APPENDIX F
RFP Response Template

As stated in Part II of the RFP, the Offeror's response to this RFP must consist of three (3) separately sealed submittals. The submittals are as follows: (a) Technical Submittal, (b) Disadvantaged Business Submittal, and (c) Cost Submittal. A response to this request for proposals is considered to be complete if it includes the following documents:

1. Proposal Cover Sheet
2. Technical Submittal
    - Completed RFP Response Template in tabbed order
    - Completed and signed Confirmation Certificate
3. Disadvantaged Business Submittal
4. Cost Proposal (sealed separately)

1. Preparation of Proposal Cover Sheet (Appendix C)

The cover sheet must include: Offeror's name, mailing address, and website; contact person, contact person's phone number, facsimile number, and email address; and Offeror's federal ID number in addition to the RFP name and RFP number. The original should be clearly marked to indicate that it is the original. The Proposal Cover Sheet must be signed by an individual with legal authority to bind the Offeror.

2. Preparation of the Technical Submittal

The Technical Submittal is the most important portion of the response. This is the opportunity for the Offeror to fully describe how it intends to meet the expectations presented in Parts II and IV of this RFP. Provide the Offeror's responses to the requirements in the correct Tab listed in the outlines provided in Parts II and IV of the RFP and reiterated here for easy reference.

Tab 1. Statement of the Problem

State in succinct terms, not to exceed one page, the Offeror's understanding of the services required by this RFP. The statement of the problem provides the opportunity for Offerors to include a description of their response to the Prescription for Pennsylvania as part of the required statement.

Tab 2. Management Summary

The Management Summary must be written in succinct terms, not to exceed three pages in length, and provide an overview of the contents of the proposal. The management summary should include:

- A narrative description of the proposed effort and a list of items to be delivered and services to be provided;

- A description of the Offeror's managed care plan delivery system;
- A brief description of the Offeror's qualifications, with the Offeror's key strengths highlighted;
- An organization plan describing the Offeror's corporate relationships including joint ventures and/or subcontractor relationships;
- An organizational chart for the administration of the CHIP program;
- A description of the Offeror's experience and familiarity with the medical, educational, social, and economic needs of the population to be served by CHIP; and
- A description of the Offeror's ability to further the Department's goals for this program, including plans to control costs (without discussing costs or rates) while improving the quality of care and improving the health outcomes of enrollees.

Tab 3. Prior Experience

The corporate background and experience section must describe the history and relevant experience of the Offeror and its subcontractors. Experience shown should be work done by the individuals who will be assigned to this project as well as that of your company. Please use the following questions as a guide to providing the requested information.

a. Describe the history and relevant experience of the Offeror and any proposed subcontractors.

b. Provide documentation regarding verification of the counties in which the Offeror has been authorized to operate by the Department of Health and licensed by the Department to provide health care services.

c. Describe if the Offeror has any plans to do the following:
- ***Change financial and claims administration.***
- ***Consolidate claims/administration offices.***

d. Describe if the Offeror is currently in any discussions/has any plans to:
- ***Be purchased by another organization?***
- ***Purchase another organization?***
- ***Merge or consolidate with another organization?***

e. Indicate if the plan has received its federal qualification form from the Department of Health and Human Services. If so, provide the effective date of the qualification. If not, indicate if federal qualification has been requested and if the application is currently pending.

f. Describe any restrictions or pending reviews by state or federal authorities for non-compliance with state or federal statutes or regulations. Provide details for the past three years, including the outcome.

g. Provide the most recent rating along with the date the rating was received and to which product it applied (e.g., HMO, POS, etc.) if the Offeror is rated by the NCQA, URAC, JCAHO, or other organizations.

h. Provide references for four relevant clients that the Offeror currently services. References should include:

- ***Company's or Organization's name;***
- ***Responsible official's name, title, address, and telephone number;***
- ***Services the Offeror provides to the company or organization; and***
- ***Number of employees or participants enrolled in the Offeror's plans.***

i. Provide references for two similar clients that have terminated within the last year. Include the same information required above for current clients.

Tab 4. Personnel

The personnel tab is used to demonstrate to the Department that the Offeror will have personnel assigned to this project that have the experience, educational background, and record of past accomplishment appropriate to the scope of the effort. Please use the statements below to guide in the preparation of the response to this Tab.

a. Provide a list of executive and professional personnel who will be engaged in the work and show where they will be physically located. Attach a job description for each position.

b. Identify key personnel such as project manager and Offeror's administrator. Provide a resume or similar document with education and experience in operations and delivery of children's health insurance. Indicate the responsibilities each individual will have in this project and how long they have been with the company.

c. Provide the name(s), address(es), telephone number(s), and contact person(s) that can give references for the key administrative positions requested. Reference checks may be conducted of the Offeror's administrator and the program manager.

d. Describe any contractual relationships with organizations necessary to the Offeror's full support of the CHIP projects (e.g., actuarial services, clinical staff, data information services, etc.).

e. Provide a copy of the organizational chart depicting the unit and personnel that will support this project. Demonstrate that all of the required functions listed in the work statement in Part IV of the RFP are contained within the Offeror's organization or within a subcontractor's organization.

*f. **Describe the Offeror's client philosophy, management, and overall account service philosophy. Provide specific examples of how the Offeror's operations are structured to service the unique needs of CHIP. Indicate which divisions shall be responsible for the operation of CHIP within your organization. Identify any affiliation with any entity that operates a managed care plan in another region.***

*g. **Identify the name and position of the person authorized to negotiate a contract with the Department.***

Tab 5. Training (General)

The training tab is used to demonstrate to the Department that the Offeror will have personnel assigned to this project that have the appropriate education and training to satisfactorily complete the scope of the effort. Please use the statements below to guide in the preparation of the response to this Tab.

*a. **Describe recommended training of contractor's personnel, including the number to be trained, duration of the program, place of training, curricula, training materials to be used, number and frequency of sessions, and number and level of instructors.***

*b. **Describe recommended training of the Department's personnel, including the number to be trained, duration of the program, place of training, curricula, training materials to be used, number and frequency of sessions, and number and level of instructors.***

Tab 6. Financial Capability

The Financial Capability tab is used to demonstrate to the Department that the Offeror will have financial stability and economic capability to perform the contract requirements. Please use the statements below to guide in the preparation of the response to this Tab.

