
049-050	RELATIONSHIP	X(02) 2 2	
051-200	COVERAGE HISTORY		OCCURS 5 TIMES
	EFFECTIVE DATE	9(07) 7 7	CYYMMDD
	CANCEL DATE	9(07) 7 7	CYYMMDD
	STATUS	X(04) 4 4	COVERAGE STATUS
			FOR THIS SEGMENT
	PAYROLL LOC.	9(05) 5 5	PAYROLL LOCATION
	MEMS OPTION CODE	9(02) 2 2	See Option Table
	GROUP	9(03) 3 3	See Group Table
	COVERAGE TYPE	9(02) 2 2	10 - SINGLE
			20 - FAMILY
201-209	DEPENDENT SSNO	9(09)	
210-216	DEP PREEXISTING DT	9(07)	CYYMMDD
217-246	FILLER	X(30) 30 30	BLANKS
247-248	MEMS CONTRACTOR CODE	X(02) 2 2	See Option Table

CONTRACTOR ADDRESS (FILE LAYOUT) |

[LOCATED] [BYTES]	FIELD DESCRIPTION	FIELD NAME	#OF#OF PICTURE	COMMENTS OR BYT POS CODING STRUCTURE
001-001	GROUP CODE		X(01) 1 1 'G'	
002-002	PLAN CODE		X(01) 1 1 '2'	
003-011	SOC SEC NO		9(09) 9 9 MEMBER SSN	
012-041	NAME		X(30) 30 30	
042-056	APARTMENT NUMBER		X(15) 15 15	
057-081	STREET ADDRESS		X(25) 25 25	
082-106	CITY, STATE		X(25) 25 25	
107-115	ZIP CODE		9(09) 9 9	
116-118	COUNTY		X(03) 3 3	
119-129	PHONE NUMBER		9(11) 11 11	
130-138	HCID #		X(9) 9 9 HEALTHCARE ID#	
139-246	FILLER		X(108) 108 108	
247-248	MEMS CONTRACTOR CODE		X(02) 2 2 See Option Table	

BCMD01

MEMBERSHIP DATA FILE LAYOUT FILE - MED INTERFACE
ENROLLMENT DATE - 03-23-2004
MANAGEMENT PAGE - 01 OF 01
SYSTEM PRINTED ON (08-23-2005)

CONTRACTOR MEDICARE UPDATE LAYOUT

LOCATED	FIELD	#OF#OF	COMMENTS OR
(BYTES)	FIELD DESCRIPTION	NAME	PICTURE BYT POS CODING STRUCTURE
001-001	GROUP CODE	X(01) 1 1	'G'
002-002	PLAN CODE	X(01) 1 1	'5'
003-011	SOC SEC NO	9(09) 9 9	SUBSCRIBER SSN
012-013	SEQUENCE NUMBER	9(02) 2 2	SEQUENCE NUMBER
			00 IF SUBSCRIBER
014-038	NAME	X(25) 25 25	NAME(LAST, FIRST)
039-045	DOB	9(07) 7 7	CYYMMDD
046	SEX	X(01) 1 1	
047-048	RELATIONSHIP	X(02) 2 2	EE FOR MEMBER
049-059	MEDICARE NUMBER	X(11) 11 11	
060-066	PART A EFFECTIVE DT	9(07) 7 7	CYYMMDD
067-073	PART A CANCEL DT	9(07) 7 7	CYYMMDD
074-080	PART B EFFECTIVE DT	9(07) 7 7	CYYMMDD
081-087	PART B CANCEL DT	9(07) 7 7	CYYMMDD
088-096	SOC SEC NO	9(09) 9 9	DEPENDENT'S SSN
097-103	PART D EFFECTIVE DT	9(07) 7 7	CYYMMDD
104-110	PART D CANCEL DT	9(07) 7 7	CYYMMDD
111-246	FILLER	X(136) 136 136	BLANKS
247-248	MEMS CONTRACTOR CODE	X(02) 2 2	See Option Table

BCCA01

MEMBERSHIP DATA FILE LAYOUT [FILE - CONFIDENTIAL]
 ENROLLMENT | ADDRESS |
 MANAGEMENT (not currently used) | DATE - 08-14-2006 |
 SYSTEM |PAGE - 01 OF 01 |
 PRINTED ON (08-14-2006) |

[CONFIDENTIAL ADDRESS LAYOUT |
 |]

LOCATED	FIELD	#OF#OF	COMMENTS OR
(BYTES)	FIELD DESCRIPTION	NAME	PICTURE BYT POS CODING STRUCTURE
001-001	GROUP CODE	X(01) 1 1	'G'
002-002	PLAN CODE	X(01) 1 1	'6'
003-011	SOC SEC NO	9(09) 9 9	SUBSCRIBER SSN
012-013	SEQUENCE NUMBER	9(02) 2 2	SEQUENCE NUMBER
014-038	NAME	X(25) 25 25	NAME(LAST,FIRST)
039-045	DOB	9(07) 7 7	CYYMMDD
046	SEX	X(01) 1 1	
047-048	RELATIONSHIP	X(02) 2 2	
049-057	SOC SEC NO	9(09) 9 9	DEPENDENT'S SSN
058-072	APARTMENT NUMBER	X(15) 15 15	
073-097	STREET ADDRESS	X(25) 25 25	
098-122	CITY, STATE	X(25) 25 25	
123-131	ZIP CODE	9(09) 9 9	
132-134	COUNTY	X(03) 3 3	
135-145	PHONE NUMBER	9(11) 11 11	
146-246	FILLER	X(101) 101 101	BLANKS
247-248	MEMS CONTRACTOR CODE	X(02) 2 2	See Option Table