*a. **Provide financial documents such as audited financial statements or recent tax returns.***

b. Indicate current status of the Offeror as profit or nonprofit.

Profit Status		
Offeror Name	Profit	Nonprofit

c. Provide the Offeror's financial ratings from the following institutions:

Institution	Rating	Date of Rating
AM Best		
Moody's		
Standard & Poor's		

d. Describe the Offeror's ownership and organizational structure (insurance company, parent companies, affiliates, profit/nonprofit status, subsidiaries, etc.).

Tab 7. Objections and Additions to the Standard Contract Terms and Conditions.

The Objections and Additions to the Standard Contract Terms and Conditions tab is used to describe any terms or conditions the Offeror would like to negotiate. Regardless of any objections, the Offeror must submit its proposal on the basis of the terms and conditions in Appendix A, Standard Contract Terms and Conditions. Please use the statements below to guide in the preparation of the response to this Tab.

a. Describe terms and conditions contained in Appendix A, Standard Contracts Terms and Conditions, that your company would like to negotiate.

b. Describe additional terms and conditions the Offeror would like to add to the Standard Contract Terms and Conditions.

Tab 8. Business Associate Agreement

The Business Associate Agreement tab is used to describe any objections to Appendix M, Business Associate Agreement. Please use the statement below to guide in the preparation of the response to this Tab.

a. ***If the Offeror agrees with all terms in Appendix M, Business Associate Agreement, it should indicate acceptance by providing a confirmation in Appendix G, Confirmation Certificate. If the Offeror has any objections to the language in the Business Associate Agreement, state those objections in Tab 8 and indicate the deviation in the Confirmation Certificate at Appendix G.***

Tab 9. Work Statement

Please use the following statements and questions to guide you in the preparation of the work statement portion of your proposal. The outline relates directly to each task identified in Part IV of this RFP.

Please use as much space as is required to provide a complete but succinct response. Refer back to the appropriate sections of Part IV in the RFP for additional details relating to the question or request for information. If more than one approach is apparent, comment on why you chose the approach that you describe. Answer "not-applicable" to any item that is not relevant to your proposal (e.g., question referencing subcontracting).

IV-3. Tasks

A. Customer Service

A.1 Outreach

A.1.a Describe the Offeror's approach to developing an Outreach Plan. Include in the description:

- ***The strategies the Offeror will implement;***
- ***The target subpopulation(s) the Offeror hopes to reach;***
- ***The methods by which the Offeror will carry out the plan;***
- ***How and with whom the Offeror will collaborate in its outreach strategies and efforts;***
- ***The rationale for the approaches the Offeror chose and;***
- ***The experience of staff who will be responsible for this function.***

A.1.b Describe how the Offeror will identify and address special populations, including non-white and non-English speaking children and children with disabilities; reach different geographic areas, including rural and inner-city areas; and address cultural and ethnic diversity in its outreach efforts.

A.1.c Describe how the Offeror will measure the effectiveness of the Offeror's outreach efforts.

A.1.d Describe how a corrective action plan will be developed if outreach efforts do not meet standards or goals established by the Offeror.

A.1.e If the Offeror proposes to subcontract components of outreach, describe which portions the Offeror plans to subcontract; with whom it will subcontract; the relevant experience of the subcontractor; and how it will monitor/audit the subcontractor.

A.2 Enrollee Help Line

A.2.a Describe the Offeror's enrollee help line operations. Include:

- ***Hours and days of operation (at minimum Monday-Friday during normal business hours);***
- ***Location of telephone operations (If out of state, describe how it will accommodate services for Pennsylvania);***
- ***Standards for rates of response (live answer, incomplete calls, speed of answer, average length of call, etc.);***
- ***Measures in place to ensure standards are met;***
- ***Corrective action plan to address non-compliance with standards;***
- ***Process if all operators are busy;***
- ***Process for after-hours calls; and***
- ***Handling of requests for enrollment forms/materials to include timeline for distribution of requested materials .***

A.2.b Describe the Offeror's staffing plan for the telephone operations. Include:

- ***Job qualifications;***
- ***Provisions made for staffing during peak hours;***
- ***Accommodations for non-English-speaking customers;***
- ***Accommodations for customers who are visually or hearing impaired;***
- ***The ratio of representatives to all enrollees serviced by the program in the Offeror's or subcontractor's office/center that will handle the CHIP account;***
- ***Supervisor to staff ratio;***
- ***The annual turnover rate of customer service staff for 2006 and 2007 in the office/center that will handle the CHIP account;***
- ***Percentages of the customer service representatives who are bilingual in Spanish and English; and***
- ***Describe training for help line staff in the following areas:***
    - ***Cultural competency;***

- *Addressing needs of special populations;*
- *The availability of and the functions of the Special Needs Unit provided by the Offeror; and*
- *The services which the Offeror is required to make available to Pennsylvania's CHIP enrollees.*

A.2.c Describe the method to be used to assess customer satisfaction with helpline services. Include how customer satisfaction information will be utilized to improve performance.

A.3 Contractor Website

Describe the CHIP-specific information on the Offeror's Website. Include timeframe for development of the CHIP-specific information in English and Spanish on its Website and link to Department's Website. At minimum, the following items must be included in the Website:

- ***Toll-free contact number for English- and Spanish-speaking customers;***
- ***How to apply;***
- ***Benefit Information;***
- ***Participating Providers, including dentists;***
- ***Frequently Asked Questions; and***
- ***Costs related to enrollment in the program.***

A.4 Written Materials

A.4.a Describe written materials made available to enrollees including educational and preventive care programs that include an emphasis on health promotion, wellness, and healthy lifestyles and practices consistent with Rx for PA initiatives. Identify specific areas of focus for educational and preventive care program materials. Describe your strategy moving forward to improve in this area.

A.4.b Describe how the Offeror will ensure that the reading level of any written materials will be at a sixth grade level (language software package, etc.).

A.4.c Describe language alternatives that will be available to enrollees other than English and Spanish, if applicable. English and Spanish are both required.

A.4.d Describe the manner in which written materials are shared with enrollees according to preference indicated in CAPS.

A.4.e Describe how the Offeror will accommodate the visually impaired with regard to written correspondence.

***A.4.f Describe any materials provided in the Offeror's Enrollee Handbook that exceeds the minimum requirements listed in Act 1998-68, "Information for Enrollees", Section 2136*. (Note: Enrollee handbook will be requested and must be available as part of the Readiness Review.)**

A.5 Eligibility, Enrollment and Renewal Procedures

A.5.a Describe how the Offeror will meet the requirement that applications be processed and a determination of eligibility made within 15 calendar days of receipt of a completed application as required by the CHIP Procedures Manual, Part II (Appendix H).

A.5.b Describe the volume of transactions the proposed staff is expected to handle each week including, but not limited to, applications, renewals, and disenrollments.

A.5.c Describe how the Offeror will address the need for greater or fewer staff devoted to each of these functions should the workload volumes be greater or less than those delineated.

A.5.d Describe the Offeror's efforts for follow-up action on incomplete applications or renewals to include the types and frequencies of communications during the 60-day period for follow-up (e.g., phone, letters).

A.5.e Describe any use of technology to increase efficiency and effectiveness of staff, application entry, upgrades to hardware, and architecture. Technological advancement can be embodied in new or improved materials, devices, products, or processes, or represented by the technological know-how gained. (example: OCR technology).

A.5.f Describe the Offeror's timeliness standards for each of the following steps (a Gantt chart or other graphic representation of the timing will suffice). The timeline should commence with the receipt of the application. Include:

- ***Enrollment/data entry of application information into CAPS;***
- ***Follow-up when application is incomplete;***
- ***Medicaid eligibility screening and forwarding of application to the CAO, when required;***
- ***Eligibility determination from receipt of completed applications/renewals;***
- ***Follow-up for non-designation of primary care provider;***
- ***Generation and distribution of enrollment rosters;***
- ***Depositing of enrollment fee payments;***
- ***Generation of renewal notices;***

- ***Timelines for notice issuance upon completion of a decision regarding eligibility; and***
- ***Cross matches.***

A.5.g Describe the corrective steps taken if performance falls below the standards listed above in A.4.f.

A.5.h Describe protocols in place that identify persons who may be eligible for Medicaid categories of coverage for which Federal funds are available (e.g., pregnant women, persons with temporary or permanent disabilities, patients that may require transplants, etc.). These protocols must include actions at time of application and renewal as well as periodic reviews of utilization data throughout the enrollment cycle. Describe process for referring enrollee to the Department of Public Welfare for Medicaid coverage.

A.5.i Describe the Offeror's means for recommending other health care resources (FQHCs, state and federal agencies, websites, etc.) to potential customers whose CHIP application/renewal may have resulted in ineligibility.

A.5.j Describe the process through which the Offeror will instruct staff to enter all data into CAPS exactly as it appears on hardcopy applications.

A.5.k Describe process for supervisory review of negative actions that occur at the point of renewal, including movement from the free or low-cost component to a higher premium component of CHIP.

A.6 Collection of Premiums and Co-Payments

A.6.a Describe how premiums will be collected from enrollees in the Low-Cost and Full-Cost components of the program. Include whether a "lock box" subcontract will be used for this function.

A.6.b Describe the Offeror's approach to collection of the premiums, accurate and timely posting receipt of payment to the family's enrollment record, and refunding of fees when required. In the Offeror's approach, include how you will ensure that the enrollee receives premium notices at least 30 days prior to the due date.

A.6.c Describe the Offeror's approach to the exception of the collection of co-payments on well-baby and well-child care services for the Low-Cost component of the Program.

A.6.d Describe the Offeror's approach to limiting the cost sharing requirements to no more than 5 percent of household income for enrollees in the Low-Cost component of the Program. Include the Offeror's approach for

excluding all cost sharing requirements for the remainder of the annual enrollment period if notified by the Department that the family has met the five (5) percent cap.

A.6.e. Describe the Offeror's approach to excluding cost sharing requirements for American Indian and Alaska Native children enrolled in the Low-Cost component of the Program.

A.6.f. Describe the Offeror's approach to the collection of co-payments generally. Include services for which co-payments are collected and are not collected (e.g., PCP return visits, nurse visits for blood pressure monitoring, etc.). Describe how the determination for which services require a co-payment is communicated to the enrollee.

A.7 Selection of Primary Care Provider

A.7.a Assignment of PCPs

A.7.a.1 Describe the Offeror's method to ensure that all enrollees are assigned a primary care provider in the event the enrollee does not meet the ten-day selection criteria. Include a sample PCP assignment notice.

A.7.a.2 Describe the process for notifying PCPs of new enrollees.

A.7.b. Primary Care Dentist or Other Provider

A.7.b.1 Indicate whether the Offeror will require or allow for the selection of a primary care dentist or other specialty provider.

A.7.b.2 Describe the Offeror's method for including the available dentists in its network in its provider directory.

A.8 Identification Cards

A.8.a Describe how the Offeror will ensure that identification cards are issued to enrollees within ten days of their enrollment.

A.8.b Describe the process for identification card production and distribution. Include whether a subcontractor will be used in the process, with whom you subcontract, the relevant experience of the subcontractor, and how you will monitor/audit the subcontractor.

A.9. Termination of Coverage

A.9.a. ***Describe the process the Offeror will use to terminate coverage when a child no longer meets the eligibility requirements for the Program.***

A.10 Eligibility Review Process (ERP)

A.10.a Describe how the Offeror will manage the ERP. Include persons responsible for oversight of the process (including level of management responsible for the Offeror), the Offeror's goals for achieving resolution of the matter, and how that process will be used to measure or improve staff performance.

A.10.b Describe the processes and steps the Offeror will take to resolve eligibility and enrollment issues to avoid having the issues reach ERP status.

B. Benefit Plan

B.1 Benefit Package

B.1.a Indicate what services are covered with an organ transplant in terms of the donor, e.g., removal of the organ if donor is not a subscriber or enrollee of the contractor.

B.1.b Describe the Offeror's coverage of and limitations on hospice care services. Include a description of the preauthorization and certification requirement.