7.0 Worksheets

7.1. Worksheets may be obtained at www.dch.ga.gov or http://dch.georgia.gov/00/channel_title/0,2094,31446711_98938162,00.html. Offeror will need to paste into your browser to open.

8.0. Appendices

8.1. See next page.

APPENDIX A

Approach Certification

We propose to furnish and deliver any and all of the goods and/or services named in the attached Request for Approachs (RFA) for which prices have been set. The price or prices offered herein shall apply for the period of time stated in the RFA.

We further agree to strictly abide by all the terms and conditions contained in the DCH Policy Manual located at: http://dch.georgia.gov/00/channel_title/0,2094,31446711_98666131,00.html and any modifications or attached special terms and conditions, all of which are made a part hereof. Any exceptions are noted in writing and included with this bid.

It is understood and agreed that this approach constitutes an offer, which when accepted in writing by the Agency, and subject to the terms and conditions of such acceptance, will constitute a valid and binding contract between the undersigned and the Agency.

It is understood and agreed that we have read the specifications shown or referenced in the RFA and that this approach is made in accordance with the provisions of such specifications. By our original signature, entered below, we guarantee and certify that all items included in this approach meet or exceed any and all such stated specifications.

We further agree, if awarded a contract, to deliver goods and/or services that meet or exceed the specifications.

It is understood and agreed that this approach shall be valid and held open for a period of one hundred twenty days from approach opening date.

APPROACH SIGNATURE AND CERTIFICATION

(Bidder to sign and return with approach)

I certify that this approach is made without prior understanding, agreement, or connection with any corporation, firm, or person submitting a approach for the same materials, supplies, equipment, or services and is in all respects fair and without collusion or fraud. I understand collusive bidding is a violation of state and federal law and can result in fines, prison sentences, and civil damage awards. I agree to abide by all conditions of the approach and certify that I am authorized to sign this approach for the Offeror. I further certify that the provisions of the Official Code of Georgia Annotated, Sections 45-10-20 et. seq. have not been violated and will not be violated in any respect.

The Vendor also certifies that the Vendor and its Lobbyists have complied with the Lobbyist Registration Requirements in accordance with the Georgia Vendor Manual.

Date: _____

Authorized Signature _____

Print/Type Name: _____

Company Name: _____

Mailing Address: _____

Phone Number: _____ E-Mail Address: _____

APPENDIX B

Sales and Use Tax Registration Form

Section 50-5-82, of the Official Code Georgia Annotated (OCGA) prohibits the Department of Administrative Services or any other state agency from awarding a contract to an Offeror who is a "prohibited source" as determined by the Department of Revenue. The following information is required prior to award:

Vendor Name: _____

Principal Name
(Parent Company): _____

FEI: _____

Affiliate Name (Distributor): _____

FEI: _____

Vendor Sales Tax Number: _____

Type of Product or Service: _____

What type of service will your company be performing? _____

Will your company sell any tangible personal property? _____

Authorized Signature _____

Print Name: _____

Date: _____

APPENDIX C

Off Shoring Requirement Form

Offeror attests that no deliverables provided or services proposed within the request for proposal response, whether by the contractor or any subcontractor, have or will be provided or performed outside of the geographical boundaries of the United States.

If this requirement is not met at any time during the term of the Agreement, then:

(a) the contractor shall be deemed to have breached the agreement:

(b) in addition to any other rights or remedies, DCH may terminate the agreement immediate upon notice to the contractor, and

(c) the contractor will be liable to DCH for damages in an amount equal to the value of the deliverables provided or services performed outside of the geographical boundaries of the United States.

Authorized Signature: _____ Date: _____

Print/Type Name: _____

Company Name: _____

Address: _____

Phone Number: _____ E-Mail _____

APPENDIX D

SHBP Sample Contract and Performance Guarantees

APPENDIX E: Electronic Copy of Network Providers (please use format below as instructed in Section 3.14.3)

Physician Name	Provider ID	Tax Identification Number (TIN)	Address	Provider Type	Contract Type	Open/Closed Yes/No

APPENDIX F: Listing of Hospital Contracts (please use format below as instructed in Section 3.14.30)

Hospital Name	Provider ID	Tax Identification Number (TIN)	Address	Provider Type	Contract Type	Contract Expiration Date	Contract LOA/LOI

APPENDIX G: PFFS Communication Materials

APPENDIX H: Sample Reports and Documentation