B.1.c Describe how prescribed medical foods are obtained (e.g., through a pharmacy or through a DME supplier). Does the Offeror impose a supply limit (e.g., 30 days or as requested by the prescribing physician)?

B.1.d Describe the Offeror's use of a closed or restrictive formulary, if applicable. Does the Offeror use a mail order or designated pharmacy process for maintenance prescriptions?

B.1.e Indicate the Offeror's monetary allowances or other limits on preventive and routine vision care in the table below:

Benefit	Contractor Allowance
Emergency, preventive, and routine vision care (Offerors may substitute fee schedules in lieu of table): • Exams • Lenses - one prescription per year or - two prescriptions per year • Frames • Contacts Describe or attach warranty on eyewear, if applicable.	$ _____ $ _____ $ _____ $ _____

B.1.f. Indicate the Offeror's monetary or other limits on durable medical equipment in the table below:

Benefit	Contractor Allowance
Durable Medical Equipment (DME) List covered DME and individual allowance for each item or overall yearly allowance per member. **Include hearing aids.** (Offerors may substitute fee schedules in lieu of table.)	$ _____

B.2 Optional Benefits

B.2.a If applicable, describe any optional benefits or discounted services being offered at no additional cost to the enrollee or the Department and the rationale for inclusion.

B.2.b Describe the method through which any costs associated with providing these additional benefits or discounted services will be kept separate from the

Cost Submittal and historical experience data submitted to the Department in subsequent years.

B.2.c Describe the method to be used to deliver timely notice to enrollees if optional benefits or services are provided and later withdrawn.

B.3 Prior Authorization of Services

B.3.a If applicable, provide a list of service(s), medical item(s), and/or therapeutic categories of drugs for which the Offeror requires prior authorization.

B.4 Preventive/Well-Child Health Care Services

B.4.a Describe the process the Offeror has in place, or will have in place, for monitoring and notifying providers of new guidelines recommended by the American Academy of Pediatrics, the Centers for Disease Control, or DOH. If the procedure is not currently in place, indicate the date at which the process will be finalized.

B.5 Emergency Room (ER) Services

B.5.a Describe how the Offeror will monitor and analyze the appropriateness of emergency room usage by enrollees. Respond to the following:

- ***What percentage of emergency room claims are denied?***
- ***What percentage of emergency room denials go to first or second level internal appeal? Third level external appeal? In the response to this question, explain for both internal and external reviewers.***
- ***What percentage of emergency room denials are maintained on appeal?***

B.5.b Describe the management techniques, policies, procedures or initiatives the Offeror has in place to avoid unnecessary or inappropriate emergency room utilization. Describe your strategy moving forward to improve performance in this area.

IV-4. Requirements

A. Executive Management

A.1 Management Functions

A.1.a Complete the table below by providing the names, titles (if appropriate), and location of the individuals responsible for each of the listed executive management functions.

Function	Responsible Individual	Location
a. Administrator who has clear authority over the entire operation of the insurer		
b. Manager who will oversee day-to-day performance under the contract		

Function	Responsible Individual	Location
c. Supervising medical director(s) (must be a Pennsylvania licensed physician-[M.D. or Osteopath])		
d. Privacy officer (must oversee and manage the Offeror's compliance with state and federal laws and regulations addressing the privacy of financial and health information)		
e. Chief financial officer (CFO)		

A.2 Administrative Functions

A.2.a Complete the table below by providing the names, titles, if appropriate, and location of the individual responsible for each of the administrative functions listed.

Function	Responsible Individual	Location
1. Quality management coordinator with experience or education in quality management systems		
2. Utilization management coordinator with experience or education in utilization management systems		
3. Prior authorization coordinator who will supervise the staff responsible to authorize medical care twenty-four (24) hours a day, seven (7) days per week. Neither the staff nor the coordinator will be permitted to deny authorization without review by a physician or health care professional with experience or expertise generally comparable to the prescriber. Denials require contact between the reviewing professional and prescriber.		
4. Concurrent utilization review manager who will supervise staff to conduct inpatient concurrent utilization review. Staff must be qualified and experienced in concurrent utilization review. Neither the staff nor the manager will be permitted to deny care recommended by a treating physician without review by a physician with experience or expertise generally comparable to the treating physician. Denials require contact between the reviewing professional and prescriber.		

5. Consumer services manager who will be responsible for handling consumer inquiries.		
6. Claims administrator who will oversee staff that will conduct the timely and accurate processing of claims, encounter forms and other information necessary for meeting contract requirements and the efficient management of the Offeror.		
7. Outreach, eligibility and enrollment coordinator who will be the point of contact with the Department for issues related to outreach, eligibility and enrollment.		
8. Information systems (IS) coordinator, who will be the contact person for all information systems issues with the Department.		

B. Administration

B.1 Subcontracts

B.1.a Provide the names, addresses, telephone numbers, and subcontracted activities using the format below. This includes all subcontracts for medical, mental health, or administrative services and with wholly or partially owned subsidiary companies.

Subcontractor	**Indicate whether wholly or partially owned**	**Description of Contracted Service or Function**	**Contact Information**

B.1.b Describe how the Offeror will oversee/monitor subcontracts. Include method and frequency of monitoring, standards for performance, and any applicable sanctions that will be imposed for noncompliance.

B.2 Subcontracts with Behavioral Health Organizations (BHOs)

B.2.a Provide a copy of contracts with BHO subcontractors.

B.2.b Describe the process for accessing mental health and substance abuse services.

B.2.c Describe whether the BHO's access number, if applicable, is on the primary I.D. card or whether a separate I.D. card is utilized for behavioral health services.

B.2.d Describe whether the BHO or the Offeror is responsible for resolution of mental health and substance abuse complaints and grievances. If the BHO is responsible for handling this function, does the Offeror impose reporting requirements on the BHO and with what frequency?

B.2.e Does the Offeror have a recent monitoring report of the BHO's performance, if applicable? If so, briefly summarize any findings and corrective actions.

B.2.f Indicate whether the Offeror has an approved DOH oversight plan for services provided by the BHO, if applicable, and the date that the oversight plan was approved.

B.3 Records Retention and Availability

B.3.a Describe how and where records will be maintained and the process and timeframe for retrieving any records needed or requested by the Department or other Commonwealth or external review representatives. (Offerors may be required to submit written policies and procedures at a later time.)

B.4 Fraud and Abuse

B.4.a Describe the types of fraud detection methods employed by the Offeror, e.g., fraud auditing software and staff training.

B.4.b Describe the steps taken if fraud is detected.

B.4.c Describe the Offeror's plan for compliance with the Exclusion Program of the United States Department of Health and Human Services, Office of Inspector General.

B.5 Patient Safety

B.5.a Describe the Offeror's efforts, in general, related to patient safety and the reduction of medical errors, including the Offeror's infrastructure for systematic collection of data on medical errors.

B.5.b What national standard(s) does the Offeror rely upon for determining its policies and procedures related to patient safety and the reduction of medical errors?

B.5c Summarize the most current reports or studies on the results of the Offeror's efforts to reduce medical errors.

C. Disease Management

C.1.a Describe the policies, procedures, and processes you use to provide disease management for members with the following specific diseases the Department is requiring for CHIP enrollees: asthma, diabetes, obesity, and tobacco use prevention and cessation (all tobacco products). Include in your description:

- ***Identification and outreach to members requiring disease management services.***
- ***Stratification (risk levels) and interventions you will implement for each risk level to provide disease management services for these members.***
- ***Facilitation and monitoring of recipient compliance with treatment plans.***
- ***Chronic care management programs and how you manage recipients with chronic conditions.***
- ***Chronic care teams.***

Describe any future quality improvement activities or plans to improve your disease management program(s) outcomes.

C.1.b Describe, in general, the staff assigned to specific disease management programs. Include areas of specialty, experience level, and the like.

C.1.c Describe data sources used to identify potential candidates for disease management programs by using the following format. Separately identify for each disease management program. Indicate if the data source is a primary source by a checkmark in the fourth column.

Program:			
Data Sources	YES	Primary Sources	YES
Medical care inpatient claims		Medical care inpatient claims	
Medical care outpatient claims		Medical care outpatient claims	
Laboratory reports		Laboratory reports	
Pharmacy claims		Pharmacy claims	
Physician referral		Physician referral	
UM referral		UM referral	
HRAs		HRAs	
Self-referral		Self-referral	
Predictive algorithms using several different data sources		Predictive algorithms using several different data sources	

C.1.d Describe use of technology in the delivery of the Offeror's disease management programs. Include what services are currently offered on-line and any future plans for expansion. Provide web addresses and visitor ID# for demonstration. Describe the software you use to identify and track outcomes of members for whom you are managing care, including predictive modeling software (limit to two pages).

C.1.e Describe the components of the Offeror's disease management programs by using the format below. Of those identified, indicate the top three priorities. If different for each disease management program, complete a separate chart for each program. Indicate in the second column the top three primary components.

Program:	
Program Components	Primary Focus Areas
Patient education	Patient education
Physician education	Physician education
Self management	Self management
Treatment plan adherence	Treatment plan adherence
Medical therapy	Medical therapy
Lifestyle management	Lifestyle management
Behavior change approaches	Behavior change approaches

Program:	
Program Components	Primary Focus Areas
Measurement, monitoring, and reporting outcomes	Measurement, monitoring, and reporting outcomes
Other (describe)	Other (describe)

C.1.f Describe the Offeror's approach for monitoring and measuring program process and outcomes for each disease management program. Use the following format by indicating the process and outcome measure, what specifically is measured, how it is measured, and the specific tools used to evaluate the program's impact.

Program:			
Measures	Specific Measures	Method/Tool Used to Collect	Frequency of Collection
Process Measures			
Participation Rates			
Satisfaction			
Provider performance			
Other			
Outcome Measures			
Health risk changes			
Clinical outcomes			
Functional status			
Financial results			
Other			

C.1.g. Describe any provider incentive programs that reward quality outcomes, resulting in improvements in chronic care measures. Describe any hospital incentive programs that reward medical error reductions. Provide information on whether the programs have been successful, including what percent of network providers have met performance requirements and received rewards, if applicable. Describe your strategy moving forward for provider incentive programs (limit to two pages).

C.1.h. Describe any member incentive programs you have in place to encourage members to engage in wellness programs. Provide information on whether the programs were successful, including what percent of members received incentives. Describe your strategy moving forward for member incentive programs (limit to two pages).

C.1.i Describe the management techniques, policies, procedures or initiatives you have in place to effectively and appropriately control avoidable hospitalization and hospital readmissions. Describe your strategy moving forward to improve performance in this area (limit to two pages).

C.1.j. Describe any present or planned efforts to encourage use of the Chronic Care Model or the Patient-Centered Medical Home by network providers.

C.1.k. Describe any present or planned action to eliminate payment for Never Events as non-medically necessary procedures.

C.1.l. Describe any present or planned actions to eliminate payment to hospitals for additional days of care due to a healthcare-acquired infection.

D. Pharmacy Requirements

D.a Indicate and describe the type of formulary the Offeror will utilize. Open ____ Restrictive _____ . Submit a copy of the Offeror's current formulary (whether open or restrictive).

D.b If utilizing a restrictive formulary describe the exception process.

D.c. Is the formulary that will be used for CHIP the same as the formulary being utilized by the Offeror's general membership? If different, please explain the differences and the rationale for making them different.

D.1 Pharmacy Benefits Manager (PBM)

D.1.a If the Offeror will be utilizing a Pharmacy Benefit Manager (PBM) or a subsidiary company, indicate the type of arrangement and attach a copy of the contractual agreement. PBM _____ Subsidiary _____

D.1.b If applicable, who audits the PBM(s) and how often is each PBM audited?

D.1.c For out-of-state PBMs, are subcontracts written and audited based on Pennsylvania state laws and regulations related to pharmaceutical practices or are audits based on the statutory requirements of the state of domicile?

D.1.d. Does the Offeror require its PBMs or wholly owned or partially owned subsidiaries to provide periodic reports on auditing results? If so, what sanctions are imposed on the PBM or its network of pharmacists when improper activities are detected?

D.2 Rebating Practices

D.2.a For what drugs will the Offeror collect rebates? Will the Offeror obtain rebates on generic drugs as well?

D.2.b Does the Offeror report changes in the rebate program to providers, physicians, third party vendors, and manufacturers when necessary?

D.2.c What formulas will be used to calculate rebates (e.g., "Average Wholesale Price" (AWP), "Wholesale Acquisition Cost" (WAC), or "Average Manufacturer's Price"(AMP))?

D.2.d Who who will process the rebates? How?

D.2.e How will rebates be applied to CHIP?

D.2.f How will any type of disputes with the pharmaceutical manufacturer be handled by the Offeror? How will the disputes be collected and posted?

D.2.g Does the Offeror or its PBM maintain a pharmaceutical manufacturer's rebate billing, recoupment, and reconciliation program?

D.2.h Does the Offeror or its PBM maintain an on-line manufacturer rebate file at the labeler and National Drug Code (NDC) level?

D.3 Drug Utilization Review (DUR) Program

D.3.a Does the Offeror have written policies and procedures regarding DUR? Yes _____ No _____. If no, please explain.
(Note: Offeror may be required to submit written policies and procedures for review at a later date.)

D.3.b Does the Offeror or its PBM maintain a statewide, online, real-time electronic eligibility verification and claims processing system?

D.3.c Does the Offeror or its PBM maintain a surveillance and therapeutic DUR program (concurrent and retrospective) to monitor and correct, where necessary, misutilization, inappropriate prescribing, and dispensing in these programs?

D.3.d Does the Offeror or its PBM prepare routine and ad hoc summary reports to depict and analyze program expenditures, participant characteristics (cardholder, provider, physician), and drug usage patterns?

D.3.e Does the Offeror or its PBM maintain an audit recoupment system to recover monies from providers and cardholders who have had audited costs disallowed, or to suspend payments to providers when warranted?

D.3.f Does the Offeror or its PBM have a process for the communication of counseling for enrollees based on standards established by state law and for the maintenance of enrollee profiles?

E. Provider Networks

E.1 Adequacy

E.1.a Describe how the adequacy of the provider network is determined and your plan to ensure that your provider network meets the network and access requirements in the Agreement.

E.1.b. Describe the method you plan to use on an ongoing basis to assess and ensure that the network standards outlined in the Agreement are maintained for all provider types on an ongoing basis (i.e., travel requirements, appointment access standards, detection, detection of fraud and abuse).

E.1.c Describe how the Offeror conducts recruitment in the event of "gaps" or shortages in the network, especially in rural or underserved areas.

E.1.d Describe your organization's policy to ensure that all licensed health care providers – including nurses, certified registered nurse practitioners, advanced nurse practitioners, midwives, physician assistants, dental hygienists, and expanded function dental assistants can practice to the fullest extent of their education and training. Provide the percent of your network that comprises these non-physician health care providers.

E.1.e All Offerors must provide the provider network information requested in IV-4.E.1 on CDROM or diskette in the Excel format specified.

E.2 Cultural Competence

E.2.a. Describe the management techniques, policies, or initiatives you have in place to promote the cultural compentency of your network providers. Describe your strategy moving forward to improve performance in this area.

E.2.b Indicate the number of physicians in the network that have proficiency in the indicated languages using the following chart:

Language	Number of physicians	Language	Number of physicians
Afghan Persian		**Lithuanian**	
Afrikaans		**Mahratti**	
Albanian		**Malay**	
Arabic		**Malayalam**	
Aramaic		**Mandarin**	
Armenian		**Marathi**	
Asian Indian		**Norwegian**	
Assyrian		**Pakistani**	
Bengali		**Pashai**	
Burmese		**Pashtu**	
Cantonese		**Pilipino**	
Chinese		**Polish**	
Chinese Dialect		**Portuguese**	
Croatian		**Punjabi**	
Czech		**Rumanian**	
Danish		**Russian**	
Dutch		**Sanskrit**	
Egyptian		**Serbian**	
Farsi		**Setswana**	
Finnish		**Shona**	
Flemish		**Sign Language**	
French		**Sindhi**	
German		**Sinhalese**	
Greek		**Slovak**	
Gujarati		**Spanish**	
Hebrew		**Swahili**	
Hindi		**Swedish**	
Hindu		**Tagalog**	
Hungarian		**Taiwanese**	
Ibo		**Tamil**	
Ilocano		**Telugu**	
Indian		**Thai**	
Indonesian		**Tunisian**	
Iranian		**Turkish**	
Italian		**Turkmen**	
Japanese		**Ukrainian**	
Kannada		**Urdu**	
Korean		**Vietnamese**	
Laos		**Visayan**	
Latvian		**Yiddish**	
Lebanese		**Yoruba**	

E.2.c Describe any specific efforts to recruit or address a culturally diverse provider network.

E.2.d Provide a detailed narrative of how the Offeror monitors contracts for Civil Rights compliance and ensures that individuals with Limited English Proficiency are provided with access to benefits and services by the plan.

E.2.e Describe specific efforts to recruit certified or other bilingual translators for customer service functions or to use language lines to ensure that parents/patients speaking another language can communicate with network providers.

E.3. PCP/Medical Home Responsibility

E.3.a. Describe your method of monitoring and evaluating PCP compliance with availability and scheduling requirements outlined in the Agreement. What is your plan to ensure PCP-to-member ratio requirements are maintained throughout the term of the Agreement?

E.3.b Describe your method of ensuring that members have access to medical care for needs that arise after hours and for urgent, non-emergency situations. How do you monitor providers to ensure that follow-up is done with the member and the member's PCP to facilitate transfer of information from the after-hours provider? Describe any incentive programs you have in place to improve access to care by rewarding providers who provide extended and/or after hours care. (Limit to two pages.)

E.4 Certified Registered Nurse Practitioner (CRNP) as a PCP/Medical Home

E.4.a Describe the Offeror's: (1) credentialing criteria for CRNPs operating as a primary care practice; (2) the number of CRNP practices, names, and locations of CRNP practices; and (3) efforts to recruit or expand the number of CRNPs and Licensed Nurse-Midwives in rural or underserved areas.

E.4.b Describe the Offeror's payment policies that reimburse Licensed Nurse-Midwives and CRNPS for all services provided within the scope of their practice.

E.5 Standing Referrals/Specialist as a PCP/Medical Home

E.5.a Describe the Offeror's guidelines for standing referrals to specialists as a PCP/Medical Home.

E.7 Physician Specialists

E.7.a Will referrals to specialists be required? If yes, does the contractor have any intention of discontinuing the need for a referral to a specialist at a future date? If only certain types of specialist referrals will be required, list those specialties.

E.8 Federally Qualified Health Centers (FQHCs) and Community Health Center (CHC) Look-alikes

E.8.a Describe whether the Offeror currently contracts with FQHCs or CHCs. If so, please provide a list of such providers, how they are reimbursed (per medical provider or by facility), and whether they are reimbursed via fee-for-service or capitation.

E.8.b If the Offeror currently has a specific mechanism in place for making referrals to FQHCs or CHCs, please describe the process.

E.8.c If the Offeror currently does not contract with FQHCs or CHCs, describe how it will recruit them.

E.11 Network Changes

E.11.a Describe whether the Offeror experienced any material changes in network composition, as defined in Part IV-4.E.11 during the past three years. Describe the circumstances for such changes and the potential or actual impact on access to care.

E.11.b Indicate by provider type (i.e., PCP, specialist, OB/GYN, etc.) the percentage of providers that were not re-credentialed in the past three years due to performance or quality reasons.

E.11.c Indicate by provider type (i.e., PCP, specialist, OB/GYN, etc.) the percentage of providers that were terminated in the past three years due to performance or quality reasons.

E.11.d Indicate the Offeror's physician turnover rate in the past year for PCPs/Medical Homes and for specialists. Also, indicate the reasons for turnover (i.e., voluntary, involuntary, retirement, etc.).

E.11.e Describe all ancillary services (e.g., labs, physical therapy, and skilled nursing facilities) that are available in network. If not all services are provided in all areas, indicate in which areas the service is not available.

E.11.f Describe how and when enrollees are informed when their providers leave the network.

E.11.g Explain your strategy to address the potential issue of a hospital choosing not to contract with all managed care organizations within a county. Past experience has shown that hospitals may competitively bid for contracts and only contract with a designated number of managed care plans. Should your organization be unable to secure an agreement with a hospital within a county, what strategies will you undertake to ensure that your members will be able to have access to both primary and specialty care? If non-participating providers are initially the only way you can guarantee access within a county, what steps will you take to recruit the providers into your network? (limit to 2 pages)

E. 12 Medical Necessity

E.12.a Provide the Offeror's definition of medical necessity, if different from the definition provided in the RFP.

F. Provider Services

F.1.a Describe the Offeror's provider service functions, including hours of operation and arrangements to deal with emergency provider issues.

G. Appointment Standards

G.1.a Describe, using the following format, the quality standards established for primary care physicians:

Number of patients seen per hour		
Acceptable patient waiting time (in minutes)		
Number of office hours each primary care physician must be available per week.		
Physician call back time in minutes	Emergency	Non-Emergency
Waiting time for scheduling a routine primary care visit.		
Waiting time for scheduling an urgent care visit.		
Access to after hours care.		
Telephone Service		

G.1.b How does the Offeror disseminate and educate its providers about appointment standards?

G.1.c How often does the contractor monitor compliance with appointment standards?

G.1.d Describe how you will ensure that appointment access standards are met when members cannot access care within your provider network and must go to an out-of-network provider.

H. Quality Management and Utilization Management Program Requirements (QM/UMP)

H.1 Objectives

H.1.a Quality Management (QM)

H.1.a.1 Describe how the Offeror monitors physician adherence to clinical guidelines/protocols and what interventions are used when physicians fail to comply.

H.1.a.2 If the Offeror pays financial bonuses to physicians tied to measures of quality, describe the measures that bonuses are tied to (e.g., measures of efficiency, quality of care, and cost containment). Provide examples and results (e.g., a sample copy of the kind of report sent to a physician).

H.1.a.3 If the Offeror pays financial bonuses to physicians tied to measures of quality specific to the CHIP population, please describe these measures if different than in H.1.a.2 above.

H.1.b Utilization Management (UM)

H.1.b.1 If the Offeror is contracting with an independent Utilization Review firm, please identify the firm(s).

H.1.b.2 Describe the Offeror's inpatient/outpatient utilization management program and include protocols for:

- ***Determining medical necessity;***
- ***Denial of services;***
- ***Prior authorization;***
- ***Hospital discharge planning;***
- ***Retrospective review of claims; and***
- ***The structure, committee, staff, or system used by the carrier to conduct utilization management activities.***

H.1.b.3 Describe the process and criteria used for concurrent review.

H.1.b.4 Describe the procedure when a call to request pre-certification is received outside of normal working hours.

H.1.b.5 Describe if and how the utilization review system is linked with claims processing.

H.1.b.6 Describe how review results are made available to claims processors. Include a description of safeguards to prevent payment for non–covered or denied services.

H.1.b.7 Describe the Offeror's internal quality control procedures.

H.1.b.8 Does the Offeror utilize predictive modeling software? If so, for what purpose?

H.1.c Complaint and Grievance Procedures

H.1.c.1 Describe how the Offeror handles complaints and grievances, and address how that process satisfies the requirements of Act 1998-68 and the managed care rules and regulations .

H.1.c.2 Describe the Offeror's enrollee appeal process including all levels of review and timing.

H.1.c.3 Describe the Offeror's criteria for referring a case to a physician. What percentage of disputes are referred to a staff physician or specialist consultant? What percentage of cases is denied? What percentage of denials is maintained on appeal?

H.1.c.4 Describe the appeals process for both denials of admissions and procedures, as well as disputes between the attending physician and review staff. Specify if the process is different in-network versus out-of-network.

H.1.c.5 Describe how the Offeror tracks and trends all complaints and grievances and how the Offeror uses that data to make changes to procedures and processes.

H.1.c.6 Describe how the Offeror monitors customer satisfaction with the Offeror's performance and services. Include how customer satisfaction data/information is used in ongoing quality-improvement efforts and the innovative approaches used to increase customer satisfaction.

H.2 General Requirements

H.2.a Describe the process and criteria used for case management, including how the Offeror will manage and what services the Offeror will provide. Address the following issues in the response:

- ***How does the Offeror identify potential case management situations?***
- ***If the Offeror uses a list of diagnoses to identify cases for management, provide the list.***

- ***Once a case is identified, how does the Offeror determine whether to pursue a case for management?***
- ***How do the Offeror's case managers interact with the patients (and the patient's primary care physician), family, and attending physicians?***
- ***What percentage of the Offeror's managed care membership is enrolled in case management?***
- ***How many levels of case management does the Offeror provide? What are the Offeror's ongoing strategies for increasing enrollment and for identifying enrollees who are eligible for case management?***
- ***Describe any measurable results in terms of clinical outcomes and cost effectiveness that have resulted from your care coordination activities.***
- ***Describe your strategy moving forward to improve coordination of care.***

H.2.b Once a patient is assigned a case manager, does that case manager remain permanently assigned to the patient throughout his/her enrollment in the program?

H.2.c Describe how case managers identify and evaluate local health care resources for alternative treatment.

H.2.d What are the Offeror's case managers' credentials?

H.2.e Is there a separate charge for services provided by a case manager?

H.2.f Provide a copy of the Offeror's NCQA accreditation certificate. If the Offeror is not accredited by NCQA, indicate circumstances that have prevented the Offeror from obtaining certification.

H.2.g If the Offeror is not submitting an NCQA accreditation certificate with this proposal due to a previous submission to the Department within the past year, please indicate below:

- ***Previously submitted to Department on (date); and***
- ***Accreditation Timeframe From: To:***

H.5 Chronic Care Learning Collaboratives Participation

H.5.a If you are currently participating in a Chronic Care Learning Collaborative, please describe your current responsibilities and the current term of your commitment.

I. Emergency Preparedness

I.1. Describe how you anticipate an emergency or crisis will impact your operations.

I.2. Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness:

- ***Employee training (describe your organization's training plan, and how frequently your plan will be shared with employees);***
- ***Identified essential business functions and key employees within your organization necessary to carry them out;***
- ***Contingency plans for:***
  - ***How your organization will handle staffing issues when a portion of key employees are incapacitated due to illness; and***
  - ***How employees in your organization will carry out the essential functions if contagion control measures prevent them from coming to the primary workplace;***
- ***How your organization will communicate with staff and suppliers when primary communications systems are overloaded or otherwise fail, including key contacts, chain of communications (including suppliers), etc.; and***
- ***How and when your emergency plan will be tested, and if the plan will be tested by a third-party.***

<u>IV-5. Financial and Project Control</u>

A. Financial Standards

A.1 Risk Protection for High Cost Cases

A.1.a Describe the Offeror's risk protection mitigation funding for high-cost cases.

C. Performance Management and Reporting Requirements

C.2 Data Processing and Communications Capabilities

C.2.b Use of CAPS

C.2.b.1 Provide a general systems description, including: A systems diagram that describes each component of the management information system and all other systems that interface with or support it and how each component will support the major functional areas of CHIP (In-Plan Services; Disease Management; Member Services; Complaints & Grievances; Pharmacy; Provider Network; Provider Services; Service Access; QM/UMP; Claims Payment and Processing; Encounter Data Reporting System, Disaster Recovery, etc.).

C.2.b.2 What is the current capacity of your MIS/claims processing? Explain your process to readily expand your MIS/claims processing should the capacity of either be exceeded through enrollment of program members.

C.2.b.3 Explain your process for ensuring your subcontractors meet the same MIS requirements for which you are responsible.

C.2.b.4 Describe the capability your management will have to access a database of service information to create ad hoc reports for both your MCP management and the Department. Include a description of the system and software, an overview of the data that will be held, and the resources and the capability you will have to use large amounts of data to create ad hoc reports.

C.2.b.5 Describe the capability you will have to access your subcontractor's information to create ad hoc reports for subcontractor oversight and for the Department upon request.

C.2.b.6 Describe in detail your process for utilizing the daily and monthly files to manage your membership. Include the process for resolving discrepancies between your membership data and the above files.

C.2.b.7 Explain in detail your process for providing membership information to each of your subcontractors (dental, vision, etc.). Include the subcontractor's name, their purpose, and how often membership data is submitted.

C.2.b.8 What is your plan to ensure that claims timeliness standards are met and that providers are paid timely?

C.2.b.9 Describe whether the Offeror has procedures for cross-matching applicants against current enrollees in commercial coverage provided by the Offeror.

C.2.c Modifications to CAPS

C.2.c.1 Explain how the process of User Acceptance Testing will be managed to ensure that the objectives listed in Part IV-5.C.2.c are met.

C.2.d Data Warehouse Requirements

C.2.d.1 Describe your approach for ensuring complete encounter data is submitted accurately and timely to the Department consistent with required formats.

C.2.d.2 How will you ensure and verify that providers and subcontractor(s) submit timely, accurate, complete and required encounter data elements to you for subsequent transmission to the Department?

C.2.d.3 How will you manage the non-submission of encounter data by a provider or subcontractor? Will it result in any assessment of penalties?

C.2.d.4 Explain your process for maintaining your provider file with detailed information on each provider that is able to support provider payment and also meet the Department's reporting and Encounter Data Requirements. Include how you cross-reference your internal provider ID number with the provider's NPI number.

3. Preparation of the Disadvantaged Business Submittal

Offerors should prepare the Disadvantaged Business Submittal according to the directions in the RFP at Part II, Section II-10. Evaluation of the Disadvantaged Business Submittal will be as described in Part III, Section III-4.C. As a reminder, this submittal should be sealed separately from the technical submittal and the cost submittal.

4. Preparation of the Domestic Workforce Utilization Certificate

Offerors should prepare the Domestic Workforce Utilization Certificate contained in Appendix B of the RFP and explained in Part II, Section II-12. Offerors who seek consideration for this criterion must submit in hardcopy the signed Domestic Workforce Utilization Certification Form in the same sealed envelope with the Cost Submittal.

5. Preparation of the Cost Submittal

The cost proposal must be prepared according to the instructions contained in Part II-11 of the RFP.

Each proposal must include the cost proposal sealed separately from the Technical Submittal and from the Disadvantaged Business Submittal. An original and two (2) copies of the cost proposal must be provided.

Include the Rate Calculation Sheet (RCS) for each Contracted Service Area.